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# Health & Human Services Committee

**Wednesday, February 26, 2020  
9:00 AM – 12:00 PM  
Morris Hall (17 HOB)**

**Meeting Packet**

# Committee Meeting Notice

## HOUSE OF REPRESENTATIVES

### Health & Human Services Committee

**Start Date and Time:** Wednesday, February 26, 2020 09:00 am

**End Date and Time:** Wednesday, February 26, 2020 12:00 pm

**Location:** Morris Hall (17 HOB)

**Duration:** 3.00 hrs

#### Consideration of the following bill(s):

HB 389 Testing for and Treatment of Influenza and Streptococcus by Sirois

HB 563 Procurement of Human Organs and Tissue by Daley

CS/HB 607 Health Care Practitioners by Health Quality Subcommittee, Pigman

CS/HB 731 Agency for Health Care Administration by Health Market Reform Subcommittee, Perez

CS/HB 945 Children's Mental Health by Children, Families & Seniors Subcommittee, Silvers

CS/HB 1163 Intermediate Care Facilities by Health Market Reform Subcommittee, Burton

HB 1341 Massage Therapy by Goff-Marcil

CS/HB 1373 Long-term Care by Health Market Reform Subcommittee, Webb

HB 7017 Advanced Practice Registered Nurses' Registration Fees by Health Quality Subcommittee, Plasencia

HB 7085 Dependency Proceedings and Child Protection Services by Children, Families & Seniors

Subcommittee, Roth

#### Consideration of the following proposed committee substitute(s):

PCS for CS/HB 7053 -- Direct Care

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, February 25, 2020.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, February 25, 2020.

**NOTICE FINALIZED on 02/24/2020 4:05PM by Dewees.Cheryl**



## 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.<sup>1</sup> The Board of Pharmacy (board), in conjunction with the Department of Health (DOH), regulates the practice of pharmacists pursuant to ch. 465, F.S.<sup>2</sup> To be licensed as a pharmacist in Florida, a person must:<sup>3</sup>

- 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;<sup>4</sup>
- 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.<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>

##### Pharmacist Scope of Practice

In Florida, the practice of the profession of pharmacy includes:<sup>8</sup>

- 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;<sup>9</sup>
- Administering vaccines to adults;<sup>10</sup>
- Administering epinephrine injections;<sup>11</sup> and

<sup>1</sup> American Association of Colleges of Pharmacy, *About AACP*, available at <https://www.aacp.org/about-aacp> (last visited October 30, 2019).

<sup>2</sup> Sections 465.004 and 465.005, F.S.

<sup>3</sup> 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.

<sup>4</sup> 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

<sup>5</sup> Section 465.009, F.S.

<sup>6</sup> Section 465.009(6), F.S.

<sup>7</sup> Section 465.1893, F.S.

<sup>8</sup> Section 465.003(13), F.S.

<sup>9</sup> A Class III institutional pharmacy are those pharmacies affiliated with a hospital. See s. 465.019(2)(d), F.S.

<sup>10</sup> See s. 465.189, F.S.

- Administering antipsychotic medications by injection.<sup>12</sup>

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.<sup>13</sup>

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.<sup>14</sup> The formulary may only include:<sup>15</sup>

- 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:<sup>16</sup>

- 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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<sup>11</sup> *Id.*

<sup>12</sup> Section 465.1893, F.S.

<sup>13</sup> *Supra* note 8.

<sup>14</sup> Section 465.186, F.S.

<sup>15</sup> *Id.*

<sup>16</sup> Rule 64B16-27.220, F.A.C.

wherever they live.<sup>17</sup> 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.<sup>18</sup>

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.<sup>19</sup> 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.<sup>20</sup>

### *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.<sup>21</sup> 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.;<sup>22</sup> which must:<sup>23</sup>
  - 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;<sup>24</sup>
- Pass an examination and demonstrate vaccine administration technique;<sup>25</sup>
- 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;<sup>26</sup> and
- Maintain at least \$200,000 of professional liability insurance.<sup>27</sup>

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

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<sup>17</sup> American Society of Consultant Pharmacists, *What is a Consultant Pharmacist*, available at <http://www.ascp.com/page/whatisacp> (last visited October 30, 2019).

<sup>18</sup> Rule 64B16-26.300(3), F.A.C.

<sup>19</sup> Section 465.0125(1), F.S.

<sup>20</sup> 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.

<sup>21</sup> Section 465.189, F.S. A registered intern may also administer immunizations or vaccinations under the supervision of a certified pharmacist.

<sup>22</sup> Section 465.189(1), F.S.

<sup>23</sup> Section 465.189(7), F.S.

<sup>24</sup> 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.

<sup>25</sup> *Id.*

<sup>26</sup> 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.

<sup>27</sup> Section 465.189(3), F.S.

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

### *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<sup>30</sup> approved by the United States Food and Drug Administration.<sup>31</sup> To be eligible to administer such injections, a pharmacist must:<sup>32</sup>

- 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,<sup>33</sup> 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.<sup>34</sup>

### Diagnostic Tests for Influenza and Streptococcus

#### *Influenza*

Influenza (flu) is a viral, contagious respiratory illness that infects the nose, throat, and sometimes the lungs.<sup>35</sup> Although the flu virus may be detected at any time of the year, the flu virus is most common during the fall and winter.<sup>36</sup> 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.<sup>37</sup> Annually, the flu costs businesses and employers \$10.4 billion in direct costs for hospitalizations and outpatient visits for adults.<sup>38</sup>

A person who has contracted the flu virus is most contagious in the first three to four days after the illness begins.<sup>39</sup> 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.<sup>40</sup> According to the CDC, most people infected with the flu will have a mild illness and do not need medical care or antiviral medication.<sup>41</sup> The CDC recommends an annual vaccination as the best way to prevent flu.<sup>42</sup>

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<sup>28</sup> Section 465.189(2), F.S.

<sup>29</sup> Section 465.189(5), F.S.

<sup>30</sup> 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).

<sup>31</sup> Chapter 2017-134, Laws of Fla., codified at s. 465.1893, F.S.

<sup>32</sup> Id.

<sup>33</sup> Section 381.0098, F.S., and r. 64E-16, F.A.C., regulate the disposal of biomedical waste.

<sup>34</sup> Section 465.1893(1)(b), F.S.

<sup>35</sup> 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).

<sup>36</sup> 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).

<sup>37</sup> *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).

<sup>38</sup> 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](https://www.cdc.gov/flu/pdf/business/toolkit_seasonal_flu_for_businesses_and_employers.pdf) (last visited October 30, 2019).

<sup>39</sup> *Supra* note 35.

<sup>40</sup> Id.

<sup>41</sup> 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.<sup>43</sup> 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.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup>

Rapid molecular assays are a new type of diagnostic test to detect viral flu and provide results in 15-30 minutes.<sup>47</sup> 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.<sup>48</sup>

Testing is not needed for all patients with signs and symptoms of flu to make antiviral treatment conditions.<sup>49</sup> 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.<sup>50</sup> 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).<sup>51</sup> Group B strep may cause blood infections, pneumonia, and meningitis in newborns,

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<sup>42</sup> *Supra* note 35.

<sup>43</sup> *Supra* note 41.

<sup>44</sup> *Supra* note 35.

<sup>45</sup> 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](https://www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm) (last visited October 30, 2019).

<sup>46</sup> *Id.*

<sup>47</sup> 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).

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*, and *supra* note 45.

<sup>50</sup> 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)).

<sup>51</sup> 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.<sup>52</sup> Strep throat, along with minor skin infections, are the most common group A strep infection.<sup>53</sup>

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.<sup>54</sup> 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.<sup>55</sup> 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.<sup>56</sup>

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.<sup>57</sup> Results are generally available in 7 to 15 minutes.<sup>58</sup> RADTs, in general, have high diagnostic accuracy, with tests using newer techniques providing the greatest accuracy.<sup>59</sup>

### 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.<sup>60</sup> DOH, by rule, has designated the diseases and conditions that must be reported, as well as the timeframes for such reports.<sup>61</sup> A suspected or confirmed diagnosis of flu that is caused by a novel or pandemic strain must be reported immediately.<sup>62</sup> 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.<sup>63</sup> The practitioner must make the patient's medical records for such diseases available for onsite inspection by DOH.<sup>64</sup>

### 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

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<sup>52</sup> Id.

<sup>53</sup> 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).

<sup>54</sup> 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).

<sup>55</sup> 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).

<sup>56</sup> *Supra* note 51.

<sup>57</sup> John Mersch, MD, FAAP, MedicineNet.Com, *Rapid Strep Test*, available at [https://www.medicinenet.com/rapid\\_strep\\_test/article.htm](https://www.medicinenet.com/rapid_strep_test/article.htm) (last visited February 21, 2019).

<sup>58</sup> American Academy of Family Physicians, *Rapid Strep Test*, available at <https://familydoctor.org/rapid-strep-test/?adfree=true> (last visited October 31, 2019).

<sup>59</sup> 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).

<sup>60</sup> Section 381.0031, F.S. and r. 64D-3.030, F.A.C. Medical examiners, hospitals, and laboratories are also required to report the diagnosis or suspected existence of such diseases to DOH.

<sup>61</sup> 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).

<sup>62</sup> Id.

<sup>63</sup> Rule 64D-3.030, F.A.C.

<sup>64</sup> 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);<sup>65</sup>
- 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.<sup>66</sup> 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.

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<sup>65</sup> 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://www.cdc.gov/clia/resources/waivedtests/default.aspx> (last visited February 21, 2019).

<sup>66</sup> 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

1                                   A bill to be entitled  
 2           An act relating to the testing for and treatment of  
 3           influenza and streptococcus; amending s. 381.0031,  
 4           F.S.; requiring specified licensed pharmacists to  
 5           report certain information to the Department of  
 6           Health; amending s. 465.003, F.S.; revising the  
 7           definition of the term "practice of the profession of  
 8           pharmacy"; creating s. 465.1895, F.S.; authorizing  
 9           pharmacists to test for and treat influenza and  
 10          streptococcus and providing requirements relating  
 11          thereto; requiring that the written protocol between a  
 12          pharmacist and supervising physician contain certain  
 13          information, terms, and conditions; requiring the  
 14          Board of Pharmacy to adopt rules within a specified  
 15          time period; requiring that a pharmacist notify a  
 16          patient's primary care provider within a specified  
 17          time period after providing any such testing or  
 18          treatment; providing an effective date.

19  
 20 Be It Enacted by the Legislature of the State of Florida:

21  
 22           Section 1. Subsection (2) of section 381.0031, Florida  
 23 Statutes, is amended to read:

24           381.0031 Epidemiological research; report of diseases of  
 25 public health significance to department.—

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

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

39 465.003 Definitions.—As used in this chapter, the term:

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

51 with the patient's prescribing health care provider as licensed  
52 under chapter 458, chapter 459, chapter 461, or chapter 466, or  
53 similar statutory provision in another jurisdiction, or such  
54 provider's agent or such other persons as specifically  
55 authorized by the patient, regarding the drug therapy. However,  
56 nothing in this subsection may be interpreted to permit an  
57 alteration of a prescriber's directions, the diagnosis or  
58 treatment of any disease, the initiation of any drug therapy,  
59 the practice of medicine, or the practice of osteopathic  
60 medicine, unless otherwise permitted by law. "Practice of the  
61 profession of pharmacy" also includes any other act, service,  
62 operation, research, or transaction incidental to, or forming a  
63 part of, any of the foregoing acts, requiring, involving, or  
64 employing the science or art of any branch of the pharmaceutical  
65 profession, study, or training, and shall expressly permit a  
66 pharmacist to transmit information from persons authorized to  
67 prescribe medicinal drugs to their patients. The practice of the  
68 profession of pharmacy also includes the administration of  
69 vaccines to adults pursuant to s. 465.189, the testing for and  
70 treatment of influenza and streptococcus pursuant to s.  
71 465.1895, and the preparation of prepackaged drug products in  
72 facilities holding Class III institutional pharmacy permits.

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

75 465.1895 Testing for and treatment of influenza and



76 streptococcus.—

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

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

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

85 (c) The pharmacist uses a testing system that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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COMMITTEE/SUBCOMMITTEE ACTION

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

---

1 Committee/Subcommittee hearing bill: Health & Human Services  
 2 Committee

3 Representative Sirois offered the following:

4  
 5 **Amendment (with title amendment)**

6 Remove everything after the enacting clause and insert:

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

9 381.0031 Epidemiological research; report of diseases of  
 10 public health significance to department.-

11 (2) Any practitioner licensed in this state to practice  
 12 medicine, osteopathic medicine, chiropractic medicine,  
 13 naturopathy, or veterinary medicine; any licensed pharmacist  
 14 authorized under a protocol with a supervising licensed  
 15 physician, under s. 465.1895, or a collaborative pharmacy  
 16 practice agreement, as defined in s. 465.1865, to perform or

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17 order and evaluate laboratory and clinical tests; any hospital  
18 licensed under part I of chapter 395; or any laboratory  
19 appropriately certified by the Centers for Medicare and Medicaid  
20 Services under the federal Clinical Laboratory Improvement  
21 Amendments and the federal rules adopted thereunder which  
22 diagnoses or suspects the existence of a disease of public  
23 health significance shall immediately report the fact to the  
24 Department of Health.

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

27 465.003 Definitions.—As used in this chapter, the term:

28 (13) "Practice of the profession of pharmacy" includes  
29 compounding, dispensing, and consulting concerning contents,  
30 therapeutic values, and uses of any medicinal drug; consulting  
31 concerning therapeutic values and interactions of patent or  
32 proprietary preparations, whether pursuant to prescriptions or  
33 in the absence and entirely independent of such prescriptions or  
34 orders; and conducting other pharmaceutical services. For  
35 purposes of this subsection, "other pharmaceutical services"  
36 means the monitoring of the patient's drug therapy and assisting  
37 the patient in the management of his or her drug therapy, and  
38 includes review of the patient's drug therapy and communication  
39 with the patient's prescribing health care provider as licensed  
40 under chapter 458, chapter 459, chapter 461, or chapter 466, or  
41 similar statutory provision in another jurisdiction, or such

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42 provider's agent or such other persons as specifically  
43 authorized by the patient, regarding the drug therapy; and  
44 initiating, modifying, or discontinuing drug therapy for a  
45 chronic health condition under a collaborative pharmacy practice  
46 agreement. ~~However,~~ Nothing in this subsection may be  
47 interpreted to permit an alteration of a prescriber's  
48 directions, the diagnosis or treatment of any disease, the  
49 initiation of any drug therapy, the practice of medicine, or the  
50 practice of osteopathic medicine, unless otherwise permitted by  
51 law or specifically authorized by s. 465.1865 or s. 465.1895.  
52 "Practice of the profession of pharmacy" also includes any other  
53 act, service, operation, research, or transaction incidental to,  
54 or forming a part of, any of the foregoing acts, requiring,  
55 involving, or employing the science or art of any branch of the  
56 pharmaceutical profession, study, or training, and shall  
57 expressly permit a pharmacist to transmit information from  
58 persons authorized to prescribe medicinal drugs to their  
59 patients. The practice of the profession of pharmacy also  
60 includes the administration of vaccines to adults pursuant to s.  
61 465.189, the administration of long-acting medication pursuant  
62 to s. 465.1893, the testing or screening for and treatment of  
63 minor, nonchronic health conditions under s. 465.1895, and the  
64 preparation of prepackaged drug products in facilities holding  
65 Class III institutional pharmacy permits.

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66 Section 3. Section 465.1865, Florida Statutes, is created  
67 to read:

68 465.1865 Collaborative pharmacy practice for chronic  
69 health conditions.-

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

71 (a) "Collaborative pharmacy practice agreement" means a  
72 written agreement between a pharmacist who meets the  
73 qualifications of this section and a physician licensed under  
74 chapter 458 or chapter 459 in which a collaborating physician  
75 authorizes a pharmacist to provide specified patient care  
76 services to the collaborating physician's patients.

77 (b) "Chronic health condition" means a condition that  
78 typically lasts more than 1 year and requires ongoing medical  
79 attention, limits activities of daily living, or both. Such  
80 condition may include, but is not limited to:

81 1. Arthritis;

82 2. Asthma;

83 3. Congestive heart failure;

84 4. Chronic obstructive pulmonary diseases;

85 5. Diabetes;

86 6. Emphysema;

87 7. Human immunodeficiency virus or acquired  
88 immunodeficiency syndrome;

89 8. Hypertension;

90 9. Obesity;

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91 10. Renal disease; or

92 11. Any other chronic condition or comorbidity identified  
93 by the collaborating physician.

94 (2) To provide services under a collaborative pharmacy  
95 practice agreement, a pharmacist must:

96 (a) Hold an active and unencumbered license to practice  
97 pharmacy in this state.

98 (b) Have earned a degree of doctor of pharmacy or have  
99 completed 5 years of experience as a licensed pharmacist.

100 (c) Complete an initial 20-hour course approved by the  
101 board that includes, at a minimum, instruction on the following:

102 1. Performance of patient assessments.

103 2. Ordering, performing, and interpreting clinical and  
104 laboratory tests related to collaborative pharmacy practice.

105 3. Evaluating and managing diseases and health conditions  
106 in collaboration with other health care practitioners.

107 4. Any other area required by the board by rule.

108 (d) Maintain at least \$250,000 of professional liability  
109 insurance coverage. However, a pharmacist who maintains  
110 professional liability insurance coverage pursuant to s.  
111 465.1895 satisfies this requirement.

112 (e) Submit a copy of the signed collaborative pharmacy  
113 practice agreement and proof of satisfying the conditions of  
114 this section to the board before commencing practice.



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115 (f) Maintain records of all patients receiving services  
116 under a collaborative pharmacy practice agreement for a period  
117 of 5 years.

118 (3) The terms and conditions of the collaborative pharmacy  
119 practice agreement must be appropriate to the pharmacist's  
120 training and the services delegated to the pharmacist must be  
121 within the collaborating physician's scope of practice.

122 (a) A collaborative pharmacy practice agreement must  
123 include the following:

124 1. Name of the patient or patients for whom a pharmacist  
125 may provide services.

126 2. Each chronic disease to be collaboratively managed.

127 3. Specific medicinal drug or drugs to be managed by the  
128 pharmacist.

129 4. Circumstances under which the pharmacist may order or  
130 perform and evaluate laboratory or clinical tests.

131 5. Conditions and events upon which the pharmacist must  
132 notify the collaborating physician and the manner and timeframe  
133 in which such notification must occur.

134 6. Beginning and ending dates for the collaborative  
135 pharmacy practice agreement and termination procedures,  
136 including procedures for patient notification and medical  
137 records transfers.

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138 7. A statement that the collaborative pharmacy practice  
139 agreement may be terminated, in writing, by either party at any  
140 time.

141 (b) A collaborative pharmacy practice agreement must be  
142 renewed at least every 2 years.

143 (c) The pharmacist, along with the collaborating  
144 physician, must maintain on file the collaborative pharmacy  
145 practice agreement at his or her practice location, and must  
146 make such agreements available upon request or inspection.

147 (4) A pharmacist may not:

148 (a) Modify or discontinue medicinal drugs prescribed by a  
149 health care practitioner with whom he or she does not have a  
150 collaborative practice agreement.

151 (b) Enter into a collaborative pharmacy practice agreement  
152 while acting as an employee without the written approval of the  
153 owner of the pharmacy.

154 (5) A physician may not delegate the authority to initiate  
155 or prescribe a controlled substance as defined in s. 893.03 or  
156 21 U.S.C. s. 812 to a pharmacist.

157 (6) A pharmacist who practices under a collaborative  
158 pharmacy practice agreement must complete an 8-hour continuing  
159 education course approved by the board that addresses issues  
160 related to collaborative pharmacy practice each biennial  
161 licensure renewal in addition to the continuing education  
162 requirements under s. 465.009. A pharmacist must submit

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163 confirmation of having completed such course when applying for  
164 licensure renewal. A pharmacist who fails to comply with this  
165 subsection shall be prohibited from practicing under a  
166 collaborative pharmacy practice agreement as authorized in this  
167 section.

168 (7) The board shall adopt rules pursuant to ss. 120.536(1)  
169 and 120.54 to implement this section.

170 Section 4. Subsections (2) through (8) of section 465.189,  
171 Florida Statutes, are renumbered as sections (3) through (9),  
172 respectively, subsection (1) and present subsection (6) are  
173 amended, and a new subsection (2) is added to that section, to  
174 read:

175 465.189 Administration of vaccines and epinephrine  
176 autoinjection.—

177 (1) In accordance with guidelines of the Centers for  
178 Disease Control and Prevention for each recommended immunization  
179 or vaccine, a pharmacist, or a registered intern under the  
180 supervision of a pharmacist who is certified under subsection  
181 (7) (6), may administer the following vaccines to an adult  
182 within the framework of an established protocol under a  
183 supervising physician licensed under chapter 458 or chapter 459:

184 (a) Immunizations or vaccines listed in the ~~Adult~~  
185 ~~Immunization Schedule as of February 1, 2015, by the United~~  
186 ~~States Centers for Disease Control and~~ Prevention's Recommended  
187 ~~Prevention. The board may authorize, by rule, additional~~

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188 ~~immunizations or vaccines as they are added to the Adult~~  
189 Immunization Schedule, the United States Centers for Disease  
190 Control and Prevention's Health Information for International  
191 Travel, or the United States Food and Drug Administration's  
192 Vaccines Licensed for Use in the United States.

193 ~~(b) Immunizations or vaccines recommended by the United~~  
194 ~~States Centers for Disease Control and Prevention for~~  
195 ~~international travel as of July 1, 2015. The board may~~  
196 ~~authorize, by rule, additional immunizations or vaccines as they~~  
197 ~~are recommended by the United States Centers for Disease Control~~  
198 ~~and Prevention for international travel.~~

199 (b)(e) Immunizations or vaccines approved by the board in  
200 response to a state of emergency declared by the Governor  
201 pursuant to s. 252.36.

202  
203 A registered intern who administers an immunization or vaccine  
204 under this subsection must be supervised by a certified  
205 pharmacist at a ratio of one pharmacist to one registered  
206 intern.

207 (2) A pharmacist who is certified under subsection (7) may  
208 administer influenza vaccines to individuals 7 years of age and  
209 older within the framework of an established protocol under a  
210 supervising physician licensed under chapter 458 or chapter 459.

211 (7)(6) Any pharmacist or registered intern seeking to  
212 administer vaccines ~~to adults~~ under this section must be

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213 certified to administer such vaccines pursuant to a  
214 certification program approved by the Board of Pharmacy in  
215 consultation with the Board of Medicine and the Board of  
216 Osteopathic Medicine. The certification program shall, at a  
217 minimum, require that the pharmacist attend at least 20 hours of  
218 continuing education classes approved by the board and the  
219 registered intern complete at least 20 hours of coursework  
220 approved by the board. The program shall have a curriculum of  
221 instruction concerning the safe and effective administration of  
222 such vaccines, including, but not limited to, potential allergic  
223 reactions to such vaccines.

224 Section 5. Paragraph (a) of subsection (1) and paragraph  
225 (a) of subsection (2) of section 465.1893, Florida Statutes, are  
226 amended to read:

227 465.1893 Administration of antipsychotic medication by  
228 injection.—

229 (1)(a) A pharmacist, at the direction of a physician  
230 licensed under chapter 458 or chapter 459, may administer a  
231 long-acting antipsychotic medication and extended-release  
232 medications, including controlled substances, to treat substance  
233 abuse disorder or dependency that have been approved by the  
234 United States Food and Drug Administration by injection to a  
235 patient if the pharmacist:

236 1. Is authorized by and acting within the framework of an  
237 established protocol with the prescribing physician.

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238 2. Practices at a facility that accommodates privacy for  
239 nondeltoid injections and conforms with state rules and  
240 regulations regarding the appropriate and safe disposal of  
241 medication and medical waste.

242 3. Has completed the course required under subsection (2).

243 (2) (a) A pharmacist seeking to administer ~~a long-acting~~  
244 ~~antipsychotic~~ medication as described in paragraph (1) (a) of  
245 this section by injection must complete an 8-hour continuing  
246 education course offered by:

247 1. A statewide professional association of physicians in  
248 this state accredited to provide educational activities  
249 designated for the American Medical Association Physician's  
250 Recognition Award (AMA PRA) Category 1 Credit or the American  
251 Osteopathic Association (AOA) Category 1-A continuing medical  
252 education (CME) credit; and

253 2. A statewide association of pharmacists.

254 Section 6. Section 465.1895, Florida Statutes, is created  
255 to read:

256 465.1895 Testing or screening for and treatment of minor,  
257 nonchronic health conditions.-

258 (1) The board, in consultation with the Board of Medicine  
259 and the Board of Osteopathic Medicine, shall adopt rules  
260 identifying the minor, nonchronic health conditions for which a  
261 pharmacist may test or screen for and treat. For purposes of  
262 this section a minor, nonchronic health condition is typically a

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263 short-term condition that is generally managed with minimal  
264 treatment or self-care, including, but not limited to, the  
265 following:

266 (a) Influenza.

267 (b) Streptococcus.

268 (c) Lice.

269 (d) Skin conditions, such as ringworm and athlete's foot.

270 (e) Minor, uncomplicated infections.

271 (2) A pharmacist who tests or screens for and treats  
272 minor, nonchronic health conditions under this section must:

273 (a) Hold an active and unencumbered license to practice  
274 pharmacy in this state.

275 (b) Complete an initial 20-hour education course approved  
276 by the board. The course, at a minimum, must address patient  
277 assessments; point-of-care testing procedures; safe and  
278 effective treatment of minor, nonchronic health conditions; and  
279 identification of contraindications.

280 (c) Maintain at least \$250,000 of liability coverage. A  
281 pharmacist who maintains liability coverage pursuant to s.  
282 465.1865 satisfies this requirement.

283 (d) Report a diagnosis or suspected existence of a disease  
284 of public health significance to the department pursuant to s.  
285 381.0031.

286 (e) Upon request of a patient, furnish patient records to  
287 a health care practitioner designated by the patient.

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288 (f) Maintain records of all patients receiving services  
289 under this section for a period of 5 years.

290 (3) The board shall adopt, by rule, a formulary of  
291 medicinal drugs that a pharmacist may prescribe for the minor,  
292 nonchronic health conditions approved under subsection (1). The  
293 formulary must include medicinal drugs approved by the United  
294 States Food and Drug Administration which are indicated for  
295 treatment of the minor, nonchronic health condition, including  
296 any over-the-counter medication. The formulary may not include  
297 any controlled substance as defined in s. 893.03 or 21 U.S.C. s.  
298 812.

299 (4) A pharmacist who tests or screens for and treats  
300 minor, nonchronic health conditions under this section may use  
301 any tests that may guide diagnosis or clinical decisionmaking  
302 which the Centers for Medicare and Medicaid Services has  
303 determined qualifies for a waiver under the federal Clinical  
304 Laboratory Improvement Amendments of 1988, or the federal rules  
305 adopted thereunder, or any established screening procedures that  
306 can safely be performed by a pharmacist.

307 (5) A pharmacist who tests for and treats influenza or  
308 streptococcus under this section may only provide such services  
309 within the framework of an established written protocol with a  
310 supervising physician licensed under chapter 458 or chapter 459,  
311 and must submit the protocol to the board.



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312 (a) The protocol between a pharmacist and supervising  
313 physician under this subsection must include particular terms  
314 and conditions imposed by the supervising physician relating to  
315 the testing for and treatment of influenza and streptococcus  
316 under this section. The terms and conditions must be appropriate  
317 to the pharmacist's training. At a minimum, the protocol shall  
318 include:

319 1. Specific categories of patients who the pharmacist is  
320 authorized to test for and treat influenza and streptococcus.

321 2. The supervising physician's instructions for the  
322 treatment of influenza and streptococcus based on the patient's  
323 age, symptoms, and test results, including negative results.

324 3. A process and schedule for the supervising physician to  
325 review the pharmacist's actions under the protocol.

326 4. A process and schedule for the pharmacist to notify the  
327 supervising physician of the patient's condition, tests  
328 administered, test results, and course of treatment.

329 5. Other requirements as established by the board in rule.

330 (b) A pharmacist authorized to test for and treat  
331 influenza and streptococcus under the protocol shall provide  
332 evidence of current certification by the board to the  
333 supervising physician. A supervising physician shall review the  
334 pharmacist's actions in accordance with the protocol.

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335 (6) A pharmacist providing services under this section may  
336 not perform such services while acting as an employee without  
337 the written approval of the owner of the pharmacy.

338 (7) A pharmacist providing services under this section  
339 must complete a 3-hour continuing education course approved by  
340 the board addressing issues related to minor, nonchronic health  
341 conditions each biennial licensure renewal in addition to the  
342 continuing education requirements under s. 465.009. Each  
343 pharmacist must submit confirmation of having completed the  
344 course when applying for licensure renewal. A pharmacist who  
345 fails to comply with this subsection may not provide testing,  
346 screening, or treatment services.

347 Section 7. This act shall take effect July 1, 2020.

348 -----  
349  
350 **T I T L E A M E N D M E N T**

351 Remove everything before the enacting clause and insert:  
352 An act relating to the practice of pharmacy; amending s.  
353 381.0031, F.S.; requiring specified licensed pharmacists to  
354 report certain information relating to public health to the  
355 Department of Health; amending s. 465.003, F.S.; revising the  
356 definition of the term "practice of the profession of pharmacy";  
357 creating s. 465.1865, F.S.; providing definitions; providing  
358 requirements for pharmacists to provide services under a  
359 collaborative pharmacy practice agreement; requiring the terms

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## Amendment No. 1

360 and conditions of such agreement to be appropriate to the  
361 training of the pharmacist and the scope of practice of the  
362 physician; requiring notification to the board upon practicing  
363 under a collaborative pharmacy practice agreement; requiring  
364 pharmacists to submit a copy of the signed collaborative  
365 practice agreement to the Board of Pharmacy; providing for the  
366 maintenance of patient records for a certain period of time;  
367 providing for renewal of such agreement; requiring a pharmacist  
368 and the collaborating physician to maintain on file and make  
369 available the collaborative pharmacy practice agreement;  
370 prohibiting certain actions relating to the collaborative  
371 pharmacy practice agreement; requiring specified continuing  
372 education for a pharmacist who practices under a collaborative  
373 pharmacy practice agreement; requiring the Board of Pharmacy to  
374 adopt rules; amending s. 465.189, F.S.; revising the recommended  
375 immunizations or vaccines a pharmacist, or a registered intern  
376 under certain conditions, may administer; authorizing a  
377 certified pharmacist to administer the influenza vaccine to  
378 specified individuals; amending s. 465.1893, F.S.; authorizing  
379 pharmacists who meet certain requirements to administer certain  
380 extended release medications; creating s. 465.1895, F.S.;  
381 requiring the board to identify minor, nonchronic health  
382 conditions that a pharmacist may test or screen for and treat;  
383 providing requirements for a pharmacist to test or screen for  
384 and treat minor, nonchronic health conditions; requiring the

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Amendment No. 1

385 board to develop a formulary of medicinal drugs that a  
386 pharmacist may prescribe; providing requirements for the written  
387 protocol between a pharmacist and a supervising physician;  
388 prohibiting a pharmacist from providing certain services under  
389 certain circumstances; requiring a pharmacist to complete a  
390 specified amount of continuing education; providing an effective  
391 date.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 563 Procurement of Human Organs and Tissue  
**SPONSOR(S):** Daley  
**TIED BILLS:** IDEN./SIM. **BILLS:** SB 798

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N	Morris	Calamas
2) Justice Appropriations Subcommittee	11 Y, 0 N	Jones	Gusky
3) Health & Human Services Committee		Morris	Calamas

### SUMMARY ANALYSIS

Organ and tissue donation is the process of surgically removing an organ or tissue from one person (the donor) and transplanting it into another person (the recipient). Transplantation in such cases is necessary because the recipient's organ has failed or has been damaged by disease or injury. Federal and state law prohibit the purchase and sale of human organs, including tissue, eyes, and corneas.

Eye banks are certified by the Agency for Health Care Administration (AHCA) and engage in screening, testing, retrieving, processing, distributing, or storing human eye tissue. AHCA currently certifies 24 eye banks; three located in Florida and 21 located in other states. All three Florida eye banks are non-profit entities.

HB 563 prohibits for-profit entities from obtaining certification as eye banks and from collecting any eye, cornea, eye tissue, or corneal tissue. The bill provides exceptions for hospitals, ambulatory surgical centers, and district medical examiners.

The bill has an insignificant, negative fiscal impact on AHCA. Additionally, the Criminal Justice Impact Conference considered the bill on February 10, 2020, and determined the bill will have a positive insignificant impact on prison beds (an increase of 10 or fewer beds) by expanding the elements of a second degree felony offense. See Fiscal Analysis and Impact Statement. The bill has no 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

##### **Organ and Tissue 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.<sup>1</sup> 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.<sup>2</sup>

A single person can save up to eight lives through organ donation, and dozens more lives may be improved through tissue donation.<sup>3</sup> 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.<sup>4</sup> There are about as many living donors every year as there are deceased donors.<sup>5</sup>

Despite advances in medicine and technology, and increased awareness of organ donation and transplantation, more donors are needed to meet the demand for transplants.<sup>6</sup> As of January 2020, there are more than 112,000 children and adults<sup>7</sup>, including over 5,000 Floridians, on the waiting list to receive an organ.<sup>8</sup> Over 39,000 organ transplants were performed in 2019 with organs from more than 19,000 donors.<sup>9</sup>

##### Organ Donation Network

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.<sup>10</sup> The United Network for Organ Sharing (UNOS), a private, non-profit organization based in Richmond, Virginia, serves as the OPTN under contract with the U.S. Department of Health and Human Resources.<sup>11</sup> UNOS coordinates how donor organs are matched and allocated to patients on the waiting list.<sup>12</sup> Non-profit, federally designated organ procurement organizations (OPOs) work closely with UNOS, hospitals, and transplant centers to facilitate the organ donation and transplantation process,<sup>13</sup> including conducting a thorough medical

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<sup>1</sup> Donate Life Florida, *Frequently Asked Questions*, <https://www.donateliflorida.org/categories/donation/> (last visited Jan. 24, 2020).

<sup>2</sup> Id.

<sup>3</sup> Id.

<sup>4</sup> 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 Jan. 24, 2020).

<sup>5</sup> Id.

<sup>6</sup> Organ Procurement and Transplantation Network, U.S. Department of Health & Human Services, <https://optn.transplant.hrsa.gov/> (last visited Jan. 24, 2020).

<sup>7</sup> Id.

<sup>8</sup> *Supra*, note 1.

<sup>9</sup> Id.

<sup>10</sup> 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 Jan. 24, 2020).

<sup>11</sup> Id.

<sup>12</sup> 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 Jan. 24, 2020).

<sup>13</sup> Donate Life Florida, *Organ Procurement Organizations and Transplant Centers*, <https://www.donateliflorida.org/local-resources/transplant-centers/> (last visited Jan. 24, 2020).

and social history of the potential donor to help determine the suitability of his or her organs for transplantation.<sup>14</sup> The NOTA prohibits human organs, including tissue, eyes, and corneas, from being bought or sold.<sup>15</sup>

### State Regulation of Eye Banks

Procurement organizations are OPOs, eye banks, or tissue banks that are certified by the Agency for Health Care Administration (AHCA)<sup>16</sup> which engage in the retrieval, recovery, processing, storage, or distribution of human organs or tissues for transplantation, therapy, research, or education.<sup>17</sup> Currently, 155 procurement organizations are certified by AHCA, 24 of which are eye banks 127 are tissue banks, and four are OPOs.<sup>18</sup>

Of the 24 eye banks certified by AHCA, three are physically located in Florida and the remaining 21 are located outside of the state.<sup>19</sup> All three eye banks physically located in Florida are not-for-profit corporations.<sup>20</sup> Of the 21 out-of-state eye banks, 13 are not-for-profit and eight are for-profit.<sup>21</sup>

Florida's three eye banks are located in Miami, Tampa, and Orlando. Lions Eye Bank and Lions Eye Institute are located in Miami and Tampa, respectively, while Keralink International is located in Orlando. The certified, out-of-state eye banks are located in Alabama, California, Illinois, Massachusetts, Maryland, Michigan, Missouri, North Carolina, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, and Washington.<sup>22</sup>

Florida law prohibits the buying, selling, and transfer of human organs, tissue, and body parts, including eyes and corneas, by any person, violation of which is a second degree felony,<sup>23</sup> punishable by up to 30 years in prison and/or a fine up to \$10,000.<sup>24</sup> The interaction of these provisions with the OPO certification statute,<sup>25</sup> which does not ban for-profit entities from becoming certified, is unclear. Because organ procurement can involve distribution – or transfer – of organs, it appears this provision would prevent certification of for-profit procurement organizations if they receive valuable consideration for the distribution (transfer).

### Trends in the Eye Banking Industry

Recently, the market for corneal tissue procurement, transport, and surgeon partnership has shifted from local, community-based eye banks to larger companies.<sup>26</sup> Some of these larger companies are represented by not-for-profit corporations affiliated with for-profit “daughter” companies. In partnership with each other, these organizations play defined roles in the eye and cornea procurement process, with the non-profit organization recovering the tissue while the for-profit organization processes, evaluates, and distributes the tissues to cornea surgeons.<sup>27</sup>

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<sup>14</sup> 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 Jan. 24, 2020).

<sup>15</sup> 42 U.S.C. 274e.

<sup>16</sup> Agency for Health Care Administration, Agency Analysis of 2020 SB 798, p. 2 (Jan. 21, 2020). See also s. 765.511, F.S.

<sup>17</sup> S 765.511(15), F.S.

<sup>18</sup> *Supra*, note 16.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> Email from Lauren Keenan, Deputy Director of Legislative Affairs, Agency for Health Care Administration, RE: Bill Analysis, (Jan. 21, 2020) (On file with Health Market Reform Subcommittee staff).

<sup>23</sup> S. 873.01, F.S.

<sup>24</sup> Ss. 775.082, 775.083, and 775.084, F.S.

<sup>25</sup> S. 765.542, F.S.

<sup>26</sup> Majid Moshirfar, Jackson L. Goldberg, et al., *A paradigm shift in eye banking: how new models are challenging the status quo*, U.S. National Library of Medicine, National Institutes of Health (Dec. 27, 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6311318/> (last visited Jan. 31, 2020).

<sup>27</sup> *Id.*



## **Effect of Proposed Changes**

HB 563 prohibits for-profit entities from procuring, directly or indirectly, any eye, cornea, eye tissue, or corneal tissue. The bill provides exceptions for hospitals, ambulatory surgical centers, and district medical examiners. As a result, eight AHCA-certified, for-profit, out-of-state eye banks will no longer be certified and collect any eye, cornea, eye tissue, or corneal tissue within this state. Non-profit eye banks, located within or outside of Florida, would still be able to be certified and perform such actions.

Because the buying, selling, and transfer of human organs, tissue, and body parts, including eyes and corneas, is a second degree felony under current law, any for-profit entity that engages in the procurement, directly or indirectly, of any eye, cornea, eye tissue, or corneal tissue would be committing a crime under the bill.

### **B. SECTION DIRECTORY:**

**Section 1:** Amends s. 873.01, F.S., relating to purchase or sale of human organs and tissue prohibited.

**Section 2:** Amends s. 765.542, F.S., relating to requirements to engage in organ, tissue, or eye procurement.

**Section 3:** Provides an effective date of July 1, 2020.

## **II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT**

### **A. FISCAL IMPACT ON STATE GOVERNMENT:**

#### **1. Revenues:**

The bill has an insignificant, negative fiscal impact on AHCA. AHCA estimates a total loss of \$4,000 in annual assessment fees per year because the bill would cause eight for-profit, out-of-state certified eye banks to lose their certification.<sup>28</sup> The current annual assessment fee for eye banks is \$500.<sup>29</sup>

#### **2. Expenditures:**

The Criminal Justice Impact Conference considered the bill on February 10, 2020, and determined the bill will have a positive, insignificant impact on prison beds (an increase of 10 or fewer beds) by expanding the elements of a second degree felony offense.

### **B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

#### **1. Revenues:**

None.

#### **2. Expenditures:**

None.

### **C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

The bill has a negative impact on the eight out-of-state, for-profit eye banks that will no longer be licensed by AHCA and will not be able to conduct business in Florida.

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<sup>28</sup> *Supra*, note 16, at 3.

<sup>29</sup> Ch. 59A-1.004(3), F.A.C.

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 rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

**IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

1                                   A bill to be entitled  
 2           An act relating to the procurement of human organs and  
 3           tissue; amending s. 873.01, F.S.; prohibiting for-  
 4           profit entities from procuring certain human organs  
 5           and tissue, with certain exceptions; amending s.  
 6           765.542, F.S.; prohibiting for-profit entities from  
 7           procuring certain human organs and tissue, with  
 8           certain exceptions; providing an effective date.

9  
 10 Be It Enacted by the Legislature of the State of Florida:

11  
 12           Section 1. Present subsections (3) and (4) of section  
 13           873.01, Florida Statutes, are redesignated as subsections (4)  
 14           and (5), respectively, a new subsection (3) is added to that  
 15           section, and subsections (1) and (2) of that section are  
 16           amended, to read:

17           873.01 Purchase or sale of human organs and tissue  
 18           prohibited.—

19           (1) A ~~No~~ person may not ~~shall~~ knowingly offer to purchase  
 20           or sell, or purchase, sell, or otherwise transfer, any human  
 21           organ or tissue for valuable consideration.

22           (2) A ~~No~~ for-profit corporation or any employee thereof  
 23           may not ~~shall~~ transfer or arrange for the transfer of any human  
 24           body part for valuable consideration.

25           (3) A for-profit entity may not engage, directly or

26 | indirectly, in the procurement, as defined in s. 765.511, of any  
27 | eye, cornea, eye tissue, or corneal tissue. This subsection does  
28 | not apply to a hospital or an ambulatory surgical center  
29 | licensed under chapter 395 or to a district medical examiner  
30 | appointed under chapter 406.

31 | Section 2. Present subsection (4) of section 765.542,  
32 | Florida Statutes, is redesignated as subsection (5), and a new  
33 | subsection (4) is added to that section to read:

34 | 765.542 Requirements to engage in organ, tissue, or eye  
35 | procurement.—

36 | (4) A for-profit entity may not engage, directly or  
37 | indirectly, in the procurement of any eye, cornea, eye tissue,  
38 | or corneal tissue. This subsection does not apply to a hospital  
39 | or an ambulatory surgical center licensed under chapter 395 or  
40 | to a district medical examiner appointed under chapter 406.

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



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 607 Health Care Practitioners  
**SPONSOR(S):** Health Quality Subcommittee, Pigman  
**TIED BILLS:** HB 7017 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	14 Y, 1 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

Florida law requires advanced practice registered nurses (APRNs) to practice under a supervising protocol with a physician and only to the extent that a written protocol allows. Similarly, physician assistants (PAs) must practice under a supervising physician and may only perform those tasks delegated by the physician. CS/HB 607 authorizes APRNs who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol and authorizes PAs to practice primary care without physician supervision. These APRNs and PAs may act as a patient's primary care provider; provide a signature, certification, stamp, verification, affidavit, or other endorsement currently required to be provided by a physician; certify a cause of death and sign, correct, and file death certificates.

The bill authorizes an advisory committee comprised of physicians and APRNs to develop a list of medical acts that an APRN engaging in autonomous practice may perform. The bill requires the Council on Physician Assistants (Council) to develop rules defining the primary specialties in which an autonomous PA may practice.

Pursuant to the bill, an APRN or a PA who practices autonomously must report adverse incidents that result in the death of a patient, permanent physical injury to the patient, or a need to transfer a patient to hospital to the Department of Health (DOH). DOH must review each report to determine whether the APRN or PA is subject to disciplinary action. The bill also subjects autonomous APRNs to disciplinary action if they commit specified prohibited acts related to unethical and substandard business practices.

The bill requires all APRNs to apply to the Board of Nursing for licensure, rather than DOH, to reflect current practices.

The bill revises the composition of the Council so that it has a PA majority. The bill requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill expands the scope of practice for all PAs by authorizing them to certify a person for involuntary examination under the Baker Act, file death certificates and certify a cause of death, and participate in guardianship plans. The bill authorizes an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse to examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court. The bill removes a requirement that a PA must notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill appropriates 3.5 FTE and \$219,089 in recurring and \$17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to implement the requirements of the bill. The bill has no fiscal impact on local governments.

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

**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

**STORAGE NAME:** h0607d.HHS

**DATE:** 2/24/2020

# FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. EFFECT OF PROPOSED CHANGES:

#### Current Situation

##### Health Care Workforce

##### Health Care Professional Shortage

The U.S. has a current health care provider shortage.<sup>1</sup> As of December 31, 2019, the U.S. Department of Health and Human Services has designated 7,655 Primary Medical Health Professional Shortage Areas (HPSAs) (requiring 14,392 additional primary care physicians to eliminate the shortage), 6,520 Dental HPSAs (requiring 10,258 additional dentists to eliminate the shortage), and 6,117 Mental Health HPSAs (requiring 6,335 additional psychiatrists to eliminate the shortage).<sup>2</sup>

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population<sup>3</sup> and ongoing efforts to expand access.<sup>4</sup> Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.<sup>5</sup> Additionally, as more individuals qualify for health care benefits, there will necessarily be greater demand for more health care professionals to provide these services.

Florida is not immune to this national problem and also has a health care provider shortage itself. Florida has 735 HPSAs just for primary care, dental care, and mental health.<sup>6</sup> It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.<sup>7</sup>

##### Health Care Workforce Data

##### *Physician Workforce*

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 46,900 and 121,900 across all specialties by 2032.<sup>8</sup> In 2018, there were 277.8 physicians<sup>9</sup> actively practicing per 100,000 population in the U.S., ranging from a high of 449.5 in Massachusetts to a low of 191.3 in Mississippi.<sup>10</sup> The states with the highest number of

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<sup>1</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Dec. 31, 2019), available at <https://data.hrsa.gov/topics/health-workforce/shortage-areas> (last visited February 20, 2020). Click on "Designated HPSA Quarterly Summary" to access the report.

<sup>2</sup> *Id.*

<sup>3</sup> There will be an increase in the U.S. population, estimated to grow from just over 323 million in 2016 to approximately 355 million in 2030, eventually reaching just under 405 million in 2060. See U.S. Census Bureau, *2017 National Populations Projections Tables* available at <https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html> (last visited February 20, 2020). Click on "Table 1. Projected population size and births, deaths, and migration."

<sup>4</sup> Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, (April 2019), available at [https://www.aamc.org/system/files/c/2/31-2019\\_update\\_-\\_the\\_complexities\\_of\\_physician\\_supply\\_and\\_demand\\_-\\_projections\\_from\\_2017-2032.pdf](https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf) (last visited February 20, 2020).

<sup>5</sup> *Id.*

<sup>6</sup> *Supra* note 1.

<sup>7</sup> *Id.*

<sup>8</sup> *Supra* note 4.

<sup>9</sup> These totals include allopathic and osteopathic physicians.

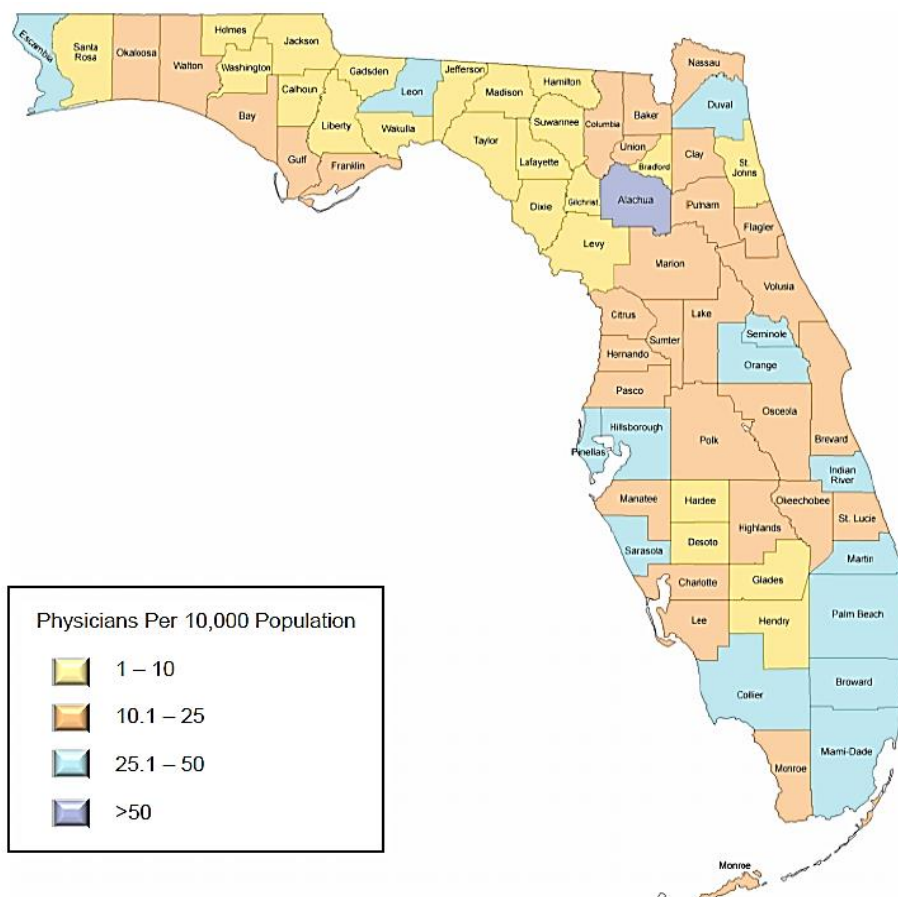
<sup>10</sup> Association of American Medical Colleges, *2019 State Physician Workforce Data Book*, November 2019, pg. 5, available at <https://store.aamc.org/2019-state-physician-workforce-data-report.html> (last visited on February 21, 2020). The book must be downloaded to view its contents.

physicians per 100,000 population are concentrated in the northeastern states. Regarding primary care physicians, there were 92.5 per 100,000 population.<sup>11</sup>

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.<sup>12</sup> Although Florida is the third most populous state in the nation,<sup>13</sup> it ranks as having the 23rd highest physician to population ratio.<sup>14</sup> In 2018, Florida had a ratio of 86.8 primary care physicians providing direct patient care per 100,000 population, ranking Florida 31st compared to other states.<sup>15</sup>

In its 2019 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 12.5 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.<sup>16</sup> Additionally, 35 percent of practicing physicians are age 60 and older.<sup>17</sup>

The following map illustrates that not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.<sup>18</sup>



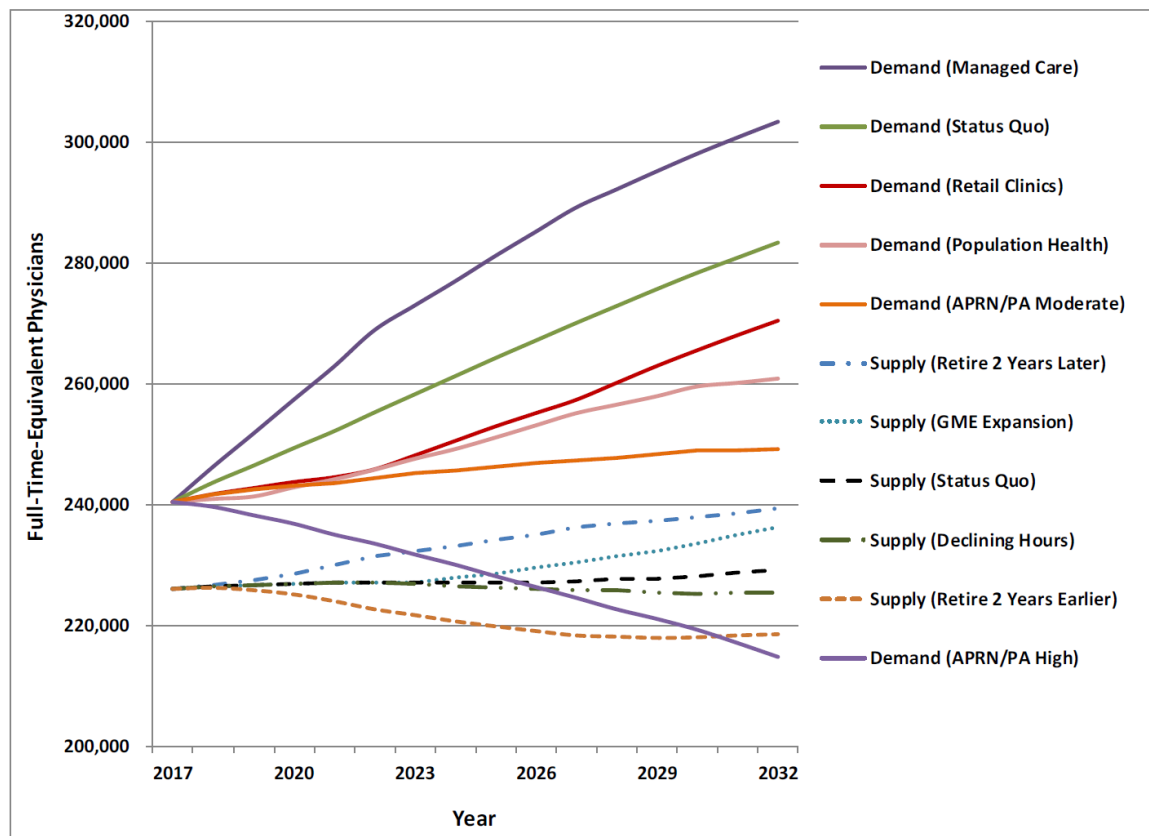
<sup>11</sup> Id.  
<sup>12</sup> *Supra* note 10, at pp. 7-8  
<sup>13</sup> As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 21,299,325 residents, behind California (39,557,045) and Texas (28,701,845). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates*, available at: [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP\\_2014\\_PEPANNRES&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table) (last visited on February 21, 2020).  
<sup>14</sup> *Supra* note 10, at pp. 7-8.  
<sup>15</sup> *Supra* note 10, at pp. 12-13.  
<sup>16</sup> Florida Department of Health, "2019 Physician Workforce Annual Report," (Nov. 2019), available at: <http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2019DOHPhysicianWorkforceReport-10-30-19.pdf> (last visited on February 21, 2020).  
<sup>17</sup> Id. at p. 9.  
<sup>18</sup> Id. at p. 42.  
**STORAGE NAME:** h0607d.HHS  
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The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.<sup>19</sup> Currently, primary care physicians make up 28 percent of the physician workforce.<sup>20</sup> In 2018, 26 percent of new medical school graduates entered the workforce as primary care providers, and this rate will maintain the status quo of the supply of primary care physicians.<sup>21</sup> However, in almost any scenario, the projected supply and demand for primary care physicians demonstrate that demand will exceed supply except the scenario that reflects the highest use of APRNs and PAs.<sup>22</sup>

The table below compares the effects of a moderate increase in the use of APRNs and PAs, greater use of alternate settings such as retail clinics, delayed physician retirement, expansion in graduate medical education, and changes in payment and delivery system, on the supply and demand for primary care physicians.<sup>23</sup>

**Exhibit 3: Projected Supply and Demand for Primary Care Physicians, 2017-2032**



In Florida, more than a third of the practicing physicians are primary care physicians (34.9 percent).<sup>24</sup> Of these, 14.2 percent of family medicine physicians and 11.0 percent of general internal medicine physicians have expressed an intention to retire in the next five years and approximately 4.5 percent and 4.4 percent, respectively, have expressed an intention to relocate out of the state in the next five years.<sup>25</sup>

<sup>19</sup> *Supra* note 4. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.

<sup>20</sup> *Id.* at p. 45.

<sup>21</sup> *Id.* at p. 46.

<sup>22</sup> *Id.* at p. 18.

<sup>23</sup> *Id.*

<sup>24</sup> *Supra* note 16 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.

<sup>25</sup> *Id.* at p. 25.

## Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNP), 45,000 certified registered nurse anesthetists (CRNAs), 6,500 certified nurse midwives (CNMs), and 3,059,800 registered nurses (RNs) employed in the U.S.<sup>26</sup> There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.<sup>27</sup>

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.<sup>28</sup> There are also 309,761 actively licensed registered nurses. Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 156 APRNs and 1,469 RNs.<sup>29</sup> The Florida Center for Nursing Center) estimates that in 2016 and 2017, the number of APRNs who are actually working is 22,795,<sup>30</sup> and the number of RNs who are actually working is 208,870.<sup>31</sup> Using these numbers the figures are: 108 APRNs and 990 RNs per 100,000 population.

The Center also reports that approximately 45 percent of Florida's RNs<sup>32</sup> and 39 percent of the state's APRNs<sup>33</sup> are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.<sup>34</sup>

## Physician Assistant Workforce

In Florida, there are approximately 9,784 actively licensed physician assistants (PAs),<sup>35</sup> which means there are approximately 46 PAs per 100,000 Florida population. Approximately 21 percent of certified PAs in Florida are practicing in primary care, which includes family medicine, general internal medicine, and general pediatrics.<sup>36</sup> On average, a full-time PA sees 83 patients a week.<sup>37</sup>

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<sup>26</sup> U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," available at <http://data.bls.gov/projections/occupationProj> (last visited on February 21, 2020).

<sup>27</sup> These ratios were calculated using the U.S. Census Bureau's total population estimate for 2018, which was 327,167,434, which is available at:

[http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP\\_2014\\_PEPANNRES&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table) (last visited on February 21, 2020) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.

<sup>28</sup> 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 21, 2020).

<sup>29</sup> These ratios were calculated using population estimates as of April 1, 2019 provided by the Florida Office of Economic & Demographic Research, which is 21,091,609, and available at: [http://edr.state.fl.us/Content/population-demographics/data/2019\\_Pop\\_Estimates.pdf](http://edr.state.fl.us/Content/population-demographics/data/2019_Pop_Estimates.pdf) (last visited February 21, 2020).

<sup>30</sup> Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Advanced Registered Nurse Practitioners*, (June 2018), available at [https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core\\_Download&EntryId=1611&PortalId=0&TabId=151](https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1611&PortalId=0&TabId=151) (last visited on February 21, 2020).

<sup>31</sup> Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Registered Nurses*, (June 2018), available at [https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core\\_Download&EntryId=1608&PortalId=0&TabId=151](https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1608&PortalId=0&TabId=151) (last visited on February 21, 2020).

<sup>32</sup> *Supra* note 31. Of working RNs in this state, 25.4 percent are 51 to 60 years old and 20.1 percent are 61 or older.

<sup>33</sup> *Supra* note 30. Of working APRNs in this state, 22.6 percent are 51 to 60 years old and 16.7 percent are 61 or older.

<sup>34</sup> Florida Center for Nursing, Presentation on Florida's Nurse Workforce, January 23, 2019, available at [https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting\\_Packets&FileName=hqs\\_1-23-19.pdf](https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting_Packets&FileName=hqs_1-23-19.pdf) (last visited on November 20, 2019).

<sup>35</sup> *Supra* note 28.

<sup>36</sup> National Commission on Certification of Physician Assistants, *2018 Statistical Profile of Certified Physician Assistants by State: An Annual Report of the National Commission on Certification of Physician Assistants*, (Jan. 2019), available at <https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPhysicianAssistants.pdf> (last visited March 12, 2019). Please note that PAs must pass the initial certification examination to qualify for licensure in Florida; however, certification is not an ongoing requirement for licensure.

<sup>37</sup> Id at p. 47.

## Advanced Practice Nurses

### Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)<sup>38</sup> is licensed in one of four roles: a certified nurse practitioner (CNP), certified nurse midwife (CNM), clinical nurse specialist (CNS), or certified registered nurse anesthetist (CRNA).<sup>39</sup> As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.<sup>40</sup>

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (Board), established under s. 464.004, F.S., provides by rule the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices. Additionally, the Board is responsible for administratively disciplining an APRN who commits an act prohibited under ss. 464.018 or 456.072, F.S.

Section 464.003(2), F.S., defines the term “advanced or specialized nursing practice” to include, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician’s protocol.<sup>41</sup> In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician’s protocol.<sup>42</sup>

To be eligible to be licensed as an APRN, an applicant must be licensed as a registered nurse, have a master’s degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.<sup>43</sup> A nursing specialty board must:<sup>44</sup>

- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

Pursuant to s. 456.048, F.S., all APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility within sixty days of licensure and prior to each biennial licensure renewal. The APRN must have professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000 or an unexpired irrevocable letter of credit in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000 and which is payable to the APRN as beneficiary.<sup>45</sup> By comparison, physicians must establish some method of financial

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<sup>38</sup> Section 464.003(3), F.S.

<sup>39</sup> Section 464.012(4), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from “Advanced Registered Nurse Practitioner (APRN)” to “Advanced Practice Registered Nurse (APRN),” and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (see ch. 2018-106, Laws of Fla.). DOH is still in the process of effectuating this transition.

<sup>40</sup> Email correspondence from DOH dated November 25, 2019, on file with committee staff.

<sup>41</sup> Section 464.012(3)-(4), F.S.

<sup>42</sup> Section 464.003, F.S., and s. 464.012, F.S.

<sup>43</sup> Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.

<sup>44</sup> Rule 64B9-4.002(3), F.A.C.

<sup>45</sup> Rule 64B9-4.002, F.A.C. DOH Form DH-MQA 1186, 01/09, “Financial Responsibility,” is incorporated into the rule by reference. Certain licensees, such as those who practice exclusively for federal or state governments, only practice in conjunction with a teaching position, or can demonstrate no malpractice exposure in this state are exempt from the financial responsibility requirements.

responsibility with the same coverage amounts and can choose one of three options for doing so: malpractice insurance, an escrow account, or a letter of credit. However, physicians who agree to pay adverse judgments, up to certain statutory limits, are exempt from this requirement but must notify patients that they have chosen not to carry malpractice insurance.<sup>46</sup>

Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, HB 423 eliminated the joint committee and instead, authorized physicians and APRNs to determine the medical acts the APRN could perform within the supervisory protocol.<sup>47</sup>

### APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:<sup>48</sup>

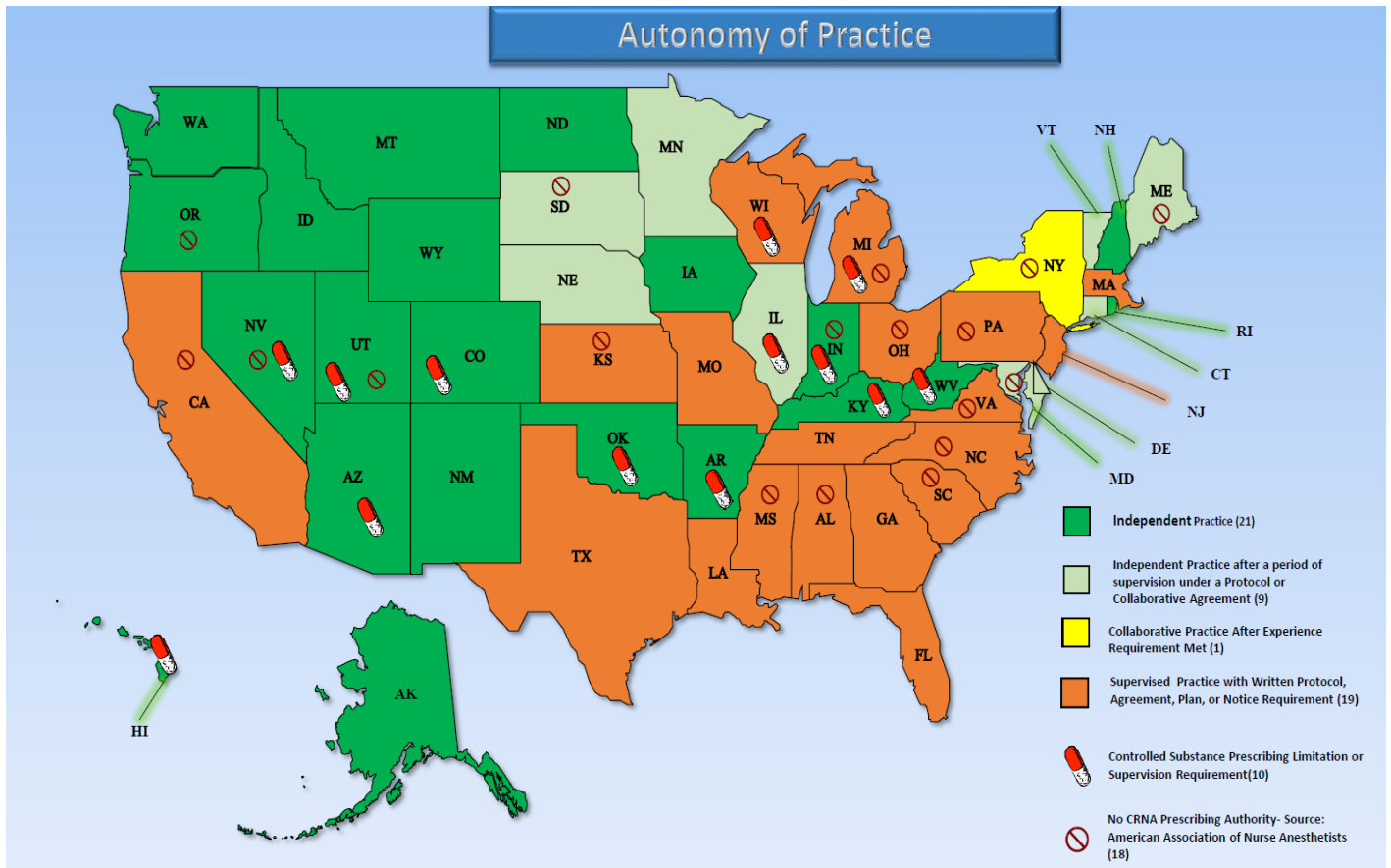
1. Independent nursing practice;
2. Transitory period in which an APRN is supervised by a physician or independent APRN prior to authority to engage in independent nursing practice;
3. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement; or
4. Supervised nursing practice or prescribing that requires physician supervision with a written agreement, protocol, notice, or plan signed by the physician, who has discretion as to what practices are authorized, including controlled substance prescribing.

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<sup>46</sup> If allopathic and osteopathic physicians meet certain eligibility criteria and post signage at their medical office disclosing to the public that they do not carry medical malpractice insurance, they are exempt from medical malpractice or proof of financial responsibility requirements provided in ss. 458.320 and 459.0085, F.S., respectively.

<sup>47</sup> Chapter 2016-224, Laws of Fla.

<sup>48</sup> Findings based on research conducted by professional staff of the Health and Human Services Committee.



### APRN Autonomy in Veterans Health Administration Facilities

The U.S. Department of Veterans Affairs (VA) adopted a rule in December 2016, which permits APRN full practice authority.<sup>49</sup> Under the rule, an APRN working within the scope of his or her VA employment is authorized to perform specified services within the scope of his or her training, education, and certification without the clinical oversight of a physician, regardless of state law restrictions. However, the rule expressly provides that the full practice of an APRN is subject to state law with regard to the prescribing or administration of controlled substances. The rule is limited to CNPs, CNMs, and CNSs, and does not apply to CRNAs. In Florida, 59 VA medical centers and health care clinics are affected by this policy change.<sup>50</sup>

### APRN Autonomy in Florida

Florida is a supervisory state. Under s. 464.012(3), F.S., APRNs may perform only those nursing and medical practices delineated in a written physician protocol. A physician providing primary health care services may supervise APRNs in up to four medical offices,<sup>51</sup> in addition to the physician’s primary practice location. If the physician provides specialty health care services, then only two medical offices

<sup>49</sup> U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, “VA Grants Full Practice Authority to Advanced Practice Registered Nurses,” (December 14, 2016), available at <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847> (last visited February 21, 2020). The final rule can be found at <https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf> (last visited on February 21, 2020).

<sup>50</sup> U.S. Department of Veterans Affairs, Veterans Health Administration, “Locations: Florida,” available at: <http://www.va.gov/directory/guide/state.asp?STATE=FL&dnum=1> (last visited February 21, 2020).

<sup>51</sup> The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.

in addition to the physician's primary practice location may be supervised.<sup>52</sup> Furthermore, a special limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.<sup>53</sup>

### APRN Scope of Practice

State laws vary as to the scope within which an APRN may practice, which is often determined by whether the APRN is a CNP, CNM, CNS, or CRNA, and often relates to the authority to prescribe drugs and sign documents.

Twenty of the 30 independent practice states authorize an APRN to prescribe controlled substances to a patient without physician supervision. Several independent practice states, such as Arkansas, Kentucky, Michigan, Oklahoma, and Wisconsin, require APRNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.<sup>54</sup> In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017.<sup>55</sup> The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,<sup>56</sup> as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.<sup>57</sup> The map on p. 7 illustrates the varying controlled substance prescribing requirements throughout the U.S.

Thirty-nine states, including Florida, recognize APRNs as "primary care providers" in policy.<sup>58</sup> Recognizing APRNs as primary care providers assists them with being able to directly bill public or private payers for services provided, order certain tests, and establish independent primary care practices.<sup>59</sup> Insurers may be unwilling to contract directly with a provider who is supervised by another provider.

### *APRN Scope of Practice in Florida*

Within the framework of the written protocol, an APRN may:

- Prescribe, dispense, administer, or order any drug;<sup>60</sup>
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy; and

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<sup>52</sup> Sections 458.348, and 459.025, F.S.

<sup>53</sup> *Id.*

<sup>54</sup> *Supra* note 48. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.

<sup>55</sup> Chapter 2016-224, Laws of Fla.

<sup>56</sup> Pursuant to s. 893.03(2), a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.

<sup>57</sup> *Supra* note 48.

<sup>58</sup> Scope of Practice Policy, *Nurse Practitioners: Nurse Practitioner as Primary Care Provider*, available at <http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/> (last visited February 21, 2020). APRNs may practice as a primary care provider in states that do not specifically recognize them as such.

<sup>59</sup> Tine Hansen-Turton, BA, MGA, et. al., "Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change," *POLICY, POLITICS & NURSING PRACTICE*, 7:3 (Aug. 2006), pp. 216-226.

<sup>60</sup> Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.

- Perform certain acts within his or her specialty.<sup>61</sup>

APRNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APRNs are not authorized to sign a certificate to initiate the involuntary examination of a person under the Baker Act, to sign for the release of persons in receiving facilities under the Baker Act, or to sign death certificates.<sup>62</sup>

## Reports and Studies Related to Advanced Practice Nurses

### *Patient Health Care Outcomes*

Despite concerns that APRNs provide a different quality of care than physicians,<sup>63</sup> a multitude of reports and studies suggest treatment by an APRN is just as safe as treatment by a physician. In 2018, the Cochrane Collaboration updated a review of the findings of 25 articles comparing physician and APRN patient outcomes, which was first published in 2009. The review found that, in general, compared to primary care physicians, APRNs:<sup>64</sup>

- Probably provide equal or possibly even better quality of care compared to primary care physicians;
- Probably achieve equal or better health outcomes for patients;
- Probably achieve higher levels of patient satisfaction;
- Had longer consultation lengths and higher return visits; and
- Had comparable resource utilization outcomes.

The study was unable to ascertain the effects of nurse-led care on the costs of care.

Similar to the Cochrane review, the National Governors Association performed a review of various studies to determine whether there were differences in the quality of care provided by CNPs compared to physicians. The studies measured quality of care components such as patient satisfaction, time spent with patients, and prescribing accuracy. The review of those studies found that CNPs provided at least equal quality of care to patients as compared to physicians and, in fact, CNPs were found to have equal or higher patient satisfaction rates and tended to spend more time with patients during clinical visits.<sup>65</sup>

A recently published study of medically complex patients within the VA health care system found that patients of primary care APRNs and PAs incurred less outpatient, pharmacy, and total expenditures than patients of physicians.<sup>66</sup> This same study found that patients of APRNs and PAs also sought care at in an emergency department of a hospital less frequently than patients of physicians. A 2013 study,

<sup>61</sup> Sections 464.012(3),(4), and 464.003, F.S.

<sup>62</sup> Sections 394.463(2) and 382.008, F.S.

<sup>63</sup> When 972 clinicians, including 467 nurse practitioners and 505 physicians, were surveyed in a study as to whether physicians provide a higher quality of examination and consultation, the respondents were diametrically opposed. Approximately 66.1% of physicians agreed with the statement and 75.3% of nurse practitioners disagreed with the statement. Donelan, K., Sc.D., DesRoches, C., Dr. P.H., Dittus, R., M.D., M.P.H., and Buerhaus, P., R.N., Ph.D., "Perspectives of Physicians and Nurse Practitioners on Primary Care Practice," N. ENGL. J. MED. 2013, 368:1898-1906, available at <http://www.nejm.org/doi/full/10.1056/NEJMsa1212938> (last visited on February 21, 2020).

<sup>64</sup> Laurant, M., et al., The Cochrane Collaboration, "Nurses as Substitute for Doctors in Primary Care," July 16, 2018, available at <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001271.pub3/full> (last visited on February 21, 2020).

<sup>65</sup> National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, available at <http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf> (last visited on February 21, 2020).

<sup>66</sup> Perri A. Morgan, et. al. "Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients," HEALTH AFFAIRS, 38:6 (2019), available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00014> (last visited February 21, 2020).

found that allowing CNPs to practice and prescribe drugs without physician oversight leads to increased primary health care utilization and improvements in health outcomes.<sup>67</sup>

### *Cost Savings*

The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. These rising costs will only be intensified by the increasing number of persons with health care coverage and the shortage of health care workers.<sup>68</sup>

A 2012 Texas analysis of APRN practice concluded that more efficient use of APRNs in the provision of patient care, especially primary care, would improve patient outcomes, reduce overall health care costs, and increase access to health care.<sup>69</sup> The report estimated savings of \$16.1 billion in total expenditures and \$8 billion in output (gross product) each year.<sup>70</sup> Additionally, it was estimated that 97,205 permanent jobs would be added to Texas' workforce. Finally, the report estimated that Texas would receive additional tax receipts of up to \$483.9 million to the state and \$233.2 million to local government entities each year.<sup>71</sup>

Another study found that states that allow APRNs to practice and prescribe without physician supervision experience 16-35% increases in health care utilization, increases in care quality, and reductions in inappropriate emergency room use.<sup>72</sup> The researchers concluded these advances were primarily due to elimination of supervision time (10%) and lower indirect costs (such as better appointment availability and lower patient travel costs).<sup>73</sup>

Finally, a study found that individuals treated by primary care APRNs who were dually-eligible for Medicaid and Medicare had a lower risk of preventable hospitalizations and emergency department use than those cared for by primary care physicians.<sup>74</sup> The study also found that primary care APRNs treating those with chronic illnesses received the same health care services consistent with established guidelines as those treated by primary care physicians.<sup>75</sup>

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.<sup>76</sup> The FTC finds scope of practice restrictions anti-competitive, reduce competitive market pressures, increase out-of-pocket prices, limit service hours, and reduce the distribution of services.<sup>77</sup> The FTC poses that if such constraints were eliminated, not only would access to services be increased, but also there would be benefits to price competition that would help contain health care costs.<sup>78</sup>

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<sup>67</sup> Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," May 4, 2014, available at [http://www2.hawaii.edu/~jtraczyn/paperdraft\\_050414\\_ASHE.pdf](http://www2.hawaii.edu/~jtraczyn/paperdraft_050414_ASHE.pdf) (last visited on February 21, 2020).

<sup>68</sup> The Perryman Group, "The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas," May 2012, available at <https://cdn.ymaws.com/www.texasnp.org/resource/resmgr/Advocacy/Perryman%20APRN%20Utilization%20Economic%20Impact%20Report%20May%202012.pdf> (last visited on February 21, 2020).

<sup>69</sup> Id.

<sup>70</sup> Id.

<sup>71</sup> Id.

<sup>72</sup> *Supra* note 67.

<sup>73</sup> Id.

<sup>74</sup> Peter Buerhaus, American Enterprise Institute, *Nurse Practitioners: A Solution to America's Primary Care Crisis*, (Sept. 2018), available at <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/> (last visited February 21, 2020).

<sup>75</sup> Id.

<sup>76</sup> Federal Trade Commission, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, (Mar. 2014), available at <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf> (last visited February).

<sup>77</sup> Id.

<sup>78</sup> Id.



## Physician Assistants

PAs are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S.

### Council on Physician Assistants

The Council consists of five members including three physicians who are members of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and one licensed PA appointed by the Surgeon General.<sup>79</sup> Two of the physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:<sup>80</sup>

- Making recommendations to DOH regarding the licensure of PAs;
- Developing rules for the regulation of PAs for consideration for adoption by the boards;
- Making recommendations to the boards regarding all matters relating to PAs;
- Addressing concerns and problems of practicing PAs to ensure patient safety; and
- Denying, restricting, or placing conditions on the license of PA who fails to meet the licensing requirements.

### Licensure and Regulation of PAs

An applicant for a PA license must apply to DOH, and DOH must issue a license to a person certified by the Council as having met all of the following requirements.<sup>81</sup>

- Completed an approved PA training program;
- Obtained a passing score on the National Commission on Certification of Physician Assistants exam;
- Acknowledged any prior felony convictions;
- Submitted to a background screening and have no disqualifying offenses;<sup>82</sup>
- Acknowledged any previous revocation or denial of licensure in any state; and
- Provided a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.<sup>83</sup> To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially and must take a re-certification examination every 10 years.<sup>84</sup>

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<sup>79</sup> Sections 458.347(9) and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. See ss. 458.307 and 459.004, F.S., respectively.

<sup>80</sup> Id.

<sup>81</sup> Sections 458.347(7) and 459.022(7), F.S.

<sup>82</sup> Section 456.0135, F.S.

<sup>83</sup> Sections 458.347(7)(c) and 459.022(7)(c), F.S.

<sup>84</sup> National Commission on Certification of Physician Assistants, *Maintaining Certification*, available at <https://www.nccpa.net/CertificationProcess> (last visited February 21, 2020).

## PA Education

PA education programs are typically three years and award master's degrees.<sup>85</sup> Many programs require students to have health care experience as a condition for admission.<sup>86</sup> PA students receive classroom training in:<sup>87</sup>

- Anatomy;
- Physiology;
- Biochemistry;
- Pharmacology;
- Physical diagnosis;
- Pathophysiology;
- Microbiology;
- Clinical laboratory science;
- Behavioral science; and
- Medical Ethics.

A PA student must also complete approximately 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices, and acute or long-term care facilities.<sup>88</sup> A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.<sup>89</sup>

## PA Scope of Practice

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.<sup>90</sup> A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.<sup>91</sup> The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.<sup>92</sup>

The Boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate, is dependent upon the:

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.<sup>93</sup>

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<sup>85</sup> American Academy of PAs, *Become a PA*, available at <https://www.aapa.org/career-central/become-a-pa/> (last visited February 21, 2020).

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> Sections 458.347(2)(f) and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.

<sup>91</sup> Rules 64B8-30.012 and 64B15-6.010, F.A.C.

<sup>92</sup> Sections 458.347(15) and 459.022(15), F.S.

<sup>93</sup> Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.

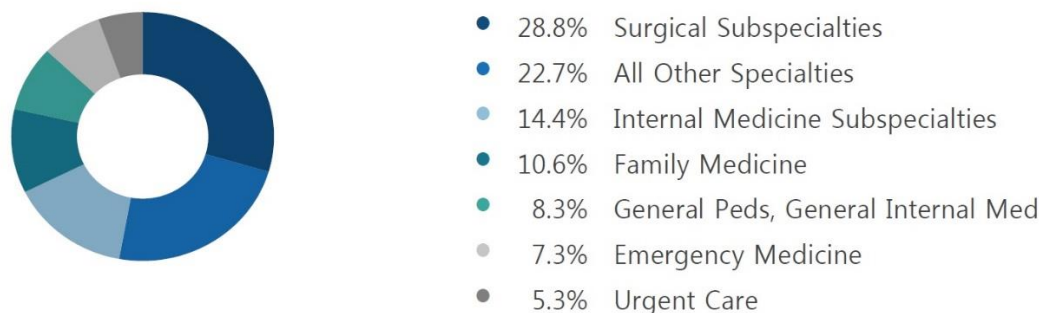
A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.<sup>94</sup> A supervising physician may delegate the authority for a PA to:

- Prescribe or dispense any medicinal drug used in the supervising physician’s practice unless such medication is listed in the formulary established by the Council;<sup>95</sup>
- Order any medication for administration to the supervising physician’s patient in a hospital or other facility licensed under chapter 395, F.S., or a nursing homes licensed under part II of chapter 400, F.S.;<sup>96</sup> and
- Perform any other service that are is not expressly prohibited in ch. 458, F.S., ch. 459, F.S., or the rules adopted thereunder.<sup>97</sup>

### PA Practice Characteristics

In the United States, approximately 26 percent of PAs work in primary care, which includes family medicine, general internal medicine, and general pediatrics.<sup>98</sup> Approximately 19 percent of Florida-licensed PAs practice primary care, but may also practice in other disciplines of medical practice:<sup>99</sup>

Percent of PAs by Specialty in Florida



### PA Adverse Incident Reporting

A PA must report to DOH, any adverse incident occurring in an office practice setting within 15 days after the occurrence of the adverse incident.<sup>100</sup> DOH must review each report to determine if discipline against the PA’s license is warranted.<sup>101</sup>

An adverse incident in an office setting is defined as an event over which the PA could exercise control and which is associated with a medical intervention and results in one of the following patient injuries.<sup>102</sup>

<sup>94</sup> “Direct supervision” refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. “Indirect supervision” refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication. *Supra* note 93.

<sup>95</sup> Sections 458.347(4)(f), F.S., and 459.022(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C., prohibits PAs from prescribing: general, spinal or epidural anesthetics; radiographic contrast materials; and psychiatric mental health controlled substances for children younger than 18 years of age. It also restricts the prescribing of Schedule II controlled substances to a 7-day supply. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in hospitals and other facilities licensed under ch. 395, F.S.

<sup>96</sup> Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.

<sup>97</sup> Sections 458.347(4) and 459.022(e), F.S.

<sup>98</sup> *Supra* note 36.

<sup>99</sup> American Academy of PAs, *Florida Practice Profile*, available at [https://www.aapa.org/wp-content/uploads/2016/12/PAs\\_In\\_Florida.pdf](https://www.aapa.org/wp-content/uploads/2016/12/PAs_In_Florida.pdf) (last visited March 14, 2019).

<sup>100</sup> Sections 458.351 and 459.026, F.S.

<sup>101</sup> Sections 458.351(5) and 459.026(5), F.S.

<sup>102</sup> Sections 458.351(4) and 459.026(4), F.S.

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- If the procedure results in death; brain or spinal damage; permanent disfigurement; the fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory functions; or any condition that required the transfer of a patient, the performance of:
  - A wrong-site surgical procedure;
  - A wrong surgical procedure; or
  - A surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process;
- A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
- Any condition that required the transfer of a patient to a hospital from an ambulatory surgical center or any facility or any office maintained by a physician for the practice of medicine which is not licensed under ch. 395, F.S.

### Reports and Studies Related to Physician Assistants

Several studies have shown that PAs provide care that is comparable to physicians. One study examined more than 23,000 patient visits to more than 1,100 practitioners to determine the quality of care provided by APRNs, PAs, and physicians.<sup>103</sup> The study found that there was no statistically significant differences in the care provided by APRNs and PAs and that provided by primary care physicians.<sup>104</sup> Additionally, the study noted that PAs provided more health education services than primary care physicians.<sup>105</sup>

Another study assessed the care PAs, APRNs, and primary care physicians provided to diabetic patients within the VA health care system. This study suggests that there are similar chronic illness outcomes for physicians, APRNs, and PAs.<sup>106</sup>

Finally, a study assessed the care received by medically complex patients within the VA health care system and found that the patients of primary care APRNs and PAs incurred less outpatient, pharmacy, and total expenditures than patients of physicians.<sup>107</sup>

### Effect of Proposed Changes

#### Autonomous Practice

##### *Registration Requirements*

The bill authorizes an APRN who meets certain eligibility criteria to register with the Board of Nursing to engage in autonomous practice and perform acts of advanced or specialized nursing practice without a supervisory protocol or supervision by a physician. The bill also authorizes a PA who meets certain eligibility to register with the Board of Medicine or the Board of Osteopathic Medicine to practice primary care as an autonomous PA without supervision by a physician.

<sup>103</sup> Kurtzman, Ellen T. PhD, MPH, RN, FAAN and Barnow, Burt S. PhD., "A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers," 55 MEDICAL CARE 6: 615 (June 2017), abstract available at [https://journals.lww.com/ww-medicalcare/Abstract/2017/06000/A\\_Comparison\\_of\\_Nurse\\_Practitioners\\_Physician.11.aspx](https://journals.lww.com/ww-medicalcare/Abstract/2017/06000/A_Comparison_of_Nurse_Practitioners_Physician.11.aspx) (last visited February 21, 2020).

<sup>104</sup> Id.

<sup>105</sup> Id.

<sup>106</sup> Jackson, G., et. al., "Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study," ANNALS OF INTERNAL MEDICINE 169:825–835 (Nov. 2018), abstract, available at <https://annals.org/aim/article-abstract/2716077/intermediate-diabetes-outcomes-patients-managed-physicians-nurse-practitioners-physician-assistants> (last visited February 21, 2020).

<sup>107</sup> *Supra* note 66.

To register to engage in autonomous practice, an APRN or PA must hold an active and unencumbered Florida license and must have:

- Completed, in any U.S. jurisdiction, at least 2,000 clinical instructional hours or clinical practice hours supervised by an actively licensed physician within the 5-year period for APRNs or 3-year period for PAs immediately preceding the registration request;
- Not been subject to any disciplinary action during the five years immediately preceding the application;
- Completed a graduate level course in pharmacology; and
- Any other appropriate requirement adopted by rule by the respective boards.

The bill also requires APRNs and PAs (jointly referred to as practitioners) who practice autonomously to obtain and maintain liability coverage at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000. However, this requirement does not apply to practitioners who:

- Practices exclusively as an officer, employee, or agent of the federal government or of the state or its agencies or subdivisions;
- Is not practicing in this state and whose license is inactive;
- Practices only in conjunction with teaching duties at an accredited school or its main teaching hospitals; and
- Not practicing in this state but holds an active license to practice. Such practitioners must notify DOH if they initiate or resume autonomous practice in this state.

The registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN or PA license. To maintain registration, an APRN must complete at least 10 hours of continuing education approved by the Board in pharmacology for each biennial renewal.<sup>108</sup> An autonomous PA does not have to complete any additional continuing medical education hours above the 100 hours required for PA licensure renewal.

The bill directs DOH to create practitioner profiles for autonomous PAs, which conspicuously informs the public of the autonomous PA's registration. The bill also requires that DOH conspicuously distinguishes the practitioner profiles of APRNs registered to engage in autonomous practice.

### *Scope of Practice*

Pursuant to the bill, an APRN registered to engage in autonomous practice is authorized to perform any advanced or specialized nursing act currently authorized for an APRN, without the supervision of a physician or a written protocol. In addition to those acts, the registered APRN may autonomously and without supervision or a written protocol perform the following acts:

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility, as authorized under federal law or rule.
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.
- Certify causes of death and sign, correct, and file death certificates.
- Act as a patient's primary care provider.
- Execute a certificate to subject a person to involuntary examination under the Baker Act.
- Examine, and approve the release of, a person admitted into a receiving facility under the Baker Act, if the APRN holds a national certification as a psychiatric-mental health advanced practice nurse.

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<sup>108</sup> The bill provides an exception to the 10 hours of continuing education in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.

- Perform certain physical examinations currently reserved to physicians and physician assistants by Florida law, such as examinations of pilots, law enforcement officers, and suspected child abuse victims.
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

The bill reestablishes the advisory committee that was abolished in 2016, to make evidence-based recommendations about medical acts an APRN who is practicing autonomously may perform. The 7-member joint committee is to be composed of four APRNs appointed by the Board of Nursing, two physicians recommended by the Board of Medicine, and the State Surgeon General or his or her designee. The bill requires the Board of Nursing to act on any recommendation of the committee within 90 days of submission. The Board may choose to adopt a recommendation, reject a recommendation, or otherwise act on it as the Board deems appropriate. Under current law, APRNs may only perform medical acts as authorized within the framework of a physician protocol. The advisory committee recommendations may provide autonomous APRNs the authority to perform certain medical acts that they are currently performing under protocols.

The bill authorizes an autonomous PA to:

- Only render primary care services as defined by the applicable board rule;
- Render services consistent with the scope of his or her education and experience and provided in accordance with rules adopted by the applicable board;
- Prescribe, dispense, administer, or order any medicinal drug to the extent authorized under a formulary adopted by the Council;
- Order any medication for administration to a patient in a facility licensed under ch. 395, F.S., or part II of ch. 400, F.S.;<sup>109</sup>
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court; and
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.

The bill requires the Council to develop rules defining the primary specialties in which an autonomous PA may practice. Such specialties may include internal medicine, general pediatrics, family medicine, geriatrics, and general obstetrics and gynecology.

The bill also authorizes autonomous PAs to participate in the Public School Volunteer Health Care Practitioner Program. This program allows any participating health care practitioner who agrees to provide his or her services, without compensation, in a public school for at least 80 hours a year for each school year during the biennial licensure period to be eligible for waiver of the biennial license renewal fee for an active license and fulfillment of a maximum of 25 percent of the continuing education hours required for license renewal under s. 456.013(9), F.S.

The bill also requires autonomous PAs to comply with the Florida Patient's Bill of Rights and Responsibilities Act.

#### *Accountability Measures*

The bill imposes safeguards to ensure APRNs registered to engage in autonomous practice do so safely, similar to those for physicians.<sup>110</sup> The bill defines an adverse incident as an event over which the APRN could exercise control and which is associated with a medical or nursing intervention, including the prescribing of controlled substances, rather than a condition for which such intervention occurred, which results in at least one of the following:

<sup>109</sup> This includes ambulatory surgical centers, hospitals, and nursing homes.

<sup>110</sup> See ss. 458.351 and 459.026, F.S.

- A condition that requires the transfer to a hospital;
- Permanent physical injury to the patient; or
- Death of the patient.

If such an event occurs, the APRN must report the adverse incident to DOH, in writing, within 15 days of its occurrence or discovery of its occurrence, consistent with the requirements for doctors. DOH must review the adverse incident to determine if the APRN committed any act that would make the APRN subject to disciplinary action.

PAs are subject to the existing adverse incident requirements for physicians.

In addition, the bill requires several other accountability measures for APRNs registered to engage in autonomous practice. The bill authorizes the Board to administratively discipline and APRN for several delineated prohibited acts related to relationships with patients, business practices, and nursing practices:

- Paying or receiving any commission, bonus, kickback, rebate, or engaging in a slit-fee arrangement with a health care practitioner, organization, agency, or person for patient referrals;
- Exercising influence over a patient for the purpose of engaging in sexual activity;
- Making deceptive, untrue, or fraudulent representation related to advanced or specialized nursing practice;
- Soliciting patients, personally or through an agent, using fraud, intimidation, undue influence, or overreaching or vexatious conduct;
- Failing to keep legible medical records;
- Performing professional services that have not been authorized by the patient or his or her representative except as provided by the Medical Consent Law<sup>111</sup> and the Good Samaritan Act;<sup>112</sup>
- Performing any procedure or prescribing any medicinal drug that would constitute experimentation on a human subject, without full, informed, and written consent of the patient;
- Delegating professional responsibilities to an unqualified or unlicensed person;
- Conspiring with another person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;
- Advertising or holding oneself out as having a certification in a specialty that the APRN has not received;
- Failing to inform patients about patient rights and how to file a patient complaint; and
- Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.

PAs are subject to the same discipline as physicians as it relates to relationships with patients, business practices, and medical practices.

### General APRN Provisions

The bill requires APRNs to apply to the Board for licensure, rather than DOH, to reflect current practice. Currently, applicants for licensure as APRNs submit documentation that they meet certification and financial responsibility requirements directly to the Board, rather than DOH. The bill also authorizes APRNs to sign, certify, stamp, verify, or endorse any document that requires the signature, certification, stamp, verification, or endorsement of a physician.

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<sup>111</sup> Section 766.103, F.S.

<sup>112</sup> Section 768.13, F.S.

## General PA Provisions

The bill also revises the composition of the Council so that it has a PA majority. Under the bill, the Council is composed of one physician who is a member of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and three licensed PAs appointed by the Surgeon General. The physician members must supervise PAs in their practices.

The bill requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill removes a requirement that a PA must notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill expands the scope of practice for PAs to authorize them to:

- Certify a person for involuntary examination under the Baker Act;
- File death certificates and certify a cause of death; and
- Examine and provide a report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

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

### B. SECTION DIRECTORY:

- Section 1:** Amends s. 456.0391, F.S., relating to advanced practice registered nurses; information required for licensure.
- Section 2:** Amends s. 456.041, F.S., relating to practitioner profile; creation.
- Section 3:** Amends s. 458.347, F.S., relating to physician assistants.
- Section 4:** Amends s. 459.022, F.S., relating to physician assistants.
- Section 5:** Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees; and controlled substance prescribing.
- Section 6:** Creates s. 464.0123, F.S., autonomous practice by an advanced practice registered nurse.
- Section 7:** Creates s. 464.0155, F.S., relating to reports of adverse incidents by advanced practice registered nurses.
- Section 8:** Amends s. 464.018, F.S., relating to disciplinary actions.
- Section 9:** Amends s. 39.01, F.S., relating to definitions.
- Section 10:** Amends s. 39.303, F.S., relating to child protection teams and sexual abuse treatment programs; services; eligible cases.
- Section 11:** Amends s. 39.304, F.S., relating to photographs, medical examinations, X rays, and medical treatment of abused, abandoned, or neglected child.
- Section 12:** Amends s. 110.12315, F.S., relating to the prescription drug program.
- Section 13:** Amends s. 252.515, F.S., relating to the Postdisaster Relief Assistance Act; immunity from civil liability.
- Section 14:** Amends s. 310.071, F.S., relating to deputy pilot certification.
- Section 15:** Amends s. 310.073, F.S., relating to state pilot licensing.
- Section 16:** Amends s. 310.081, F.S., relating to department to examine and license state pilots and certificate deputy pilots; vacancies.
- Section 17:** Amends s. 320.0848, F.S., relating to persons who have disabilities, issuance of disabled parking permits, temporary permits, and permits for certain providers of transportation services to persons who have disabilities.
- Section 18:** Amends s. 381.00315, F.S., relating to public health advisories, public health emergencies; isolation and quarantines.
- Section 19:** Amends s. 381.00593, F.S., relating to public school volunteer health care practitioner program.



- Section 20:** Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
- Section 21:** Amends s. 382.008, F.S., relating to death, fetal death, and nonviable birth registration.
- Section 22:** Amends s. 382.011, F.S., relating to medical examiner determination of cause of death.
- Section 23:** Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
- Section 24:** Amends s. 390.0111, F.S., relating to termination of pregnancies.
- Section 25:** Amends s. 390.012, F.S., relating to powers of agency; rules; and disposal of fetal remains.
- Section 26:** Amends s. 394.463, F.S., relating to involuntary examination.
- Section 27:** Amends s. 395.0191, F.S., relating to staff membership and clinical privileges.
- Section 28:** Amends s. 395.602, F.S., relating to rural hospitals.
- Section 29:** Amends s. 397.501, F.S., relating to rights of individuals.
- Section 30:** Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
- Section 31:** Amends s. 397.6793, F.S., relating to professional's certificate for emergency admission.
- Section 32:** Amends s. 400.021, F.S., relating to definitions.
- Section 33:** Amends s. 400.172, F.S., relating to respite care provided in nursing home facilities.
- Section 34:** Amends s. 400.487, F.S., relating to home health service agreements; physician's, physician assistants, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services, and orders not to resuscitate.
- Section 35:** Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; and penalties.
- Section 36:** Amends s. 400.9973, F.S., relating to client admission, transfer, and discharge.
- Section 37:** Amends s. 400.9974, F.S., relating to client comprehensive treatment plans; client services.
- Section 38:** Amends s. 400.9976, F.S., relating to administration of medication.
- Section 39:** Amends s. 400.9979, F.S., relating to restraint and seclusion; client safety.
- Section 40:** Amends s. 401.445, F.S., relating to emergency examination and treatment of incapacitated persons.
- Section 41:** Amends s. 409.906, F.S., relating to optional Medicaid services.
- Section 42:** Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
- Section 43:** Amends s. 409.973, F.S., relating to benefits.
- Section 44:** Amends s. 429.26, F.S., relating to appropriateness of placements and examinations of residents.
- Section 45:** Amends s. 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center.
- Section 46:** Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
- Section 47:** Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
- Section 48:** Amends s. 456.072, F.S., relating to grounds for discipline; penalties; and enforcement.
- Section 49:** Amends s. 456.44, F.S., relating to controlled substance prescribing.
- Section 50:** Amends s. 458.3265, F.S., relating to pain-management clinics.
- Section 51:** Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
- Section 52:** Amends s. 459.0137, F.S., relating to pain-management clinics.
- Section 53:** Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
- Section 54:** Amends s. 464.003, F.S., relating to definitions.
- Section 55:** Amends s. 464.0205, relating to retired volunteer nurse certificate.
- Section 56:** Amends s. 480.0475, F.S., relating to massage establishments and prohibited practices.
- Section 57:** Amends s. 493.6108, F.S., relating to investigation of applicants by Department of Agriculture and Consumer Services.
- Section 58:** Amends s. 626.9707, F.S., relating to disability insurance; discrimination on basis of sickle-cell trait prohibited.
- Section 59:** Amends s. 627.357, F.S., relating to medical malpractice self-insurance.

- Section 60:** Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; and claims.
- Section 61:** Amends s. 633.412, F.S., relating to firefighters and qualifications for certification.
- Section 62:** Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
- Section 63:** Amends s. 744.2006, F.S., relating to Office of Public and Professional Guardians; appointment, notification.
- Section 64:** Amends s. 744.331, F.S., relating to procedures to determine incapacity.
- Section 65:** Amends s. 744.3675, F.S., relating to the annual guardianship plan.
- Section 66:** Amends s. 766.103, F.S., relating to Florida Medical Consent Law.
- Section 67:** Amends s. 766.105, F.S., relating to Florida Patient's Compensation Fund.
- Section 68:** Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
- Section 69:** Amends s. 766.1116, F.S., relating to health care practitioner; waiver of license renewal fees and continuing education requirements.
- Section 70:** Amends s. 766.118, F.S., relating to determination of noneconomic damages.
- Section 71:** Amends s. 768.135, F.S., relating to volunteer team physicians; immunity.
- Section 72:** Amends s. 794.08, F.S., relating to female genital mutilation.
- Section 73:** Amends s. 893.02, F.S., relating to definitions.
- Section 74:** Amends s. 943.13, F.S., relating to officers' minimum qualifications for employment or appointment.
- Section 75:** Amends s. 945.603, F.S., relating to powers and duties of authority.
- Section 76:** Amends s. 948.03, F.S., relating to terms and conditions of probation.
- Section 77:** Amends s. 984.03, F.S., relating to definitions.
- Section 78:** Amends s. 985.03, F.S., relating to definitions.
- Section 79:** Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
- Section 80:** Amends s. 1002.42, F.S., relating to private schools.
- Section 81:** Amends s. 1006.062, F.S., relating to administration of medication and provision of medical services by district school board personnel.
- Section 82:** Amends s. 1006.20, F.S., relating to athletics in public K-12 schools.
- Section 83:** Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.
- Section 84:** Provides an appropriation.
- Section 85:** Provides an effective date of July 1, 2020.

## **II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT**

### **A. FISCAL IMPACT ON STATE GOVERNMENT:**

#### **1. Revenues:**

HB 7017, linked to CS/HB 607, authorizes an initial registration fee of \$100 for APRNs who choose to practice autonomously, and a biennial renewal fee of \$50 to maintain such registration. The total revenue DOH will receive from such fees is indeterminate because the number of APRNs who will choose to register to engage in autonomous practice is not predictable.

#### **2. Expenditures:**

DOH will incur costs associated with rulemaking to implement the bill's provisions, developing the registration application, and updating the LEIDS licensing system. Current resources are adequate to absorb these costs.

DOH will incur costs associated with the regulation of PAs who practice autonomously. Current resources are adequate to absorb these costs.

DOH will incur costs associated with the regulation of APRNs who practice autonomously. DOH estimates 3.5 FTE positions will be required to implement the provisions of the bill. The below table summarizes the various functions and costs associated with the regulation of autonomous APRNs under the bill:

<i>Function</i>	<i>FTE Request and Description</i>	<i>Salary Rate</i>	<i>Salary/Expenses/HR Transfer</i>	<i>NR Expenses</i>	<i>Total For Function</i>
Processing	One regulatory specialist to analyze, approve or deny registration applications, and update practitioner profiles	39,934	46,331	4,429	50,760
Investigation and Prosecution	One attorney and 1.5 FTE investigative specialists to review complaints and determine if legally sufficient for investigation and prosecution	143,961	172,758	13,287	186,045
<b>Total</b>	<b>3.50</b>	<b>183,895</b>	<b>\$ 219,089</b>	<b>\$ 17,716</b>	<b>\$ 236,805</b>

The bill appropriates from the Medical Quality Assurance Trust Fund to DOH for the regulation of autonomous APRNs: 3.5 full-time equivalent positions, 183,895 in associated salary rate, \$219,089 in recurring funds, and \$17,716 in nonrecurring funds.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

1. Revenues:

None.

2. Expenditures:

None.

**C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

APRNs who register to practice independently must pay a registration fee, as well as a fee to renew their registration. HB 7017 authorizes the Board of Nursing to set the application and biennial renewal fees, up to \$100 and \$50, respectively. Such APRNs will also have to pay for the additional continuing education hours required by the bill.

APRNs and PAs who have paid physicians for supervision will achieve cost-savings if they register to practice autonomously since supervision will no longer be needed.

**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 sufficient rule-making authority to implement its provisions.

**C. DRAFTING ISSUES OR OTHER COMMENTS:**

None.

**IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

On December 11, 2019, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Authorized advanced practice registered nurses to practice autonomously without a physician protocol;
- Authorized autonomous physician assistants to practice primary care without physician supervision;
- Established the qualifications for a physician assistant or an advanced practice registered nurse to practice autonomously, including a requirement to maintain liability coverage;
- Required the Department of Health to publish online practitioner profiles for autonomous physician assistants;
- Deleted a requirement that a physician assistant notify a patient of his or her right to see a doctor prior to a physician assistant prescribing a medication;
- Required the Boards of Medicine and Osteopathic Medicine to approve physician assistant education programs;
- Revised the composition of the Council on Physician Assistants;
- Appropriated 3.5 full-time equivalent positions, \$183,895 in associated salary rate, \$219,089 in recurring funds, and \$17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to DOH for the regulation of autonomous APRNs and PAs;
- Authorized an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse to examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court; and
- Made conforming changes throughout statute.

This analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

1                                   A bill to be entitled  
2           An act relating to health care practitioners; amending  
3           s. 456.0391, F.S.; requiring an autonomous physician  
4           assistant to submit certain information to the  
5           Department of Health; requiring the department to send  
6           a notice to autonomous physician assistants regarding  
7           the required information; requiring autonomous  
8           physician assistants who have submitted required  
9           information to update such information in writing;  
10          providing penalties; amending s. 456.041, F.S.;  
11          requiring the department to provide a practitioner  
12          profile for an autonomous physician assistant;  
13          amending ss. 458.347 and 459.022, F.S.; defining the  
14          term "autonomous physician assistant"; authorizing  
15          third-party payors to reimburse employers for services  
16          provided by autonomous physician assistants; deleting  
17          a requirement that a physician assistant must inform a  
18          patient of a right to see a physician before  
19          prescribing or dispensing a prescription; revising the  
20          requirements for physician assistant education and  
21          training programs; authorizing the Board of Medicine  
22          to impose certain penalties upon an autonomous  
23          physician assistant; requiring the board to register a  
24          physician assistant as an autonomous physician  
25          assistant if the applicant meets certain criteria;

26 providing requirements; providing exceptions;  
27 requiring the department to distinguish such  
28 autonomous physician assistants' licenses; authorizing  
29 such autonomous physician assistants to perform  
30 specified acts without physician supervision or  
31 supervisory protocol; requiring biennial registration  
32 renewal; requiring the Council on Physician Assistants  
33 to establish rules; revising the membership and duties  
34 of the council; prohibiting a person who is not  
35 registered as an autonomous physician assistant from  
36 using the title; providing for the denial, suspension,  
37 or revocation of the registration of an autonomous  
38 physician assistant; requiring the board to adopt  
39 rules; requiring autonomous physician assistants to  
40 report adverse incidents to the department; amending  
41 s. 464.012, F.S.; requiring applicants for  
42 registration as an advanced practice registered nurse  
43 to apply to the Board of Nursing; authorizing an  
44 advanced practice registered nurse to sign, certify,  
45 stamp, verify, or endorse a document that requires the  
46 signature, certification, stamp, verification,  
47 affidavit, or endorsement of a physician within the  
48 framework of an established protocol; providing an  
49 exception; creating s. 464.0123, F.S.; defining the  
50 term "autonomous practice"; providing for the

51 registration of an advanced practice registered nurse  
52 to engage in autonomous practice; providing  
53 registration requirements; requiring the department to  
54 distinguish such advanced practice registered nurses'  
55 licenses and include the registration in their  
56 practitioner profiles; authorizing such advanced  
57 practice registered nurses to perform specified acts  
58 without physician supervision or supervisory protocol;  
59 requiring biennial registration renewal and continuing  
60 education; authorizing the Board of Nursing to  
61 establish an advisory committee to determine the  
62 medical acts that may be performed by such advanced  
63 practice registered nurses; providing for appointment  
64 and terms of committee members; requiring the board to  
65 adopt rules; creating s. 464.0155, F.S.; requiring  
66 advanced practice registered nurses registered to  
67 engage in autonomous practice to report adverse  
68 incidents to the Department of Health; providing  
69 requirements; defining the term "adverse incident";  
70 providing for department review of such reports;  
71 authorizing the department to take disciplinary  
72 action; amending s. 464.018, F.S.; providing  
73 additional grounds for denial of a license or  
74 disciplinary action for advanced practice registered  
75 nurses registered to engage in autonomous practice;

76 | amending s. 39.01, F.S.; revising the definition of  
77 | the term "licensed health care professional" to  
78 | include an autonomous physician assistant; amending s.  
79 | 39.303, F.S.; authorizing a specified autonomous  
80 | physician assistant to review certain cases of abuse  
81 | or neglect and standards for face-to-face medical  
82 | evaluations by a Child Protection Team; amending s.  
83 | 39.304, F.S.; authorizing an autonomous physician  
84 | assistant to perform or order an examination and  
85 | diagnose a child without parental consent under  
86 | certain circumstances; amending s. 110.12315, F.S.;  
87 | revising requirements for reimbursement of pharmacies  
88 | for specified prescription drugs and supplies under  
89 | the state employees' prescription drug program;  
90 | amending s. 252.515, F.S.; providing immunity from  
91 | civil liability for an autonomous physician assistant  
92 | under the Postdisaster Relief Assistance Act; amending  
93 | ss. 310.071, 310.073, and 310.081, F.S.; authorizing  
94 | an autonomous physician assistant and a physician  
95 | assistant to administer the physical examination  
96 | required for deputy pilot certification and state  
97 | pilot licensure; authorizing an applicant for a deputy  
98 | pilot certificate or a state pilot license to use  
99 | controlled substances prescribed by an autonomous  
100 | physician assistant; amending s. 320.0848, F.S.;



101 authorizing an autonomous physician assistant to  
102 certify that a person is disabled to satisfy  
103 requirements for certain permits; amending s.  
104 381.00315, F.S.; providing for the temporary  
105 reactivation of the registration of an autonomous  
106 physician assistant in a public health emergency;  
107 amending s. 381.00593, F.S.; revising the definition  
108 of the term "health care practitioner" to include an  
109 autonomous physician assistant for purposes of the  
110 Public School Volunteer Health Care Practitioner Act;  
111 amending s. 381.026, F.S.; revising the definition of  
112 the term "health care provider" to include an advanced  
113 practice registered nurse and an autonomous physician  
114 assistant for purposes of the Florida Patient's Bill  
115 of Rights and Responsibilities; amending s. 382.008,  
116 F.S.; authorizing an autonomous physician assistant, a  
117 physician assistant, and an advanced practice  
118 registered nurse to file a certificate of death or  
119 fetal death under certain circumstances; authorizing a  
120 certified nurse midwife to provide certain information  
121 to the funeral director within a specified time  
122 period; replacing the term "primary or attending  
123 physician" with "primary or attending practitioner";  
124 defining the term "primary or attending practitioner";  
125 amending s. 382.011, F.S.; conforming a provision to

126 changes made by the act; amending s. 383.14, F.S.;

127 authorizing the release of certain newborn tests and

128 screening results to an autonomous physician

129 assistant; revising the definition of the term "health

130 care practitioner" to include an autonomous physician

131 assistant for purposes of screening for certain

132 disorders and risk factors; amending s. 390.0111,

133 F.S.; authorizing a certain action by an autonomous

134 physician assistant before an abortion procedure;

135 amending s. 390.012, F.S.; authorizing certain actions

136 by an autonomous physician assistant during and after

137 an abortion procedure; amending s. 394.463, F.S.;

138 authorizing an autonomous physician assistant, a

139 physician assistant, and an advanced practice

140 registered nurse to initiate an involuntary

141 examination for mental illness under certain

142 circumstances; authorizing a physician assistant to

143 examine a patient; amending s. 395.0191, F.S.;

144 providing an exception to certain onsite medical

145 direction requirements for a specified advanced

146 practice registered nurse; amending 395.602, F.S.;

147 authorizing the Department of Health to use certain

148 funds to increase the number of autonomous physician

149 assistants in rural areas; amending s. 397.501, F.S.;

150 prohibiting the denial of certain services to an

151 individual who takes medication prescribed by an  
152 autonomous physician assistant, a physician assistant,  
153 or an advanced practice registered nurse; amending ss.  
154 397.679 and 397.6793, F.S.; authorizing an autonomous  
155 physician assistant to execute a certificate for  
156 emergency admission of a person who is substance abuse  
157 impaired; amending s. 400.021, F.S.; revising the  
158 definition of the term "geriatric outpatient clinic"  
159 to include a site staffed by an autonomous physician  
160 assistant; amending s. 400.172, F.S.; authorizing an  
161 autonomous physician assistant and an advanced  
162 practice registered nurse to provide certain medical  
163 information to a prospective respite care resident;  
164 amending s. 400.487, F.S.; authorizing an autonomous  
165 physician assistant to establish treatment orders for  
166 certain patients under certain circumstances; amending  
167 s. 400.506, F.S.; requiring an autonomous physician  
168 assistant to comply with specified treatment plan  
169 requirements; amending ss. 400.9973, 400.9974,  
170 400.9976, and 400.9979, F.S.; authorizing an  
171 autonomous physician assistant to prescribe client  
172 admission to a transitional living facility and care  
173 for such client, order treatment plans, supervise and  
174 record client medications, and order physical and  
175 chemical restraints, respectively; amending s.

176 401.445, F.S.; prohibiting recovery of damages in  
177 court against a registered autonomous physician  
178 assistant under certain circumstances; requiring an  
179 autonomous physician assistant to attempt to obtain a  
180 person's consent before providing emergency services;  
181 amending ss. 409.906 and 409.908, F.S.; authorizing  
182 the agency to reimburse an autonomous physician  
183 assistant for providing certain optional Medicaid  
184 services; amending s. 409.973, F.S.; requiring managed  
185 care plans to cover autonomous physician assistant  
186 services; amending s. 429.26, F.S.; prohibiting  
187 autonomous physician assistants from having a  
188 financial interest in the assisted living facility at  
189 which they are employed; authorizing an autonomous  
190 physician assistant to examine an assisted living  
191 facility resident before admission; amending s.  
192 429.918, F.S.; revising the definition of the term  
193 "ADRD participant" to include a participant who has a  
194 specified diagnosis from an autonomous physician  
195 assistant; authorizing an autonomous physician  
196 assistant to provide signed documentation to an ADRD  
197 participant; amending s. 440.102, F.S.; authorizing an  
198 autonomous physician assistant to collect a specimen  
199 for a drug test for specified purposes; amending s.  
200 456.053, F.S.; revising definitions; authorizing an

201 advanced practice registered nurse registered to  
202 engage in autonomous practice and an autonomous  
203 physician assistant to make referrals under certain  
204 circumstances; conforming a cross-reference; amending  
205 s. 456.072, F.S.; providing penalties for an  
206 autonomous physician assistant who prescribes or  
207 dispenses a controlled substance in a certain manner;  
208 amending s. 456.44, F.S.; revising the definition of  
209 the term "registrant" to include an autonomous  
210 physician assistant for purposes of controlled  
211 substance prescribing; providing requirements for an  
212 autonomous physician assistant who prescribes  
213 controlled substances for the treatment of chronic  
214 nonmalignant pain; amending ss. 458.3265 and 459.0137,  
215 F.S.; requiring an autonomous physician assistant to  
216 perform a physical examination of a patient at a pain-  
217 management clinic under certain circumstances;  
218 amending ss. 458.331 and 459.015, F.S.; providing  
219 grounds for denial of a license or disciplinary action  
220 against an autonomous physician assistant for certain  
221 violations; amending s. 464.003, F.S.; revising the  
222 definition of the term "practice of practical nursing"  
223 to include an autonomous physician assistant for  
224 purposes of authorizing such assistant to supervise a  
225 licensed practical nurse; amending s. 464.0205, F.S.;

226 | authorizing an autonomous physician assistant to  
227 | directly supervise a certified retired volunteer  
228 | nurse; amending s. 480.0475, F.S.; authorizing the  
229 | operation of a massage establishment during specified  
230 | hours if the massage therapy is prescribed by an  
231 | autonomous physician assistant; amending s. 493.6108,  
232 | F.S.; authorizing an autonomous physician assistant to  
233 | certify the physical fitness of a certain class of  
234 | applicants to bear a weapon or firearm; amending s.  
235 | 626.9707, F.S.; prohibiting an insurer from refusing  
236 | to issue and deliver certain disability insurance that  
237 | covers any medical treatment or service furnished by  
238 | an autonomous physician assistant or an advanced  
239 | practice registered nurse; amending s. 627.357, F.S.;  
240 | revising the definition of the term "health care  
241 | provider" to include an autonomous physician assistant  
242 | for purposes of medical malpractice self-insurance;  
243 | amending s. 627.736, F.S.; requiring personal injury  
244 | protection insurance to cover a certain percentage of  
245 | medical services and care provided by specified health  
246 | care providers; providing for specified reimbursement  
247 | of advanced practice registered nurses registered to  
248 | engage in autonomous practice or autonomous physician  
249 | assistants; amending s. 633.412, F.S.; authorizing an  
250 | autonomous physician assistant to medically examine an

251 applicant for firefighter certification; amending s.  
252 641.495, F.S.; requiring certain health maintenance  
253 organization documents to disclose that certain  
254 services may be provided by autonomous physician  
255 assistants or advanced practice registered nurses;  
256 amending s. 744.2006, F.S.; authorizing an autonomous  
257 physician assistant to carry out guardianship  
258 functions under a contract with a public guardian;  
259 conforming terminology; amending s. 744.331, F.S.;  
260 authorizing an autonomous physician assistant or a  
261 physician assistant to be an eligible member of an  
262 examining committee; conforming terminology; amending  
263 s. 744.3675, F.S.; authorizing an advanced practice  
264 registered nurse, autonomous physician assistant, or  
265 physician assistant to provide the medical report of a  
266 ward in an annual guardianship plan; amending s.  
267 766.103, F.S.; prohibiting recovery of damages against  
268 an autonomous physician assistant under certain  
269 conditions; amending s. 766.105, F.S.; revising the  
270 definition of the term "health care provider" to  
271 include an autonomous physician assistants for  
272 purposes of the Florida Patient's Compensation Fund;  
273 amending ss. 766.1115 and 766.1116, F.S.; revising the  
274 definitions of the terms "health care provider" and  
275 "health care practitioner," respectively, to include

276 autonomous physician assistants for purposes of the  
277 Access to Health Care Act; amending s. 766.118, F.S.;  
278 revising the definition of the term "practitioner" to  
279 include an advanced practice registered nurse  
280 registered to engage in autonomous practice and an  
281 autonomous physician assistant; amending s. 768.135,  
282 F.S.; providing immunity from liability for an  
283 advanced practice registered nurse registered to  
284 engage in autonomous practice or an autonomous  
285 physician assistant who provides volunteer services  
286 under certain circumstances; amending s. 794.08, F.S.;  
287 providing an exception to medical procedures conducted  
288 by an autonomous physician assistant under certain  
289 circumstances; amending s. 893.02, F.S.; revising the  
290 definition of the term "practitioner" to include an  
291 autonomous physician assistant; amending s. 943.13,  
292 F.S.; authorizing an autonomous physician assistant to  
293 conduct a physical examination for a law enforcement  
294 or correctional officer to satisfy qualifications for  
295 employment or appointment; amending s. 945.603, F.S.;  
296 authorizing the Correctional Medical Authority to  
297 review and make recommendations relating to the use of  
298 autonomous physician assistants as physician  
299 extenders; amending s. 948.03, F.S.; authorizing an  
300 autonomous physician assistant to prescribe drugs or



301 narcotics to a probationer; amending ss. 984.03 and  
302 985.03, F.S.; revising the definition of the term  
303 "licensed health care professional" to include an  
304 autonomous physician assistant; amending ss. 1002.20  
305 and 1002.42, F.S.; providing immunity from liability  
306 for autonomous physician assistants who administer  
307 epinephrine auto-injectors in public and private  
308 schools; amending s. 1006.062, F.S.; authorizing an  
309 autonomous physician assistant to provide training in  
310 the administration of medication to designated school  
311 personnel; requiring an autonomous physician assistant  
312 to monitor such personnel; authorizing an autonomous  
313 physician assistant to determine whether such  
314 personnel may perform certain invasive medical  
315 services; amending s. 1006.20, F.S.; authorizing an  
316 autonomous physician assistant to medically evaluate a  
317 student athlete; amending s. 1009.65, F.S.;  
318 authorizing an autonomous physician assistant to  
319 participate in the Medical Education Reimbursement and  
320 Loan Repayment Program; providing appropriations and  
321 authorizing positions; providing an effective date.

322

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

324

325 Section 1. Subsections (1), (2), and (3) of section

326 | 456.0391, Florida Statutes, are amended to read:

327 |       456.0391 Advanced practice registered nurses and  
 328 | autonomous physician assistants; information required for  
 329 | licensure or registration.-

330 |       (1) (a) Each person who applies for initial licensure under  
 331 | s. 464.012 or initial registration under s. 458.347(8) or s.  
 332 | 459.022(8) must, at the time of application, and each person  
 333 | licensed under s. 464.012 or registered under s. 458.347(8) or  
 334 | s. 459.022(8) who applies for licensure or registration renewal  
 335 | must, in conjunction with the renewal of such licensure or  
 336 | registration and under procedures adopted by the Department of  
 337 | Health, and in addition to any other information that may be  
 338 | required from the applicant, furnish the following information  
 339 | to the Department of Health:

340 |       1. The name of each school or training program that the  
 341 | applicant has attended, with the months and years of attendance  
 342 | and the month and year of graduation, and a description of all  
 343 | graduate professional education completed by the applicant,  
 344 | excluding any coursework taken to satisfy continuing education  
 345 | requirements.

346 |       2. The name of each location at which the applicant  
 347 | practices.

348 |       3. The address at which the applicant will primarily  
 349 | conduct his or her practice.

350 |       4. Any certification or designation that the applicant has

351 received from a specialty or certification board that is  
352 recognized or approved by the regulatory board or department to  
353 which the applicant is applying.

354 5. The year that the applicant received initial  
355 certification, ~~or~~ licensure, or registration and began  
356 practicing the profession in any jurisdiction and the year that  
357 the applicant received initial certification, ~~or~~ or  
358 registration in this state.

359 6. Any appointment which the applicant currently holds to  
360 the faculty of a school related to the profession and an  
361 indication as to whether the applicant has had the  
362 responsibility for graduate education within the most recent 10  
363 years.

364 7. A description of any criminal offense of which the  
365 applicant has been found guilty, regardless of whether  
366 adjudication of guilt was withheld, or to which the applicant  
367 has pled guilty or nolo contendere. A criminal offense committed  
368 in another jurisdiction which would have been a felony or  
369 misdemeanor if committed in this state must be reported. If the  
370 applicant indicates that a criminal offense is under appeal and  
371 submits a copy of the notice for appeal of that criminal  
372 offense, the department must state that the criminal offense is  
373 under appeal if the criminal offense is reported in the  
374 applicant's profile. If the applicant indicates to the  
375 department that a criminal offense is under appeal, the

376 applicant must, within 15 days after the disposition of the  
377 appeal, submit to the department a copy of the final written  
378 order of disposition.

379 8. A description of any final disciplinary action taken  
380 within the previous 10 years against the applicant by a  
381 licensing or regulatory body in any jurisdiction, by a specialty  
382 board that is recognized by the board or department, or by a  
383 licensed hospital, health maintenance organization, prepaid  
384 health clinic, ambulatory surgical center, or nursing home.  
385 Disciplinary action includes resignation from or nonrenewal of  
386 staff membership or the restriction of privileges at a licensed  
387 hospital, health maintenance organization, prepaid health  
388 clinic, ambulatory surgical center, or nursing home taken in  
389 lieu of or in settlement of a pending disciplinary case related  
390 to competence or character. If the applicant indicates that the  
391 disciplinary action is under appeal and submits a copy of the  
392 document initiating an appeal of the disciplinary action, the  
393 department must state that the disciplinary action is under  
394 appeal if the disciplinary action is reported in the applicant's  
395 profile.

396 (b) In addition to the information required under  
397 paragraph (a), each applicant for initial licensure or  
398 registration or licensure or registration renewal must provide  
399 the information required of licensees pursuant to s. 456.049.

400 (2) The Department of Health shall send a notice to each

401 person licensed under s. 464.012 or registered under s.  
 402 458.347(8) or s. 459.022(8) at the licensee's or registrant's  
 403 last known address of record regarding the requirements for  
 404 information to be submitted by such person ~~advanced practice~~  
 405 ~~registered nurses~~ pursuant to this section in conjunction with  
 406 the renewal of such license or registration.

407 (3) Each person licensed under s. 464.012 or registered  
 408 under s. 458.347(8) or s. 459.022(8) who has submitted  
 409 information pursuant to subsection (1) must update that  
 410 information in writing by notifying the Department of Health  
 411 within 45 days after the occurrence of an event or the  
 412 attainment of a status that is required to be reported by  
 413 subsection (1). Failure to comply with the requirements of this  
 414 subsection to update and submit information constitutes a ground  
 415 for disciplinary action under the applicable practice act  
 416 ~~chapter 464~~ and s. 456.072(1)(k). For failure to comply with the  
 417 requirements of this subsection to update and submit  
 418 information, the department or board, as appropriate, may:

419 (a) Refuse to issue a license or registration to any  
 420 person applying for initial licensure or registration who fails  
 421 to submit and update the required information.

422 (b) Issue a citation to any certificateholder, ~~or~~  
 423 licensee, or registrant who fails to submit and update the  
 424 required information and may fine the certificateholder, ~~or~~  
 425 licensee, or registrant up to \$50 for each day that the

426 certificateholder, ~~or~~ licensee, or registrant is not in  
427 compliance with this subsection. The citation must clearly state  
428 that the certificateholder, ~~or~~ licensee, or registrant may  
429 choose, in lieu of accepting the citation, to follow the  
430 procedure under s. 456.073. If the certificateholder, ~~or~~  
431 licensee, or registrant disputes the matter in the citation, the  
432 procedures set forth in s. 456.073 must be followed. However, if  
433 the certificateholder, ~~or~~ licensee, or registrant does not  
434 dispute the matter in the citation with the department within 30  
435 days after the citation is served, the citation becomes a final  
436 order and constitutes discipline. Service of a citation may be  
437 made by personal service or certified mail, restricted delivery,  
438 to the subject at the certificateholder's, ~~or~~ licensee's, or  
439 registrant's last known address.

440 Section 2. Subsection (6) of section 456.041, Florida  
441 Statutes, is amended to read:

442 456.041 Practitioner profile; creation.—

443 (6) The Department of Health shall provide in each  
444 practitioner profile for every physician, autonomous physician  
445 assistant, or advanced practice registered nurse terminated for  
446 cause from participating in the Medicaid program, pursuant to s.  
447 409.913, or sanctioned by the Medicaid program a statement that  
448 the practitioner has been terminated from participating in the  
449 Florida Medicaid program or sanctioned by the Medicaid program.

450 Section 3. Subsections (8) through (17) of section

451 458.347, Florida Statutes, are renumbered as subsections (9)  
452 through (18), respectively, subsection (2), paragraphs (b), (e),  
453 and (f) of subsection (4), paragraph (a) of subsection (6),  
454 paragraphs (a) and (f) of subsection (7), present subsection  
455 (9), and present subsections (11) through (13) are amended,  
456 paragraph (b) is added to subsection (2), and new subsections  
457 (8) and (19) are added to that section, to read:

458 458.347 Physician assistants.—

459 (2) DEFINITIONS.—As used in this section:

460 (a) "Approved program" means a program, formally approved  
461 by the boards, for the education of physician assistants.

462 (b) "Autonomous physician assistant" means a physician  
463 assistant who meets the requirements of subsection (8) to  
464 practice primary care without physician supervision.

465 (c) ~~(b)~~ "Boards" means the Board of Medicine and the Board  
466 of Osteopathic Medicine.

467 (d) ~~(h)~~ "Continuing medical education" means courses  
468 recognized and approved by the boards, the American Academy of  
469 Physician Assistants, the American Medical Association, the  
470 American Osteopathic Association, or the Accreditation Council  
471 on Continuing Medical Education.

472 (e) ~~(e)~~ "Council" means the Council on Physician  
473 Assistants.

474 (f) ~~(e)~~ "Physician assistant" means a person who is a  
475 graduate of an approved program or its equivalent or meets

476 standards approved by the boards and is licensed to perform  
 477 medical services delegated by the supervising physician.

478 (g) "Proficiency examination" means an entry-level  
 479 examination approved by the boards, including, but not limited  
 480 to, those examinations administered by the National Commission  
 481 on Certification of Physician Assistants.

482 (h)~~(f)~~ "Supervision" means responsible supervision and  
 483 control. Except in cases of emergency, supervision requires the  
 484 easy availability or physical presence of the licensed physician  
 485 for consultation and direction of the actions of the physician  
 486 assistant. For the purposes of this definition, the term "easy  
 487 availability" includes the ability to communicate by way of  
 488 telecommunication. The boards shall establish rules as to what  
 489 constitutes responsible supervision of the physician assistant.

490 (i)~~(d)~~ "Trainee" means a person who is currently enrolled  
 491 in an approved program.

492 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

493 (b) This chapter does not prevent third-party payors from  
 494 reimbursing employers of autonomous physician assistants or  
 495 physician assistants for covered services rendered by registered  
 496 autonomous physician assistants or licensed physician  
 497 assistants.

498 (e) A supervising physician may delegate to a fully  
 499 licensed physician assistant the authority to prescribe or  
 500 dispense any medication used in the supervising physician's



501 practice unless such medication is listed on the formulary  
502 created pursuant to paragraph (f). A fully licensed physician  
503 assistant may only prescribe or dispense such medication under  
504 the following circumstances:

505 1. A physician assistant must clearly identify to the  
506 patient that he or she is a physician assistant ~~and inform the~~  
507 ~~patient that the patient has the right to see the physician~~  
508 ~~before a prescription is prescribed or dispensed by the~~  
509 ~~physician assistant.~~

510 2. The supervising physician must notify the department of  
511 his or her intent to delegate, on a department-approved form,  
512 before delegating such authority and of any change in  
513 prescriptive privileges of the physician assistant. Authority to  
514 dispense may be delegated only by a supervising physician who is  
515 registered as a dispensing practitioner in compliance with s.  
516 465.0276.

517 3. The physician assistant must complete a minimum of 10  
518 continuing medical education hours in the specialty practice in  
519 which the physician assistant has prescriptive privileges with  
520 each licensure renewal. Three of the 10 hours must consist of a  
521 continuing education course on the safe and effective  
522 prescribing of controlled substance medications which is offered  
523 by a statewide professional association of physicians in this  
524 state accredited to provide educational activities designated  
525 for the American Medical Association Physician's Recognition

526 Award Category 1 credit or designated by the American Academy of  
527 Physician Assistants as a Category 1 credit.

528 4. The department may issue a prescriber number to the  
529 physician assistant granting authority for the prescribing of  
530 medicinal drugs authorized within this paragraph upon completion  
531 of the requirements of this paragraph. The physician assistant  
532 is not required to independently register pursuant to s.  
533 465.0276.

534 5. The prescription may be in paper or electronic form but  
535 must comply with ss. 456.0392(1) and 456.42(1) and chapter 499  
536 and must contain, in addition to the supervising physician's  
537 name, address, and telephone number, the physician assistant's  
538 prescriber number. Unless it is a drug or drug sample dispensed  
539 by the physician assistant, the prescription must be filled in a  
540 pharmacy permitted under chapter 465 and must be dispensed in  
541 that pharmacy by a pharmacist licensed under chapter 465. The  
542 inclusion of the prescriber number creates a presumption that  
543 the physician assistant is authorized to prescribe the medicinal  
544 drug and the prescription is valid.

545 6. The physician assistant must note the prescription or  
546 dispensing of medication in the appropriate medical record.

547 (f)1. The council shall establish a formulary of medicinal  
548 drugs that a registered autonomous physician assistant or fully  
549 licensed physician assistant having prescribing authority under  
550 this section or s. 459.022 may not prescribe. The formulary must

551 include general anesthetics and radiographic contrast materials  
552 and must limit the prescription of Schedule II controlled  
553 substances as listed in s. 893.03 or 21 U.S.C. s. 812 to a 7-day  
554 supply. The formulary must also restrict the prescribing of  
555 psychiatric mental health controlled substances for children  
556 younger than 18 years of age.

557 2. In establishing the formulary, the council shall  
558 consult with a pharmacist licensed under chapter 465, but not  
559 licensed under this chapter or chapter 459, who shall be  
560 selected by the State Surgeon General.

561 3. Only the council shall add to, delete from, or modify  
562 the formulary. Any person who requests an addition, a deletion,  
563 or a modification of a medicinal drug listed on such formulary  
564 has the burden of proof to show cause why such addition,  
565 deletion, or modification should be made.

566 4. The boards shall adopt the formulary required by this  
567 paragraph, and each addition, deletion, or modification to the  
568 formulary, by rule. Notwithstanding any provision of chapter 120  
569 to the contrary, the formulary rule shall be effective 60 days  
570 after the date it is filed with the Secretary of State. Upon  
571 adoption of the formulary, the department shall mail a copy of  
572 such formulary to each registered autonomous physician assistant  
573 or fully licensed physician assistant having prescribing  
574 authority under this section or s. 459.022, and to each pharmacy  
575 licensed by the state. The boards shall establish, by rule, a

576 fee not to exceed \$200 to fund ~~the provisions of~~ this paragraph  
577 and paragraph (e).

578 (6) PROGRAM APPROVAL.—

579 (a) The boards shall approve programs, ~~based on~~  
580 ~~recommendations by the council,~~ for the education and training  
581 of physician assistants which meet standards established by rule  
582 of the boards. ~~The council may recommend only those physician~~  
583 ~~assistant programs that hold full accreditation or provisional~~  
584 ~~accreditation from the Commission on Accreditation of Allied~~  
585 ~~Health Programs or its successor organization. Any educational~~  
586 ~~institution offering a physician assistant program approved by~~  
587 ~~the boards pursuant to this paragraph may also offer the~~  
588 ~~physician assistant program authorized in paragraph (c) for~~  
589 ~~unlicensed physicians.~~

590 (7) PHYSICIAN ASSISTANT LICENSURE.—

591 (a) Any person desiring to be licensed as a physician  
592 assistant must apply to the department. The department shall  
593 issue a license to any person certified by the council as having  
594 met the following requirements:

- 595 1. Is at least 18 years of age.
- 596 2. Has satisfactorily passed a proficiency examination by  
597 an acceptable score established by the National Commission on  
598 Certification of Physician Assistants. If an applicant does not  
599 hold a current certificate issued by the National Commission on  
600 Certification of Physician Assistants and has not actively

601 | practiced as a physician assistant within the immediately  
 602 | preceding 4 years, the applicant must retake and successfully  
 603 | complete the entry-level examination of the National Commission  
 604 | on Certification of Physician Assistants to be eligible for  
 605 | licensure.

606 |         3. Has completed the application form and remitted an  
 607 | application fee not to exceed \$300 as set by the boards. An  
 608 | application for licensure made by a physician assistant must  
 609 | include:

610 |         a. Has graduated from a board-approved ~~A certificate of~~  
 611 | ~~completion of a~~ physician assistant training program as  
 612 | specified in subsection (6).

613 |         b. Acknowledgment of any prior felony convictions.

614 |         c. Acknowledgment of any previous revocation or denial of  
 615 | licensure or certification in any state.

616 |         d. A copy of course transcripts and a copy of the course  
 617 | description from a physician assistant training program  
 618 | describing course content in pharmacotherapy, if the applicant  
 619 | wishes to apply for prescribing authority. These documents must  
 620 | meet the evidence requirements for prescribing authority.

621 |         (f) The Board of Medicine may impose any of the penalties  
 622 | authorized under ss. 456.072 and 458.331(2) upon an autonomous  
 623 | physician assistant or a physician assistant if the autonomous  
 624 | physician assistant, physician assistant, or ~~the~~ supervising  
 625 | physician has been found guilty of or is being investigated for

626 any act that constitutes a violation of this chapter or chapter  
627 456.

628 (8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

629 (a) The boards shall register a physician assistant as an  
630 autonomous physician assistant if the applicant demonstrates  
631 that he or she:

632 1. Holds an active, unencumbered license to practice as a  
633 physician assistant in this state.

634 2. Has not been subject to any disciplinary action as  
635 specified in s. 456.072, s. 458.331, or s. 459.015, or any  
636 similar disciplinary action in any jurisdiction of the United  
637 States, within the 5 years immediately preceding the  
638 registration request.

639 3. Has completed, in any jurisdiction of the United  
640 States, at least 2,000 clinical practice hours within the 3  
641 years immediately preceding the submission of the registration  
642 request while practicing as a physician assistant under the  
643 supervision of an allopathic or osteopathic physician who held  
644 an active, unencumbered license issued by another state, the  
645 District of Columbia, or a possession or territory of the United  
646 States during the period of such supervision.

647 4. Has completed a graduate-level course in pharmacology.

648 5. Obtains and maintains professional liability coverage  
649 at the same level and in the same manner as in s. 458.320(1)(b)  
650 or (c). However, the requirements of this subparagraph do not

651 apply to:

652 a. Any person registered under this subsection who  
653 practices exclusively as an officer, employee, or agent of the  
654 Federal Government or of the state or its agencies or its  
655 subdivisions.

656 b. Any person whose license has become inactive and who is  
657 not practicing as an autonomous physician assistant in this  
658 state.

659 c. Any person who practices as an autonomous physician  
660 assistant only in conjunction with his or her teaching duties at  
661 an accredited school or its main teaching hospitals. Such  
662 practice is limited to that which is incidental to and a  
663 necessary part of duties in connection with the teaching  
664 position.

665 d. Any person who holds an active registration under this  
666 subsection who is not practicing as an autonomous physician  
667 assistant in this state. If such person initiates or resumes any  
668 practice as an autonomous physician assistant, he or she must  
669 notify the department of such activity and fulfill the  
670 professional liability coverage requirements of this  
671 subparagraph.

672 (b) The department shall conspicuously distinguish an  
673 autonomous physician assistant license if he or she is  
674 registered under this subsection.

675 (c) An autonomous physician assistant may:

676 1. Render only primary care services as defined by rule of  
677 the boards without physician supervision.

678 2. Provide any service that is within the scope of the  
679 autonomous physician assistant's education and experience and  
680 provided in accordance with rules adopted by the board without  
681 physician supervision.

682 3. Prescribe, dispense, administer, or order any medicinal  
683 drug, including those medicinal drugs to the extent authorized  
684 under paragraph (4)(f) and the formulary adopted in that  
685 paragraph.

686 4. Order any medication for administration to a patient in  
687 a facility licensed under chapter 395 or part II of chapter 400,  
688 notwithstanding chapter 465 or chapter 893.

689 5. Provide a signature, certification, stamp,  
690 verification, affidavit, or other endorsement that is otherwise  
691 required by law to be provided by a physician.

692 (d) An autonomous physician assistant must biennially  
693 renew his or her registration under this subsection. The  
694 biennial renewal shall coincide with the autonomous physician  
695 assistant's biennial renewal period for physician assistant  
696 licensure.

697 (e) The council shall develop rules defining the primary  
698 care practice of autonomous physician assistants, which may  
699 include internal medicine, general pediatrics, family medicine,  
700 geriatrics, and general obstetrics and gynecology practices.



701 (10) ~~(9)~~ COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on  
702 Physician Assistants is created within the department.

703 (a) The council shall consist of five members appointed as  
704 follows:

705 1. The chairperson of the Board of Medicine shall appoint  
706 one member who is a physician and a member ~~three members who are~~  
707 ~~physicians and members~~ of the Board of Medicine. ~~One of The~~  
708 physician ~~physicians~~ must supervise a physician assistant in his  
709 or her ~~the physician's~~ practice.

710 2. The chairperson of the Board of Osteopathic Medicine  
711 shall appoint one member who is a physician and a member of the  
712 Board of Osteopathic Medicine. The physician must supervise a  
713 physician assistant in his or her practice.

714 3. The State Surgeon General or his or her designee shall  
715 appoint three ~~a~~ fully licensed physician assistants ~~assistant~~  
716 licensed under this chapter or chapter 459.

717 (b) ~~Two of the members appointed to the council must be~~  
718 ~~physicians who supervise physician assistants in their practice.~~  
719 Members shall be appointed to terms of 4 years, except that of  
720 the initial appointments, two members shall be appointed to  
721 terms of 2 years, two members shall be appointed to terms of 3  
722 years, and one member shall be appointed to a term of 4 years,  
723 as established by rule of the boards. Council members may not  
724 serve more than two consecutive terms. The council shall  
725 annually elect a chairperson from among its members.

726 (c) The council shall:

727 1. Recommend to the department the licensure of physician  
728 assistants.

729 2. Develop all rules regulating the primary care practice  
730 of autonomous physician assistants and the use of physician  
731 assistants by physicians under this chapter and chapter 459,  
732 except for rules relating to the formulary developed under  
733 paragraph (4) (f). The council shall also develop rules to ensure  
734 that the continuity of supervision is maintained in each  
735 practice setting. The boards shall consider adopting a proposed  
736 rule developed by the council at the regularly scheduled meeting  
737 immediately following the submission of the proposed rule by the  
738 council. A proposed rule submitted by the council may not be  
739 adopted by either board unless both boards have accepted and  
740 approved the identical language contained in the proposed rule.  
741 The language of all proposed rules submitted by the council must  
742 be approved by both boards pursuant to each respective board's  
743 guidelines and standards regarding the adoption of proposed  
744 rules. If either board rejects the council's proposed rule, that  
745 board must specify its objection to the council with  
746 particularity and include any recommendations it may have for  
747 the modification of the proposed rule.

748 3. Make recommendations to the boards regarding all  
749 matters relating to autonomous physician assistants and  
750 physician assistants.

751           4. Address concerns and problems of practicing autonomous  
752 physician assistants and physician assistants in order to  
753 improve safety in the clinical practices of registered  
754 autonomous physician assistants and licensed physician  
755 assistants.

756           (d) When the council finds that an applicant for licensure  
757 has failed to meet, to the council's satisfaction, each of the  
758 requirements for licensure set forth in this section, the  
759 council may enter an order to:

760           1. Refuse to certify the applicant for licensure;

761           2. Approve the applicant for licensure with restrictions  
762 on the scope of practice or license; or

763           3. Approve the applicant for conditional licensure. Such  
764 conditions may include placement of the licensee on probation  
765 for a period of time and subject to such conditions as the  
766 council may specify, including but not limited to, requiring the  
767 licensee to undergo treatment, to attend continuing education  
768 courses, to work under the direct supervision of a physician  
769 licensed in this state, or to take corrective action.

770           ~~(12)-(11)~~ PENALTY.—Any person who has not been registered  
771 or licensed by the council and approved by the department and  
772 who holds himself or herself out as an autonomous physician  
773 assistant or a physician assistant or who uses any other term in  
774 indicating or implying that he or she is an autonomous physician  
775 assistant or a physician assistant commits a felony of the third

776 degree, punishable as provided in s. 775.082 or s. 775.084 or by  
777 a fine not exceeding \$5,000.

778 (13)~~(12)~~ DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—  
779 The boards may deny, suspend, or revoke the registration of an  
780 autonomous physician assistant or the license of a physician  
781 assistant license if a board determines that the autonomous  
782 physician assistant or physician assistant has violated this  
783 chapter.

784 (14)~~(13)~~ RULES.—The boards shall adopt rules to implement  
785 this section, including rules detailing the contents of the  
786 application for licensure and notification pursuant to  
787 subsection (7), rules relating to the registration of autonomous  
788 physician assistants under subsection (8), and rules to ensure  
789 ~~both~~ the continued competency of autonomous physician assistants  
790 and physician assistants and the proper utilization of them by  
791 physicians or groups of physicians.

792 (19) ADVERSE INCIDENTS.—An autonomous physician assistant  
793 must report adverse incidents to the department in accordance  
794 with s. 458.351.

795 Section 4. Subsections (8) through (17) of section  
796 459.022, Florida Statutes, are renumbered as subsections (9)  
797 through (18), respectively, subsection (2), paragraphs (b) and  
798 (e) of subsection (4), paragraph (a) of subsection (6),  
799 paragraphs (a) and (f) of subsection (7), present subsection  
800 (9), and present subsections (11) through (13) are amended,

801 paragraph (b) is added to subsection (2), and new subsections  
 802 (8) and (19) are added to that section, to read:

803 459.022 Physician assistants.—

804 (2) DEFINITIONS.—As used in this section:

805 (a) "Approved program" means a program, formally approved  
 806 by the boards, for the education of physician assistants.

807 (b) "Autonomous physician assistant" means a physician  
 808 assistant who meets the requirements of subsection (8) to  
 809 practice primary care without physician supervision.

810 (c)~~(b)~~ "Boards" means the Board of Medicine and the Board  
 811 of Osteopathic Medicine.

812 (d)~~(h)~~ "Continuing medical education" means courses  
 813 recognized and approved by the boards, the American Academy of  
 814 Physician Assistants, the American Medical Association, the  
 815 American Osteopathic Association, or the Accreditation Council  
 816 on Continuing Medical Education.

817 (e)~~(e)~~ "Council" means the Council on Physician  
 818 Assistants.

819 (f)~~(e)~~ "Physician assistant" means a person who is a  
 820 graduate of an approved program or its equivalent or meets  
 821 standards approved by the boards and is licensed to perform  
 822 medical services delegated by the supervising physician.

823 (g) "Proficiency examination" means an entry-level  
 824 examination approved by the boards, including, but not limited  
 825 to, those examinations administered by the National Commission

826 on Certification of Physician Assistants.

827 (h)~~(f)~~ "Supervision" means responsible supervision and  
 828 control. Except in cases of emergency, supervision requires the  
 829 easy availability or physical presence of the licensed physician  
 830 for consultation and direction of the actions of the physician  
 831 assistant. For the purposes of this definition, the term "easy  
 832 availability" includes the ability to communicate by way of  
 833 telecommunication. The boards shall establish rules as to what  
 834 constitutes responsible supervision of the physician assistant.

835 (i)~~(d)~~ "Trainee" means a person who is currently enrolled  
 836 in an approved program.

837 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

838 (b) This chapter does not prevent third-party payors from  
 839 reimbursing employers of autonomous physician assistants or  
 840 physician assistants for covered services rendered by registered  
 841 autonomous physician assistants or licensed physician  
 842 assistants.

843 (e) A supervising physician may delegate to a fully  
 844 licensed physician assistant the authority to prescribe or  
 845 dispense any medication used in the supervising physician's  
 846 practice unless such medication is listed on the formulary  
 847 created pursuant to s. 458.347. A fully licensed physician  
 848 assistant may only prescribe or dispense such medication under  
 849 the following circumstances:

850 1. A physician assistant must clearly identify to the

851 | patient that she or he is a physician assistant ~~and must inform~~  
852 | ~~the patient that the patient has the right to see the physician~~  
853 | ~~before a prescription is prescribed or dispensed by the~~  
854 | ~~physician assistant.~~

855 |         2. The supervising physician must notify the department of  
856 | her or his intent to delegate, on a department-approved form,  
857 | before delegating such authority and of any change in  
858 | prescriptive privileges of the physician assistant. Authority to  
859 | dispense may be delegated only by a supervising physician who is  
860 | registered as a dispensing practitioner in compliance with s.  
861 | 465.0276.

862 |         3. The physician assistant must complete a minimum of 10  
863 | continuing medical education hours in the specialty practice in  
864 | which the physician assistant has prescriptive privileges with  
865 | each licensure renewal.

866 |         4. The department may issue a prescriber number to the  
867 | physician assistant granting authority for the prescribing of  
868 | medicinal drugs authorized within this paragraph upon completion  
869 | of the requirements of this paragraph. The physician assistant  
870 | is not required to independently register pursuant to s.  
871 | 465.0276.

872 |         5. The prescription may be in paper or electronic form but  
873 | must comply with ss. 456.0392(1) and 456.42(1) and chapter 499  
874 | and must contain, in addition to the supervising physician's  
875 | name, address, and telephone number, the physician assistant's

876 prescriber number. Unless it is a drug or drug sample dispensed  
 877 by the physician assistant, the prescription must be filled in a  
 878 pharmacy permitted under chapter 465, and must be dispensed in  
 879 that pharmacy by a pharmacist licensed under chapter 465. The  
 880 inclusion of the prescriber number creates a presumption that  
 881 the physician assistant is authorized to prescribe the medicinal  
 882 drug and the prescription is valid.

883 6. The physician assistant must note the prescription or  
 884 dispensing of medication in the appropriate medical record.

885 (6) PROGRAM APPROVAL.—

886 (a) The boards shall approve programs, ~~based on~~  
 887 ~~recommendations by the council,~~ for the education and training  
 888 of physician assistants which meet standards established by rule  
 889 of the boards. ~~The council may recommend only those physician~~  
 890 ~~assistant programs that hold full accreditation or provisional~~  
 891 ~~accreditation from the Commission on Accreditation of Allied~~  
 892 ~~Health Programs or its successor organization.~~

893 (7) PHYSICIAN ASSISTANT LICENSURE.—

894 (a) Any person desiring to be licensed as a physician  
 895 assistant must apply to the department. The department shall  
 896 issue a license to any person certified by the council as having  
 897 met the following requirements:

- 898 1. Is at least 18 years of age.
- 899 2. Has satisfactorily passed a proficiency examination by
- 900 an acceptable score established by the National Commission on



901 Certification of Physician Assistants. If an applicant does not  
902 hold a current certificate issued by the National Commission on  
903 Certification of Physician Assistants and has not actively  
904 practiced as a physician assistant within the immediately  
905 preceding 4 years, the applicant must retake and successfully  
906 complete the entry-level examination of the National Commission  
907 on Certification of Physician Assistants to be eligible for  
908 licensure.

909 3. Has completed the application form and remitted an  
910 application fee not to exceed \$300 as set by the boards. An  
911 application for licensure made by a physician assistant must  
912 include:

913 a. Has graduated from a board-approved ~~A certificate of~~  
914 ~~completion of a~~ physician assistant training program as  
915 specified in subsection (6).

916 b. Acknowledgment of any prior felony convictions.

917 c. Acknowledgment of any previous revocation or denial of  
918 licensure or certification in any state.

919 d. A copy of course transcripts and a copy of the course  
920 description from a physician assistant training program  
921 describing course content in pharmacotherapy, if the applicant  
922 wishes to apply for prescribing authority. These documents must  
923 meet the evidence requirements for prescribing authority.

924 (f) The Board of Osteopathic Medicine may impose any of  
925 the penalties authorized under ss. 456.072 and 459.015(2) upon

926 an autonomous physician assistant or a physician assistant if  
927 the autonomous physician assistant, physician assistant, or the  
928 supervising physician has been found guilty of or is being  
929 investigated for any act that constitutes a violation of this  
930 chapter or chapter 456.

931 (8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

932 (a) The boards shall register a physician assistant as an  
933 autonomous physician assistant if the applicant demonstrates  
934 that he or she:

935 1. Holds an active, unencumbered license to practice as a  
936 physician assistant in this state.

937 2. Has not been subject to any disciplinary action as  
938 specified in s. 456.072, s. 458.331, or s. 459.015, or any  
939 similar disciplinary action in any jurisdiction of the United  
940 States, within the 5 years immediately preceding the  
941 registration request.

942 3. Has completed, in any jurisdiction of the United  
943 States, at least 2,000 clinical practice hours within the 3  
944 years immediately preceding the submission of the registration  
945 request while practicing as a physician assistant under the  
946 supervision of an allopathic or osteopathic physician who held  
947 an active, unencumbered license issued by any state, the  
948 District of Columbia, or a possession or territory of the United  
949 States during the period of such supervision.

950 4. Has completed a graduate-level course in pharmacology.

951        5. Obtains and maintains professional liability coverage  
952 at the same level and in the same manner as in s. 458.320(1)(b)  
953 or (c). However, the requirements of this subparagraph do not  
954 apply to:

955        a. Any person registered under this subsection who  
956 practices exclusively as an officer, employee, or agent of the  
957 Federal Government or of the state or its agencies or its  
958 subdivisions.

959        b. Any person whose license has become inactive and who is  
960 not practicing as an autonomous physician assistant in this  
961 state.

962        c. Any person who practices as an autonomous physician  
963 assistant only in conjunction with his or her teaching duties at  
964 an accredited school or its main teaching hospitals. Such  
965 practice is limited to that which is incidental to and a  
966 necessary part of duties in connection with the teaching  
967 position.

968        d. Any person who holds an active registration under this  
969 subsection who is not practicing as an autonomous physician  
970 assistant in this state. If such person initiates or resumes any  
971 practice as an autonomous physician assistant, he or she must  
972 notify the department of such activity and fulfill the  
973 professional liability coverage requirements of this  
974 subparagraph.

975        (b) The department shall conspicuously distinguish an

976 | autonomous physician assistant license if he or she is  
 977 | registered under this subsection.

978 | (c) An autonomous physician assistant may:

979 | 1. Render only primary care services as defined by rule of  
 980 | the boards without physician supervision.

981 | 2. Provide any service that is within the scope of the  
 982 | autonomous physician assistant's education and experience and  
 983 | provided in accordance with rules adopted by the board without  
 984 | physician supervision.

985 | 3. Prescribe, dispense, administer, or order any medicinal  
 986 | drug, including those medicinal drugs to the extent authorized  
 987 | under paragraph (4) (f) and the formulary adopted thereunder.

988 | 4. Order any medication for administration to a patient in  
 989 | a facility licensed under chapter 395 or part II of chapter 400,  
 990 | notwithstanding chapter 465 or chapter 893.

991 | 5. Provide a signature, certification, stamp,  
 992 | verification, affidavit, or other endorsement that is otherwise  
 993 | required by law to be provided by a physician.

994 | (d) An autonomous physician assistant must biennially  
 995 | renew his or her registration under this subsection. The  
 996 | biennial renewal shall coincide with the autonomous physician  
 997 | assistant's biennial renewal period for physician assistant  
 998 | licensure.

999 | (e) The council shall develop rules defining the primary  
 1000 | care practice of autonomous physician assistants, which may

1001 include internal medicine, general pediatrics, family medicine,  
 1002 geriatrics, and general obstetrics and gynecology practices.

1003 ~~(10)-(9)~~ COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on  
 1004 Physician Assistants is created within the department.

1005 (a) The council shall consist of five members appointed as  
 1006 follows:

1007 1. The chairperson of the Board of Medicine shall appoint  
 1008 one member who is a physician and a member ~~three members who are~~  
 1009 ~~physicians and members~~ of the Board of Medicine. ~~One of The~~  
 1010 physician ~~physicians~~ must supervise a physician assistant in his  
 1011 or her ~~the physician's~~ practice.

1012 2. The chairperson of the Board of Osteopathic Medicine  
 1013 shall appoint one member who is a physician and a member of the  
 1014 Board of Osteopathic Medicine. The physician must supervise a  
 1015 physician assistant in his or her practice.

1016 3. The State Surgeon General or her or his designee shall  
 1017 appoint three ~~a~~ fully licensed physician assistants ~~assistant~~  
 1018 licensed under chapter 458 or this chapter.

1019 (b) ~~Two of the members appointed to the council must be~~  
 1020 ~~physicians who supervise physician assistants in their practice.~~  
 1021 Members shall be appointed to terms of 4 years, except that of  
 1022 the initial appointments, two members shall be appointed to  
 1023 terms of 2 years, two members shall be appointed to terms of 3  
 1024 years, and one member shall be appointed to a term of 4 years,  
 1025 as established by rule of the boards. Council members may not

1026 | serve more than two consecutive terms. The council shall  
 1027 | annually elect a chairperson from among its members.  
 1028 | (c) The council shall:  
 1029 | 1. Recommend to the department the licensure of physician  
 1030 | assistants.  
 1031 | 2. Develop all rules regulating the primary care practice  
 1032 | of autonomous physician assistants and the use of physician  
 1033 | assistants by physicians under chapter 458 and this chapter,  
 1034 | except for rules relating to the formulary developed under s.  
 1035 | 458.347. The council shall also develop rules to ensure that the  
 1036 | continuity of supervision is maintained in each practice  
 1037 | setting. The boards shall consider adopting a proposed rule  
 1038 | developed by the council at the regularly scheduled meeting  
 1039 | immediately following the submission of the proposed rule by the  
 1040 | council. A proposed rule submitted by the council may not be  
 1041 | adopted by either board unless both boards have accepted and  
 1042 | approved the identical language contained in the proposed rule.  
 1043 | The language of all proposed rules submitted by the council must  
 1044 | be approved by both boards pursuant to each respective board's  
 1045 | guidelines and standards regarding the adoption of proposed  
 1046 | rules. If either board rejects the council's proposed rule, that  
 1047 | board must specify its objection to the council with  
 1048 | particularity and include any recommendations it may have for  
 1049 | the modification of the proposed rule.  
 1050 | 3. Make recommendations to the boards regarding all

1051 matters relating to autonomous physician assistants and  
 1052 physician assistants.

1053 4. Address concerns and problems of practicing autonomous  
 1054 physician assistants and physician assistants in order to  
 1055 improve safety in the clinical practices of registered  
 1056 autonomous physician assistants and licensed physician  
 1057 assistants.

1058 (d) When the council finds that an applicant for licensure  
 1059 has failed to meet, to the council's satisfaction, each of the  
 1060 requirements for licensure set forth in this section, the  
 1061 council may enter an order to:

- 1062 1. Refuse to certify the applicant for licensure;
- 1063 2. Approve the applicant for licensure with restrictions  
 1064 on the scope of practice or license; or
- 1065 3. Approve the applicant for conditional licensure. Such  
 1066 conditions may include placement of the licensee on probation  
 1067 for a period of time and subject to such conditions as the  
 1068 council may specify, including but not limited to, requiring the  
 1069 licensee to undergo treatment, to attend continuing education  
 1070 courses, to work under the direct supervision of a physician  
 1071 licensed in this state, or to take corrective action.

1072 ~~(12)-(11)~~ PENALTY.—Any person who has not been registered  
 1073 or licensed by the council and approved by the department and  
 1074 who holds herself or himself out as an autonomous physician  
 1075 assistant or a physician assistant or who uses any other term in

1076 | indicating or implying that she or he is an autonomous physician  
 1077 | assistant or a physician assistant commits a felony of the third  
 1078 | degree, punishable as provided in s. 775.082 or s. 775.084 or by  
 1079 | a fine not exceeding \$5,000.

1080 | (13)~~(12)~~ DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—  
 1081 | The boards may deny, suspend, or revoke the registration of an  
 1082 | autonomous physician assistant or the license of a physician  
 1083 | assistant ~~license~~ if a board determines that the autonomous  
 1084 | physician assistant or physician assistant has violated this  
 1085 | chapter.

1086 | (14)~~(13)~~ RULES.—The boards shall adopt rules to implement  
 1087 | this section, including rules detailing the contents of the  
 1088 | application for licensure and notification pursuant to  
 1089 | subsection (7), rules relating to the registration of autonomous  
 1090 | physician assistants under subsection (8), and rules to ensure  
 1091 | ~~both~~ the continued competency of autonomous physician assistants  
 1092 | and physician assistants and the proper utilization of them by  
 1093 | physicians or groups of physicians.

1094 | (19) ADVERSE INCIDENTS.—An autonomous physician assistant  
 1095 | must report adverse incidents to the department in accordance  
 1096 | with s. 459.026.

1097 | Section 5. Subsections (1) and (3) of section 464.012,  
 1098 | Florida Statutes, are amended to read:

1099 | 464.012 Licensure of advanced practice registered nurses;  
 1100 | fees; controlled substance prescribing.—



1101 (1) Any nurse desiring to be licensed as an advanced  
1102 practice registered nurse must apply to the board ~~department~~ and  
1103 submit proof that he or she holds a current license to practice  
1104 professional nursing or holds an active multistate license to  
1105 practice professional nursing pursuant to s. 464.0095 and ~~that~~  
1106 ~~he or she~~ meets one or more of the following requirements ~~as~~  
1107 ~~determined by the board:~~

1108 (a) Certification by an appropriate specialty board. Such  
1109 certification is required for initial state licensure and any  
1110 licensure renewal as a certified nurse midwife, certified nurse  
1111 practitioner, certified registered nurse anesthetist, clinical  
1112 nurse specialist, or psychiatric nurse. The board may by rule  
1113 provide for provisional state licensure of certified registered  
1114 nurse anesthetists, clinical nurse specialists, certified nurse  
1115 practitioners, psychiatric nurses, and certified nurse midwives  
1116 for a period of time determined to be appropriate for preparing  
1117 for and passing the national certification examination.

1118 (b) Graduation from a ~~program leading to a~~ master's degree  
1119 program in a nursing clinical specialty area with preparation in  
1120 specialized practitioner skills. For applicants graduating on or  
1121 after October 1, 1998, graduation from a master's degree program  
1122 is required for initial licensure as a certified nurse  
1123 practitioner under paragraph (4) (a).

1124 1. For applicants graduating on or after October 1, 2001,  
1125 graduation from a master's degree program is required for

1126 initial licensure as a certified registered nurse anesthetist  
1127 who may perform the acts listed in paragraph (4) (b).

1128 2. For applicants graduating on or after October 1, 1998,  
1129 graduation from a master's degree program is required for  
1130 initial licensure as a certified nurse midwife who may perform  
1131 the acts listed in paragraph (4) (c).

1132 3. For applicants graduating on or after July 1, 2007,  
1133 graduation from a master's degree program is required for  
1134 initial licensure as a clinical nurse specialist who may perform  
1135 the acts listed in paragraph (4) (d).

1136 (3) An advanced practice registered nurse shall perform  
1137 those functions authorized in this section within the framework  
1138 of an established protocol that must be maintained on site at  
1139 the location or locations at which an advanced practice  
1140 registered nurse practices, unless the advanced practice  
1141 registered nurse is registered to engage in autonomous practice  
1142 under s. 464.0123. In the case of multiple supervising  
1143 physicians in the same group, an advanced practice registered  
1144 nurse must enter into a supervisory protocol with at least one  
1145 physician within the physician group practice. A practitioner  
1146 currently licensed under chapter 458, chapter 459, or chapter  
1147 466 shall maintain supervision for directing the specific course  
1148 of medical treatment. Within the established framework, an  
1149 advanced practice registered nurse may:

1150 (a) Prescribe, dispense, administer, or order any drug;

1151 however, an advanced practice registered nurse may prescribe or  
1152 dispense a controlled substance as defined in s. 893.03 only if  
1153 the advanced practice registered nurse has graduated from a  
1154 program leading to a master's or doctoral degree in a clinical  
1155 nursing specialty area with training in specialized practitioner  
1156 skills.

1157 (b) Initiate appropriate therapies for certain conditions.

1158 (c) Perform additional functions as may be determined by  
1159 rule in accordance with s. 464.003(2).

1160 (d) Order diagnostic tests and physical and occupational  
1161 therapy.

1162 (e) Order any medication for administration to a patient  
1163 in a facility licensed under chapter 395 or part II of chapter  
1164 400, notwithstanding any provisions in chapter 465 or chapter  
1165 893.

1166 (f) Sign, certify, stamp, verify, or endorse a document  
1167 that requires the signature, certification, stamp, verification,  
1168 affidavit, or endorsement of a physician. However, a supervisory  
1169 physician may not delegate the authority to issue a documented  
1170 approval to release a patient from a receiving facility or its  
1171 contractor under s. 394.463(2)(f) to an advanced practice  
1172 registered nurse.

1173 Section 6. Section 464.0123, Florida Statutes, is created  
1174 to read:

1175 464.0123 Autonomous practice by an advanced practice

1176 registered nurse.-

1177 (1) For purposes of this section, the term "autonomous  
1178 practice" means advanced or specialized nursing practice by an  
1179 advanced practice registered nurse who is not subject to  
1180 supervision by a physician or a supervisory protocol.

1181 (2) The board shall register an advanced practice  
1182 registered nurse as an autonomous advanced practice registered  
1183 nurse if the applicant demonstrates that he or she:

1184 (a) Holds an active, unencumbered license to practice  
1185 advanced or specialized nursing in this state.

1186 (b) Has not been subject to any disciplinary action as  
1187 specified in s. 456.072 or s. 464.018, or any similar  
1188 disciplinary action in any other jurisdiction of the United  
1189 States, within the 5 years immediately preceding the  
1190 registration request.

1191 (c) Has completed, in any jurisdiction of the United  
1192 States, at least 2,000 clinical practice hours or clinical  
1193 instructional hours within the 5 years immediately preceding the  
1194 registration request while practicing as an advanced practice  
1195 registered nurse under the supervision of an allopathic or  
1196 osteopathic physician who held an active, unencumbered license  
1197 issued by another state, the District of Columbia, or a  
1198 possession or territory of the United States during the period  
1199 of such supervision.

1200 (d) Has completed a graduate-level course in pharmacology.

1201 (3) The board may provide by rule additional requirements  
1202 for an advanced practice registered nurse who is registered  
1203 under this section when performing acts within his or her  
1204 specialty pursuant to s. 464.012(4).

1205 (4) (a) An advanced practice registered nurse registered  
1206 under this section must by one of the following methods  
1207 demonstrate to the satisfaction of the board and the department  
1208 financial responsibility to pay claims and costs ancillary  
1209 thereto arising out of the rendering of, or the failure to  
1210 render, medical or nursing care or services:

1211 1. Obtaining and maintaining professional liability  
1212 coverage in an amount not less than \$100,000 per claim, with a  
1213 minimum annual aggregate of not less than \$300,000, from an  
1214 authorized insurer as defined in s. 624.09, from a surplus lines  
1215 insurer as defined in s. 626.914(2), from a risk retention group  
1216 as defined in s. 627.942, from the Joint Underwriting  
1217 Association established under s. 627.351(4), or through a plan  
1218 of self-insurance as provided in s. 627.357; or

1219 2. Obtaining and maintaining an unexpired, irrevocable  
1220 letter of credit, established pursuant to chapter 675, in an  
1221 amount of not less than \$100,000 per claim, with a minimum  
1222 aggregate availability of credit of not less than \$300,000. The  
1223 letter of credit must be payable to the advanced practice  
1224 registered nurse as beneficiary upon presentment of a final  
1225 judgment indicating liability and awarding damages to be paid by

1226 the advanced practice registered nurse or upon presentment of a  
1227 settlement agreement signed by all parties to such agreement  
1228 when such final judgment or settlement is a result of a claim  
1229 arising out of the rendering of, or the failure to render,  
1230 medical or nursing care and services.

1231 (b) The requirements of paragraph (a) do not apply to:

1232 1. Any person registered under this subsection who  
1233 practices exclusively as an officer, employee, or agent of the  
1234 Federal Government or of the state or its agencies or its  
1235 subdivisions.

1236 2. Any person whose license has become inactive and who is  
1237 not practicing as an advanced practice registered nurse  
1238 registered under this section in this state.

1239 3. Any person who practices as an advanced practice  
1240 registered nurse registered under this section only in  
1241 conjunction with his or her teaching duties at an accredited  
1242 school or its main teaching hospitals. Such practice is limited  
1243 to that which is incidental to and a necessary part of duties in  
1244 connection with the teaching position.

1245 4. Any person who holds an active registration under this  
1246 section who is not practicing as an autonomous advanced practice  
1247 registered nurse registered under this section in this state. If  
1248 such person initiates or resumes any practice as an autonomous  
1249 advanced practice registered nurse, he or she must notify the  
1250 department of such activity and fulfill the professional

1251 liability coverage requirements of paragraph (a).

1252 (5) The department shall conspicuously distinguish an  
 1253 advanced practice registered nurse's license if he or she is  
 1254 registered with the board under this section and include the  
 1255 registration in the advanced practice registered nurse's  
 1256 practitioner profile created under s. 456.041.

1257 (6) An advanced practice registered nurse who is  
 1258 registered under this section may perform the general functions  
 1259 of an advanced practice registered nurse under s. 464.012(3),  
 1260 the acts within his or her specialty under s. 464.012(4), and  
 1261 the following:

1262 (a) For a patient who requires the services of a health  
 1263 care facility, as defined in s. 408.032(8):

- 1264 1. Admit the patient to the facility.
- 1265 2. Manage the care received by the patient in the  
 1266 facility.
- 1267 3. Discharge the patient from the facility, unless  
 1268 prohibited by federal law or rule.

1269 (b) Provide a signature, certification, stamp,  
 1270 verification, affidavit, or endorsement that is otherwise  
 1271 required by law to be provided by a physician.

1272 (7) (a) An advanced practice registered nurse must  
 1273 biennially renew his or her registration under this section. The  
 1274 biennial renewal for registration shall coincide with the  
 1275 advanced practice registered nurse's biennial renewal period for

1276 licensure.

1277 (b) To renew his or her registration under this section,  
1278 an advanced practice registered nurse must complete at least 10  
1279 hours of continuing education approved by the board in addition  
1280 to completing the continuing education requirements established  
1281 by board rule pursuant to s. 464.013. If the initial renewal  
1282 period occurs before January 1, 2021, an advanced practice  
1283 registered nurse who is registered under this section is not  
1284 required to complete the continuing education requirement under  
1285 this paragraph until the following biennial renewal period.

1286 (8) The board may establish an advisory committee to make  
1287 evidence-based recommendations about medical acts that an  
1288 advanced practice registered nurse who is registered under this  
1289 section may perform. The committee must consist of four advanced  
1290 practice registered nurses licensed under this chapter,  
1291 appointed by the board; two physicians licensed under chapter  
1292 458 or chapter 459 who have professional experience with  
1293 advanced practice registered nurses, appointed by the Board of  
1294 Medicine; and the State Surgeon General or his or her designee.  
1295 Each committee member appointed by a board shall serve a term of  
1296 4 years, unless a shorter term is required to establish or  
1297 maintain staggered terms. The Board of Nursing shall act upon  
1298 the recommendations from the committee within 90 days after the  
1299 submission of such recommendations.

1300 (9) The board shall adopt rules as necessary to implement



1301 this section.

1302 Section 7. Section 464.0155, Florida Statutes, is created  
1303 to read:

1304 464.0155 Reports of adverse incidents by advanced practice  
1305 registered nurses.-

1306 (1) An advanced practice registered nurse registered to  
1307 engage in autonomous practice under s. 464.0123 must report an  
1308 adverse incident to the department in accordance with this  
1309 section.

1310 (2) The report must be in writing, sent to the department  
1311 by certified mail, and postmarked within 15 days after the  
1312 occurrence of the adverse incident if the adverse incident  
1313 occurs when the patient is at the office of the advanced  
1314 practice registered nurse. If the adverse incident occurs when  
1315 the patient is not at the office of the advanced practice  
1316 registered nurse, the report must be postmarked within 15 days  
1317 after the advanced practice registered nurse discovers, or  
1318 reasonably should have discovered, the occurrence of the adverse  
1319 incident.

1320 (3) For purposes of this section, the term "adverse  
1321 incident" means any of the following events when it is  
1322 reasonable to believe that the event is attributable to the  
1323 prescription of a controlled substance regulated under chapter  
1324 893 or 21 U.S.C. s. 812 by the advanced practice registered  
1325 nurse:

1326 (a) A condition that requires the transfer of a patient to  
 1327 a hospital licensed under chapter 395.

1328 (b) Permanent physical injury to the patient.

1329 (c) Death of the patient.

1330 (4) The department shall review each report of an adverse  
 1331 incident and determine whether the adverse incident was  
 1332 attributable to conduct by the advanced practice registered  
 1333 nurse. Upon such a determination, the board may take  
 1334 disciplinary action pursuant to s. 456.073.

1335 Section 8. Paragraph (r) is added to subsection (1) of  
 1336 section 464.018, Florida Statutes, to read:

1337 464.018 Disciplinary actions.—

1338 (1) The following acts constitute grounds for denial of a  
 1339 license or disciplinary action, as specified in ss. 456.072(2)  
 1340 and 464.0095:

1341 (r) For an advanced practice registered nurse registered  
 1342 to engage in autonomous practice under s. 464.0123:

1343 1. Paying or receiving any commission, bonus, kickback, or  
 1344 rebate from, or engaging in any split-fee arrangement in any  
 1345 form whatsoever with, a health care practitioner, organization,  
 1346 agency, or person, either directly or implicitly, for referring  
 1347 patients to providers of health care goods or services,  
 1348 including, but not limited to, hospitals, nursing homes,  
 1349 clinical laboratories, ambulatory surgical centers, or  
 1350 pharmacies. This subparagraph may not be construed to prevent an

1351 advanced practice registered nurse from receiving a fee for  
1352 professional consultation services.

1353 2. Exercising influence within a patient-advanced practice  
1354 registered nurse relationship for purposes of engaging a patient  
1355 in sexual activity. A patient shall be presumed to be incapable  
1356 of giving free, full, and informed consent to sexual activity  
1357 with his or her advanced practice registered nurse.

1358 3. Making deceptive, untrue, or fraudulent representations  
1359 in or related to, or employing a trick or scheme in or related  
1360 to, advanced or specialized nursing practice.

1361 4. Soliciting patients, either personally or through an  
1362 agent, by the use of fraud, intimidation, undue influence, or a  
1363 form of overreaching or vexatious conduct. As used in this  
1364 subparagraph, the term "soliciting" means directly or implicitly  
1365 requesting an immediate oral response from the recipient.

1366 5. Failing to keep legible, as defined by department rule  
1367 in consultation with the board, medical records that identify  
1368 the advanced practice registered nurse by name and professional  
1369 title who is responsible for rendering, ordering, supervising,  
1370 or billing for each diagnostic or treatment procedure and that  
1371 justify the course of treatment of the patient, including, but  
1372 not limited to, patient histories; examination results; test  
1373 results; records of drugs prescribed, dispensed, or  
1374 administered; and reports of consultations or referrals.

1375 6. Exercising influence on the patient to exploit the

1376 patient for the financial gain of the advanced practice  
1377 registered nurse or a third party, including, but not limited  
1378 to, the promoting or selling of services, goods, appliances, or  
1379 drugs.

1380 7. Performing professional services that have not been  
1381 duly authorized by the patient, or his or her legal  
1382 representative, except as provided in s. 766.103 or s. 768.13.

1383 8. Performing any procedure or prescribing any therapy  
1384 that, by the prevailing standards of advanced or specialized  
1385 nursing practice in the community, would constitute  
1386 experimentation on a human subject, without first obtaining  
1387 full, informed, and written consent.

1388 9. Delegating professional responsibilities to a person  
1389 when the advanced practice registered nurse delegating such  
1390 responsibilities knows or has reason to believe that such person  
1391 is not qualified by training, experience, or licensure to  
1392 perform such responsibilities.

1393 10. Committing, or conspiring with another to commit, an  
1394 act that would tend to coerce, intimidate, or preclude another  
1395 advanced practice registered nurse from lawfully advertising his  
1396 or her services.

1397 11. Advertising or holding himself or herself out as  
1398 having certification in a specialty that the he or she has not  
1399 received.

1400 12. Failing to comply with the requirements of ss. 381.026

1401 and 381.0261 related to providing patients with information  
1402 about their rights and how to file a complaint.

1403 13. Providing deceptive or fraudulent expert witness  
1404 testimony related to advanced or specialized nursing practice.

1405 Section 9. Subsection (43) of section 39.01, Florida  
1406 Statutes, is amended to read:

1407 39.01 Definitions.—When used in this chapter, unless the  
1408 context otherwise requires:

1409 (43) "Licensed health care professional" means a physician  
1410 licensed under chapter 458, an osteopathic physician licensed  
1411 under chapter 459, a nurse licensed under part I of chapter 464,  
1412 an autonomous physician assistant or a physician assistant  
1413 registered or licensed under chapter 458 or chapter 459, or a  
1414 dentist licensed under chapter 466.

1415 Section 10. Paragraphs (d) and (e) of subsection (5) of  
1416 section 39.303, Florida Statutes, are redesignated as paragraphs  
1417 (e) and (f), respectively, a new paragraph (d) is added to that  
1418 subsection, and paragraph (a) of subsection (6) of that section  
1419 is amended, to read:

1420 39.303 Child Protection Teams and sexual abuse treatment  
1421 programs; services; eligible cases.—

1422 (5) All abuse and neglect cases transmitted for  
1423 investigation to a circuit by the hotline must be simultaneously  
1424 transmitted to the Child Protection Team for review. For the  
1425 purpose of determining whether a face-to-face medical evaluation

1426 by a Child Protection Team is necessary, all cases transmitted  
 1427 to the Child Protection Team which meet the criteria in  
 1428 subsection (4) must be timely reviewed by:

1429 (d) An autonomous physician assistant registered under  
 1430 chapter 458 or chapter 459 who has a specialty in pediatrics or  
 1431 family medicine and is member of the Child Protection Team;

1432 (6) A face-to-face medical evaluation by a Child  
 1433 Protection Team is not necessary when:

1434 (a) The child was examined for the alleged abuse or  
 1435 neglect by a physician who is not a member of the Child  
 1436 Protection Team, and a consultation between the Child Protection  
 1437 Team medical director or a Child Protection Team board-certified  
 1438 pediatrician, advanced practice registered nurse, autonomous  
 1439 physician assistant, or physician assistant working under the  
 1440 supervision of a Child Protection Team medical director or a  
 1441 Child Protection Team board-certified pediatrician, or  
 1442 registered nurse working under the direct supervision of a Child  
 1443 Protection Team medical director or a Child Protection Team  
 1444 board-certified pediatrician, and the examining physician  
 1445 concludes that a further medical evaluation is unnecessary;

1446  
 1447 Notwithstanding paragraphs (a), (b), and (c), a Child Protection  
 1448 Team medical director or a Child Protection Team pediatrician,  
 1449 as authorized in subsection (5), may determine that a face-to-  
 1450 face medical evaluation is necessary.

1451 Section 11. Paragraph (b) of subsection (1) of section  
1452 39.304, Florida Statutes, is amended to read:

1453 39.304 Photographs, medical examinations, X rays, and  
1454 medical treatment of abused, abandoned, or neglected child.—

1455 (1)

1456 (b) If the areas of trauma visible on a child indicate a  
1457 need for a medical examination, or if the child verbally  
1458 complains or otherwise exhibits distress as a result of injury  
1459 through suspected child abuse, abandonment, or neglect, or is  
1460 alleged to have been sexually abused, the person required to  
1461 investigate may cause the child to be referred for diagnosis to  
1462 a licensed physician or an emergency department in a hospital  
1463 without the consent of the child's parents or legal custodian.  
1464 Such examination may be performed by any licensed physician,  
1465 registered autonomous physician assistant, licensed physician  
1466 assistant, or an advanced practice registered nurse licensed or  
1467 registered under ~~pursuant to~~ part I of chapter 464. Any licensed  
1468 physician, registered autonomous physician assistant, licensed  
1469 physician assistant, or advanced practice registered nurse  
1470 licensed or registered under ~~pursuant to~~ part I of chapter 464  
1471 who has reasonable cause to suspect that an injury was the  
1472 result of child abuse, abandonment, or neglect may authorize a  
1473 radiological examination to be performed on the child without  
1474 the consent of the child's parent or legal custodian.

1475 Section 12. Paragraph (d) of subsection (2) of section

1476 110.12315, Florida Statutes, is amended to read:

1477 110.12315 Prescription drug program.—The state employees'  
1478 prescription drug program is established. This program shall be  
1479 administered by the Department of Management Services, according  
1480 to the terms and conditions of the plan as established by the  
1481 relevant provisions of the annual General Appropriations Act and  
1482 implementing legislation, subject to the following conditions:

1483 (2) In providing for reimbursement of pharmacies for  
1484 prescription drugs and supplies dispensed to members of the  
1485 state group health insurance plan and their dependents under the  
1486 state employees' prescription drug program:

1487 (d) The department shall establish the reimbursement  
1488 schedule for prescription drugs and supplies dispensed under the  
1489 program. Reimbursement rates for a prescription drug or supply  
1490 must be based on the cost of the generic equivalent drug or  
1491 supply if a generic equivalent exists, unless the physician,  
1492 advanced practice registered nurse, autonomous physician  
1493 assistant, or physician assistant prescribing the drug or supply  
1494 clearly states on the prescription that the brand name drug or  
1495 supply is medically necessary or that the drug or supply is  
1496 included on the formulary of drugs and supplies that may not be  
1497 interchanged as provided in chapter 465, in which case  
1498 reimbursement must be based on the cost of the brand name drug  
1499 or supply as specified in the reimbursement schedule adopted by  
1500 the department.



1501 Section 13. Paragraph (a) of subsection (3) of section  
 1502 252.515, Florida Statutes, is amended to read:  
 1503 252.515 Postdisaster Relief Assistance Act; immunity from  
 1504 civil liability.—

1505 (3) As used in this section, the term:

1506 (a) "Emergency first responder" means:

- 1507 1. A physician licensed under chapter 458.
- 1508 2. An osteopathic physician licensed under chapter 459.
- 1509 3. A chiropractic physician licensed under chapter 460.
- 1510 4. A podiatric physician licensed under chapter 461.
- 1511 5. A dentist licensed under chapter 466.
- 1512 6. An advanced practice registered nurse licensed under s.
- 1513 464.012.
- 1514 7. An autonomous physician assistant or a physician
- 1515 assistant registered or licensed under chapter 458 ~~s. 458.347~~ or
- 1516 chapter 459 ~~s. 459.022~~.
- 1517 8. A worker employed by a public or private hospital in
- 1518 the state.
- 1519 9. A paramedic as defined in s. 401.23(17).
- 1520 10. An emergency medical technician as defined in s.
- 1521 401.23(11).
- 1522 11. A firefighter as defined in s. 633.102.
- 1523 12. A law enforcement officer as defined in s. 943.10.
- 1524 13. A member of the Florida National Guard.
- 1525 14. Any other personnel designated as emergency personnel

1526 | by the Governor pursuant to a declared emergency.

1527 |       Section 14. Paragraph (c) of subsection (1) of section  
1528 | 310.071, Florida Statutes, is amended to read:

1529 |       310.071 Deputy pilot certification.—

1530 |       (1) In addition to meeting other requirements specified in  
1531 | this chapter, each applicant for certification as a deputy pilot  
1532 | must:

1533 |       (c) Be in good physical and mental health, as evidenced by  
1534 | documentary proof of having satisfactorily passed a complete  
1535 | physical examination administered by a licensed physician within  
1536 | the preceding 6 months. The board shall adopt rules to establish  
1537 | requirements for passing the physical examination, which rules  
1538 | shall establish minimum standards for the physical or mental  
1539 | capabilities necessary to carry out the professional duties of a  
1540 | certificated deputy pilot. Such standards shall include zero  
1541 | tolerance for any controlled substance regulated under chapter  
1542 | 893 unless that individual is under the care of a physician, an  
1543 | advanced practice registered nurse, an autonomous physician  
1544 | assistant, or a physician assistant and that controlled  
1545 | substance was prescribed by that physician, advanced practice  
1546 | registered nurse, autonomous physician assistant, or physician  
1547 | assistant. To maintain eligibility as a certificated deputy  
1548 | pilot, each certificated deputy pilot must annually provide  
1549 | documentary proof of having satisfactorily passed a complete  
1550 | physical examination administered by a licensed physician. The

1551 physician must know the minimum standards and certify that the  
1552 certificateholder satisfactorily meets the standards. The  
1553 standards for certificateholders shall include a drug test.

1554 Section 15. Subsection (3) of section 310.073, Florida  
1555 Statutes, is amended to read:

1556 310.073 State pilot licensing.—In addition to meeting  
1557 other requirements specified in this chapter, each applicant for  
1558 license as a state pilot must:

1559 (3) Be in good physical and mental health, as evidenced by  
1560 documentary proof of having satisfactorily passed a complete  
1561 physical examination administered by a licensed physician within  
1562 the preceding 6 months. The board shall adopt rules to establish  
1563 requirements for passing the physical examination, which rules  
1564 shall establish minimum standards for the physical or mental  
1565 capabilities necessary to carry out the professional duties of a  
1566 licensed state pilot. Such standards shall include zero  
1567 tolerance for any controlled substance regulated under chapter  
1568 893 unless that individual is under the care of a physician, an  
1569 advanced practice registered nurse, an autonomous physician  
1570 assistant, or a physician assistant and that controlled  
1571 substance was prescribed by that physician, advanced practice  
1572 registered nurse, autonomous physician assistant, or physician  
1573 assistant. To maintain eligibility as a licensed state pilot,  
1574 each licensed state pilot must annually provide documentary  
1575 proof of having satisfactorily passed a complete physical

1576 examination administered by a licensed physician. The physician  
1577 must know the minimum standards and certify that the licensee  
1578 satisfactorily meets the standards. The standards for licensees  
1579 shall include a drug test.

1580 Section 16. Paragraph (b) of subsection (3) of section  
1581 310.081, Florida Statutes, is amended to read:

1582 310.081 Department to examine and license state pilots and  
1583 certificate deputy pilots; vacancies.-

1584 (3) Pilots shall hold their licenses or certificates  
1585 pursuant to the requirements of this chapter so long as they:

1586 (b) Are in good physical and mental health as evidenced by  
1587 documentary proof of having satisfactorily passed a physical  
1588 examination administered by a licensed physician or physician  
1589 assistant within each calendar year. The board shall adopt rules  
1590 to establish requirements for passing the physical examination,  
1591 which rules shall establish minimum standards for the physical  
1592 or mental capabilities necessary to carry out the professional  
1593 duties of a licensed state pilot or a certificated deputy pilot.  
1594 Such standards shall include zero tolerance for any controlled  
1595 substance regulated under chapter 893 unless that individual is  
1596 under the care of a physician, an advanced practice registered  
1597 nurse, an autonomous physician assistant, or a physician  
1598 assistant and that controlled substance was prescribed by that  
1599 physician, advanced practice registered nurse, autonomous  
1600 physician assistant, or physician assistant. To maintain

1601 eligibility as a certificated deputy pilot or licensed state  
 1602 pilot, each certificated deputy pilot or licensed state pilot  
 1603 must annually provide documentary proof of having satisfactorily  
 1604 passed a complete physical examination administered by a  
 1605 licensed physician. The physician must know the minimum  
 1606 standards and certify that the certificateholder or licensee  
 1607 satisfactorily meets the standards. The standards for  
 1608 certificateholders and for licensees shall include a drug test.

1609  
 1610 Upon resignation or in the case of disability permanently  
 1611 affecting a pilot's ability to serve, the state license or  
 1612 certificate issued under this chapter shall be revoked by the  
 1613 department.

1614 Section 17. Paragraph (b) of subsection (1) of section  
 1615 320.0848, Florida Statutes, is amended to read:

1616 320.0848 Persons who have disabilities; issuance of  
 1617 disabled parking permits; temporary permits; permits for certain  
 1618 providers of transportation services to persons who have  
 1619 disabilities.—

1620 (1)

1621 (b)1. The person must be currently certified as being  
 1622 legally blind or as having any of the following disabilities  
 1623 that render him or her unable to walk 200 feet without stopping  
 1624 to rest:

1625 a. Inability to walk without the use of or assistance from

1626 a brace, cane, crutch, prosthetic device, or other assistive  
1627 device, or without the assistance of another person. If the  
1628 assistive device significantly restores the person's ability to  
1629 walk to the extent that the person can walk without severe  
1630 limitation, the person is not eligible for the exemption parking  
1631 permit.

1632 b. The need to permanently use a wheelchair.

1633 c. Restriction by lung disease to the extent that the  
1634 person's forced (respiratory) expiratory volume for 1 second,  
1635 when measured by spirometry, is less than 1 liter, or the  
1636 person's arterial oxygen is less than 60 mm/hg on room air at  
1637 rest.

1638 d. Use of portable oxygen.

1639 e. Restriction by cardiac condition to the extent that the  
1640 person's functional limitations are classified in severity as  
1641 Class III or Class IV according to standards set by the American  
1642 Heart Association.

1643 f. Severe limitation in the person's ability to walk due  
1644 to an arthritic, neurological, or orthopedic condition.

1645 2. The certification of disability which is required under  
1646 subparagraph 1. must be provided by a physician licensed under  
1647 chapter 458, chapter 459, or chapter 460, by a podiatric  
1648 physician licensed under chapter 461, by an optometrist licensed  
1649 under chapter 463, by an advanced practice registered nurse  
1650 licensed under chapter 464 under the protocol of a licensed

1651 physician as stated in this subparagraph, by an autonomous  
1652 physician assistant or a physician assistant registered or  
1653 licensed under chapter 458 or chapter 459, or by a similarly  
1654 licensed physician from another state if the application is  
1655 accompanied by documentation of the physician's licensure in the  
1656 other state and a form signed by the out-of-state physician  
1657 verifying his or her knowledge of this state's eligibility  
1658 guidelines.

1659 Section 18. Paragraph (c) of subsection (1) of section  
1660 381.00315, Florida Statutes, is amended to read:

1661 381.00315 Public health advisories; public health  
1662 emergencies; isolation and quarantines.—The State Health Officer  
1663 is responsible for declaring public health emergencies, issuing  
1664 public health advisories, and ordering isolation or quarantines.

1665 (1) As used in this section, the term:

1666 (c) "Public health emergency" means any occurrence, or  
1667 threat thereof, whether natural or manmade, which results or may  
1668 result in substantial injury or harm to the public health from  
1669 infectious disease, chemical agents, nuclear agents, biological  
1670 toxins, or situations involving mass casualties or natural  
1671 disasters. Before declaring a public health emergency, the State  
1672 Health Officer shall, to the extent possible, consult with the  
1673 Governor and shall notify the Chief of Domestic Security. The  
1674 declaration of a public health emergency shall continue until  
1675 the State Health Officer finds that the threat or danger has

1676 | been dealt with to the extent that the emergency conditions no  
1677 | longer exist and he or she terminates the declaration. However,  
1678 | a declaration of a public health emergency may not continue for  
1679 | longer than 60 days unless the Governor concurs in the renewal  
1680 | of the declaration. The State Health Officer, upon declaration  
1681 | of a public health emergency, may take actions that are  
1682 | necessary to protect the public health. Such actions include,  
1683 | but are not limited to:

1684 |       1. Directing manufacturers of prescription drugs or over-  
1685 | the-counter drugs who are permitted under chapter 499 and  
1686 | wholesalers of prescription drugs located in this state who are  
1687 | permitted under chapter 499 to give priority to the shipping of  
1688 | specified drugs to pharmacies and health care providers within  
1689 | geographic areas that have been identified by the State Health  
1690 | Officer. The State Health Officer must identify the drugs to be  
1691 | shipped. Manufacturers and wholesalers located in the state must  
1692 | respond to the State Health Officer's priority shipping  
1693 | directive before shipping the specified drugs.

1694 |       2. Notwithstanding chapters 465 and 499 and rules adopted  
1695 | thereunder, directing pharmacists employed by the department to  
1696 | compound bulk prescription drugs and provide these bulk  
1697 | prescription drugs to physicians and nurses of county health  
1698 | departments or any qualified person authorized by the State  
1699 | Health Officer for administration to persons as part of a  
1700 | prophylactic or treatment regimen.



1701           3. Notwithstanding s. 456.036, temporarily reactivating  
1702 the inactive license or registration of the following health  
1703 care practitioners, when such practitioners are needed to  
1704 respond to the public health emergency: physicians, autonomous  
1705 physician assistants, or physician assistants licensed or  
1706 registered under chapter 458 or chapter 459; ~~physician~~  
1707 ~~assistants licensed under chapter 458 or chapter 459;~~ licensed  
1708 practical nurses, registered nurses, and advanced practice  
1709 registered nurses licensed under part I of chapter 464;  
1710 respiratory therapists licensed under part V of chapter 468; and  
1711 emergency medical technicians and paramedics certified under  
1712 part III of chapter 401. Only those health care practitioners  
1713 specified in this paragraph who possess an unencumbered inactive  
1714 license and who request that such license be reactivated are  
1715 eligible for reactivation. An inactive license that is  
1716 reactivated under this paragraph shall return to inactive status  
1717 when the public health emergency ends or before the end of the  
1718 public health emergency if the State Health Officer determines  
1719 that the health care practitioner is no longer needed to provide  
1720 services during the public health emergency. Such licenses may  
1721 only be reactivated for a period not to exceed 90 days without  
1722 meeting the requirements of s. 456.036 or chapter 401, as  
1723 applicable.

1724           4. Ordering an individual to be examined, tested,  
1725 vaccinated, treated, isolated, or quarantined for communicable

1726 diseases that have significant morbidity or mortality and  
1727 present a severe danger to public health. Individuals who are  
1728 unable or unwilling to be examined, tested, vaccinated, or  
1729 treated for reasons of health, religion, or conscience may be  
1730 subjected to isolation or quarantine.

1731 a. Examination, testing, vaccination, or treatment may be  
1732 performed by any qualified person authorized by the State Health  
1733 Officer.

1734 b. If the individual poses a danger to the public health,  
1735 the State Health Officer may subject the individual to isolation  
1736 or quarantine. If there is no practical method to isolate or  
1737 quarantine the individual, the State Health Officer may use any  
1738 means necessary to vaccinate or treat the individual.

1739  
1740 Any order of the State Health Officer given to effectuate this  
1741 paragraph shall be immediately enforceable by a law enforcement  
1742 officer under s. 381.0012.

1743 Section 19. Subsection (3) of section 381.00593, Florida  
1744 Statutes, is amended to read:

1745 381.00593 Public school volunteer health care practitioner  
1746 program.—

1747 (3) For purposes of this section, the term "health care  
1748 practitioner" means a physician or autonomous physician  
1749 assistant licensed or registered under chapter 458; an  
1750 osteopathic physician or autonomous physician assistant licensed

1751 or registered under chapter 459; a chiropractic physician  
1752 licensed under chapter 460; a podiatric physician licensed under  
1753 chapter 461; an optometrist licensed under chapter 463; an  
1754 advanced practice registered nurse, registered nurse, or  
1755 licensed practical nurse licensed under part I of chapter 464; a  
1756 pharmacist licensed under chapter 465; a dentist or dental  
1757 hygienist licensed under chapter 466; a midwife licensed under  
1758 chapter 467; a speech-language pathologist or audiologist  
1759 licensed under part I of chapter 468; a dietitian/nutritionist  
1760 licensed under part X of chapter 468; or a physical therapist  
1761 licensed under chapter 486.

1762 Section 20. Paragraph (c) of subsection (2) of section  
1763 381.026, Florida Statutes, is amended to read:

1764 381.026 Florida Patient's Bill of Rights and  
1765 Responsibilities.—

1766 (2) DEFINITIONS.—As used in this section and s. 381.0261,  
1767 the term:

1768 (c) "Health care provider" means a physician licensed  
1769 under chapter 458, an osteopathic physician licensed under  
1770 chapter 459, ~~or~~ a podiatric physician licensed under chapter  
1771 461, an autonomous physician assistant registered under s.  
1772 458.347(8), or an advanced practice registered nurse registered  
1773 to engage in autonomous practice under s. 464.0123.

1774 Section 21. Paragraph (a) of subsection (2) and  
1775 subsections (3), (4), and (5) of section 382.008, Florida

1776 Statutes, are amended to read:

1777       382.008 Death, fetal death, and nonviable birth  
1778 registration.—

1779       (2) (a) The funeral director who first assumes custody of a  
1780 dead body or fetus shall file the certificate of death or fetal  
1781 death. In the absence of the funeral director, the physician,  
1782 autonomous physician assistant, physician assistant, advanced  
1783 practice registered nurse, or other person in attendance at or  
1784 after the death or the district medical examiner of the county  
1785 in which the death occurred or the body was found shall file the  
1786 certificate of death or fetal death. The person who files the  
1787 certificate shall obtain personal data from a legally authorized  
1788 person as described in s. 497.005 or the best qualified person  
1789 or source available. The medical certification of cause of death  
1790 shall be furnished to the funeral director, either in person or  
1791 via certified mail or electronic transfer, by the physician,  
1792 autonomous physician assistant, physician assistant, advanced  
1793 practice registered nurse, or medical examiner responsible for  
1794 furnishing such information. For fetal deaths, the physician,  
1795 certified nurse midwife, midwife, or hospital administrator  
1796 shall provide any medical or health information to the funeral  
1797 director within 72 hours after expulsion or extraction.

1798       (3) Within 72 hours after receipt of a death or fetal  
1799 death certificate from the funeral director, the medical  
1800 certification of cause of death shall be completed and made

1801 available to the funeral director by the decedent's primary or  
1802 attending practitioner ~~physician~~ or, if s. 382.011 applies, the  
1803 district medical examiner of the county in which the death  
1804 occurred or the body was found. The primary or attending  
1805 practitioner ~~physician~~ or the medical examiner shall certify  
1806 over his or her signature the cause of death to the best of his  
1807 or her knowledge and belief. As used in this section, the term  
1808 "primary or attending practitioner ~~physician~~" means a physician,  
1809 autonomous physician assistant, physician assistant, or advanced  
1810 practice registered nurse who treated the decedent through  
1811 examination, medical advice, or medication during the 12 months  
1812 preceding the date of death.

1813 (a) The department may grant the funeral director an  
1814 extension of time upon a good and sufficient showing of any of  
1815 the following conditions:

- 1816 1. An autopsy is pending.
- 1817 2. Toxicology, laboratory, or other diagnostic reports  
1818 have not been completed.
- 1819 3. The identity of the decedent is unknown and further  
1820 investigation or identification is required.

1821 (b) If the decedent's primary or attending practitioner  
1822 ~~physician~~ or the district medical examiner of the county in  
1823 which the death occurred or the body was found indicates that he  
1824 or she will sign and complete the medical certification of cause  
1825 of death but will not be available until after the 5-day

1826 registration deadline, the local registrar may grant an  
1827 extension of 5 days. If a further extension is required, the  
1828 funeral director must provide written justification to the  
1829 registrar.

1830 (4) If the department or local registrar grants an  
1831 extension of time to provide the medical certification of cause  
1832 of death, the funeral director shall file a temporary  
1833 certificate of death or fetal death which shall contain all  
1834 available information, including the fact that the cause of  
1835 death is pending. The decedent's primary or attending  
1836 practitioner ~~physician~~ or the district medical examiner of the  
1837 county in which the death occurred or the body was found shall  
1838 provide an estimated date for completion of the permanent  
1839 certificate.

1840 (5) A permanent certificate of death or fetal death,  
1841 containing the cause of death and any other information that was  
1842 previously unavailable, shall be registered as a replacement for  
1843 the temporary certificate. The permanent certificate may also  
1844 include corrected information if the items being corrected are  
1845 noted on the back of the certificate and dated and signed by the  
1846 funeral director, physician, autonomous physician assistant,  
1847 physician assistant, advanced practice registered nurse, or  
1848 district medical examiner of the county in which the death  
1849 occurred or the body was found, as appropriate.

1850 Section 22. Subsection (1) of section 382.011, Florida

1851 Statutes, is amended to read:

1852 382.011 Medical examiner determination of cause of death.—

1853 (1) In the case of any death or fetal death due to causes  
 1854 or conditions listed in s. 406.11, any death that occurred more  
 1855 than 12 months after the decedent was last treated by a primary  
 1856 or attending physician ~~as defined in s. 382.008(3)~~, or any death  
 1857 for which there is reason to believe that the death may have  
 1858 been due to an unlawful act or neglect, the funeral director or  
 1859 other person to whose attention the death may come shall refer  
 1860 the case to the district medical examiner of the county in which  
 1861 the death occurred or the body was found for investigation and  
 1862 determination of the cause of death.

1863 Section 23. Paragraph (c) of subsection (1) of section  
 1864 383.14, Florida Statutes, is amended to read:

1865 383.14 Screening for metabolic disorders, other hereditary  
 1866 and congenital disorders, and environmental risk factors.—

1867 (1) SCREENING REQUIREMENTS.—To help ensure access to the  
 1868 maternal and child health care system, the Department of Health  
 1869 shall promote the screening of all newborns born in Florida for  
 1870 metabolic, hereditary, and congenital disorders known to result  
 1871 in significant impairment of health or intellect, as screening  
 1872 programs accepted by current medical practice become available  
 1873 and practical in the judgment of the department. The department  
 1874 shall also promote the identification and screening of all  
 1875 newborns in this state and their families for environmental risk

1876 factors such as low income, poor education, maternal and family  
1877 stress, emotional instability, substance abuse, and other high-  
1878 risk conditions associated with increased risk of infant  
1879 mortality and morbidity to provide early intervention,  
1880 remediation, and prevention services, including, but not limited  
1881 to, parent support and training programs, home visitation, and  
1882 case management. Identification, perinatal screening, and  
1883 intervention efforts shall begin before ~~prior to~~ and immediately  
1884 following the birth of the child by the attending health care  
1885 provider. Such efforts shall be conducted in hospitals,  
1886 perinatal centers, county health departments, school health  
1887 programs that provide prenatal care, and birthing centers, and  
1888 reported to the Office of Vital Statistics.

1889 (c) Release of screening results.—Notwithstanding any law  
1890 to the contrary, the State Public Health Laboratory may release,  
1891 directly or through the Children's Medical Services program, the  
1892 results of a newborn's hearing and metabolic tests or screenings  
1893 to the newborn's health care practitioner, the newborn's parent  
1894 or legal guardian, the newborn's personal representative, or a  
1895 person designated by the newborn's parent or legal guardian. As  
1896 used in this paragraph, the term "health care practitioner"  
1897 means a physician, autonomous physician assistant, or physician  
1898 assistant licensed or registered under chapter 458; an  
1899 osteopathic physician, autonomous physician assistant, or  
1900 physician assistant licensed or registered under chapter 459; an



1901 advanced practice registered nurse, registered nurse, or  
 1902 licensed practical nurse licensed under part I of chapter 464; a  
 1903 midwife licensed under chapter 467; a speech-language  
 1904 pathologist or audiologist licensed under part I of chapter 468;  
 1905 or a dietician or nutritionist licensed under part X of chapter  
 1906 468.

1907 Section 24. Paragraph (a) of subsection (3) of section  
 1908 390.0111, Florida Statutes, is amended to read:

1909 390.0111 Termination of pregnancies.—

1910 (3) CONSENTS REQUIRED.—A termination of pregnancy may not  
 1911 be performed or induced except with the voluntary and informed  
 1912 written consent of the pregnant woman or, in the case of a  
 1913 mental incompetent, the voluntary and informed written consent  
 1914 of her court-appointed guardian.

1915 (a) Except in the case of a medical emergency, consent to  
 1916 a termination of pregnancy is voluntary and informed only if:

1917 1. The physician who is to perform the procedure, or the  
 1918 referring physician, has, at a minimum, orally, while physically  
 1919 present in the same room, and at least 24 hours before the  
 1920 procedure, informed the woman of:

1921 a. The nature and risks of undergoing or not undergoing  
 1922 the proposed procedure that a reasonable patient would consider  
 1923 material to making a knowing and willful decision of whether to  
 1924 terminate a pregnancy.

1925 b. The probable gestational age of the fetus, verified by

1926 | an ultrasound, at the time the termination of pregnancy is to be  
1927 | performed.

1928 |         (I) The ultrasound must be performed by the physician who  
1929 | is to perform the abortion or by a person having documented  
1930 | evidence that he or she has completed a course in the operation  
1931 | of ultrasound equipment as prescribed by rule and who is working  
1932 | in conjunction with the physician.

1933 |         (II) The person performing the ultrasound must offer the  
1934 | woman the opportunity to view the live ultrasound images and  
1935 | hear an explanation of them. If the woman accepts the  
1936 | opportunity to view the images and hear the explanation, a  
1937 | physician or a registered nurse, licensed practical nurse,  
1938 | advanced practice registered nurse, autonomous physician  
1939 | assistant, or physician assistant working in conjunction with  
1940 | the physician must contemporaneously review and explain the  
1941 | images to the woman before the woman gives informed consent to  
1942 | having an abortion procedure performed.

1943 |         (III) The woman has a right to decline to view and hear  
1944 | the explanation of the live ultrasound images after she is  
1945 | informed of her right and offered an opportunity to view the  
1946 | images and hear the explanation. If the woman declines, the  
1947 | woman shall complete a form acknowledging that she was offered  
1948 | an opportunity to view and hear the explanation of the images  
1949 | but that she declined that opportunity. The form must also  
1950 | indicate that the woman's decision was not based on any undue

1951 influence from any person to discourage her from viewing the  
1952 images or hearing the explanation and that she declined of her  
1953 own free will.

1954 (IV) Unless requested by the woman, the person performing  
1955 the ultrasound may not offer the opportunity to view the images  
1956 and hear the explanation and the explanation may not be given  
1957 if, at the time the woman schedules or arrives for her  
1958 appointment to obtain an abortion, a copy of a restraining  
1959 order, police report, medical record, or other court order or  
1960 documentation is presented which provides evidence that the  
1961 woman is obtaining the abortion because the woman is a victim of  
1962 rape, incest, domestic violence, or human trafficking or that  
1963 the woman has been diagnosed as having a condition that, on the  
1964 basis of a physician's good faith clinical judgment, would  
1965 create a serious risk of substantial and irreversible impairment  
1966 of a major bodily function if the woman delayed terminating her  
1967 pregnancy.

1968 c. The medical risks to the woman and fetus of carrying  
1969 the pregnancy to term.

1970  
1971 The physician may provide the information required in this  
1972 subparagraph within 24 hours before the procedure if requested  
1973 by the woman at the time she schedules or arrives for her  
1974 appointment to obtain an abortion and if she presents to the  
1975 physician a copy of a restraining order, police report, medical

1976 record, or other court order or documentation evidencing that  
 1977 she is obtaining the abortion because she is a victim of rape,  
 1978 incest, domestic violence, or human trafficking.

1979 2. Printed materials prepared and provided by the  
 1980 department have been provided to the pregnant woman, if she  
 1981 chooses to view these materials, including:

1982 a. A description of the fetus, including a description of  
 1983 the various stages of development.

1984 b. A list of entities that offer alternatives to  
 1985 terminating the pregnancy.

1986 c. Detailed information on the availability of medical  
 1987 assistance benefits for prenatal care, childbirth, and neonatal  
 1988 care.

1989 3. The woman acknowledges in writing, before the  
 1990 termination of pregnancy, that the information required to be  
 1991 provided under this subsection has been provided.

1992  
 1993 Nothing in this paragraph is intended to prohibit a physician  
 1994 from providing any additional information which the physician  
 1995 deems material to the woman's informed decision to terminate her  
 1996 pregnancy.

1997 Section 25. Paragraphs (c), (e), and (f) of subsection (3)  
 1998 of section 390.012, Florida Statutes, are amended to read:

1999 390.012 Powers of agency; rules; disposal of fetal  
 2000 remains.—

2001 (3) For clinics that perform or claim to perform abortions  
2002 after the first trimester of pregnancy, the agency shall adopt  
2003 rules pursuant to ss. 120.536(1) and 120.54 to implement the  
2004 provisions of this chapter, including the following:

2005 (c) Rules relating to abortion clinic personnel. At a  
2006 minimum, these rules shall require that:

2007 1. The abortion clinic designate a medical director who is  
2008 licensed to practice medicine in this state, and all physicians  
2009 who perform abortions in the clinic have admitting privileges at  
2010 a hospital within reasonable proximity to the clinic, unless the  
2011 clinic has a written patient transfer agreement with a hospital  
2012 within reasonable proximity to the clinic which includes the  
2013 transfer of the patient's medical records held by both the  
2014 clinic and the treating physician.

2015 2. If a physician is not present after an abortion is  
2016 performed, a registered nurse, licensed practical nurse,  
2017 advanced practice registered nurse, autonomous physician  
2018 assistant, or physician assistant be present and remain at the  
2019 clinic to provide postoperative monitoring and care until the  
2020 patient is discharged.

2021 3. Surgical assistants receive training in counseling,  
2022 patient advocacy, and the specific responsibilities associated  
2023 with the services the surgical assistants provide.

2024 4. Volunteers receive training in the specific  
2025 responsibilities associated with the services the volunteers

2026 provide, including counseling and patient advocacy as provided  
2027 in the rules adopted by the director for different types of  
2028 volunteers based on their responsibilities.

2029 (e) Rules relating to the abortion procedure. At a  
2030 minimum, these rules shall require:

2031 1. That a physician, registered nurse, licensed practical  
2032 nurse, advanced practice registered nurse, autonomous physician  
2033 assistant, or physician assistant is available to all patients  
2034 throughout the abortion procedure.

2035 2. Standards for the safe conduct of abortion procedures  
2036 that conform to obstetric standards in keeping with established  
2037 standards of care regarding the estimation of fetal age as  
2038 defined in rule.

2039 3. Appropriate use of general and local anesthesia,  
2040 analgesia, and sedation if ordered by the physician.

2041 4. Appropriate precautions, such as the establishment of  
2042 intravenous access at least for patients undergoing post-first  
2043 trimester abortions.

2044 5. Appropriate monitoring of the vital signs and other  
2045 defined signs and markers of the patient's status throughout the  
2046 abortion procedure and during the recovery period until the  
2047 patient's condition is deemed to be stable in the recovery room.

2048 (f) Rules that prescribe minimum recovery room standards.  
2049 At a minimum, these rules must require that:

2050 1. Postprocedure recovery rooms be supervised and staffed

2051 to meet the patients' needs.

2052       2. Immediate postprocedure care consist of observation in  
2053 a supervised recovery room for as long as the patient's  
2054 condition warrants.

2055       3. A registered nurse, licensed practical nurse, advanced  
2056 practice registered nurse, autonomous physician assistant, or  
2057 physician assistant who is trained in the management of the  
2058 recovery area and is capable of providing basic cardiopulmonary  
2059 resuscitation and related emergency procedures remain on the  
2060 premises of the abortion clinic until all patients are  
2061 discharged.

2062       4. A physician sign the discharge order and be readily  
2063 accessible and available until the last patient is discharged to  
2064 facilitate the transfer of emergency cases if hospitalization of  
2065 the patient or viable fetus is necessary.

2066       5. A physician discuss Rho(D) immune globulin with each  
2067 patient for whom it is indicated and ensure that it is offered  
2068 to the patient in the immediate postoperative period or will be  
2069 available to her within 72 hours after completion of the  
2070 abortion procedure. If the patient refuses the Rho(D) immune  
2071 globulin, she and a witness must sign a refusal form approved by  
2072 the agency which must be included in the medical record.

2073       6. Written instructions with regard to postabortion  
2074 coitus, signs of possible problems, and general aftercare which  
2075 are specific to the patient be given to each patient. The

2076 | instructions must include information regarding access to  
 2077 | medical care for complications, including a telephone number for  
 2078 | use in the event of a medical emergency.

2079 |         7. A minimum length of time be specified, by type of  
 2080 | abortion procedure and duration of gestation, during which a  
 2081 | patient must remain in the recovery room.

2082 |         8. The physician ensure that, with the patient's consent,  
 2083 | a registered nurse, licensed practical nurse, advanced practice  
 2084 | registered nurse, autonomous physician assistant, or physician  
 2085 | assistant from the abortion clinic makes a good faith effort to  
 2086 | contact the patient by telephone within 24 hours after surgery  
 2087 | to assess the patient's recovery.

2088 |         9. Equipment and services be readily accessible to provide  
 2089 | appropriate emergency resuscitative and life support procedures  
 2090 | pending the transfer of the patient or viable fetus to the  
 2091 | hospital.

2092 |         Section 26. Paragraphs (a) and (f) of subsection (2) of  
 2093 | section 394.463, Florida Statutes, are amended to read:

2094 |         394.463 Involuntary examination.—

2095 |         (2) INVOLUNTARY EXAMINATION.—

2096 |         (a) An involuntary examination may be initiated by any one  
 2097 | of the following means:

2098 |         1. A circuit or county court may enter an ex parte order  
 2099 | stating that a person appears to meet the criteria for  
 2100 | involuntary examination and specifying the findings on which



2101 that conclusion is based. The ex parte order for involuntary  
2102 examination must be based on written or oral sworn testimony  
2103 that includes specific facts that support the findings. If other  
2104 less restrictive means are not available, such as voluntary  
2105 appearance for outpatient evaluation, a law enforcement officer,  
2106 or other designated agent of the court, shall take the person  
2107 into custody and deliver him or her to an appropriate, or the  
2108 nearest, facility within the designated receiving system  
2109 pursuant to s. 394.462 for involuntary examination. The order of  
2110 the court shall be made a part of the patient's clinical record.  
2111 A fee may not be charged for the filing of an order under this  
2112 subsection. A facility accepting the patient based on this order  
2113 must send a copy of the order to the department within 5 working  
2114 days. The order may be submitted electronically through existing  
2115 data systems, if available. The order shall be valid only until  
2116 the person is delivered to the facility or for the period  
2117 specified in the order itself, whichever comes first. If a ~~no~~  
2118 time limit is not specified in the order, the order is ~~shall be~~  
2119 valid for 7 days after the date that the order was signed.

2120 2. A law enforcement officer shall take a person who  
2121 appears to meet the criteria for involuntary examination into  
2122 custody and deliver the person or have him or her delivered to  
2123 an appropriate, or the nearest, facility within the designated  
2124 receiving system pursuant to s. 394.462 for examination. The  
2125 officer shall execute a written report detailing the

2126 | circumstances under which the person was taken into custody,  
2127 | which must be made a part of the patient's clinical record. Any  
2128 | facility accepting the patient based on this report must send a  
2129 | copy of the report to the department within 5 working days.

2130 |         3. A physician, autonomous physician assistant, physician  
2131 | assistant, clinical psychologist, psychiatric nurse, advanced  
2132 | practice registered nurse, mental health counselor, marriage and  
2133 | family therapist, or clinical social worker may execute a  
2134 | certificate stating that he or she has examined a person within  
2135 | the preceding 48 hours and finds that the person appears to meet  
2136 | the criteria for involuntary examination and stating the  
2137 | observations upon which that conclusion is based. If other less  
2138 | restrictive means, such as voluntary appearance for outpatient  
2139 | evaluation, are not available, a law enforcement officer shall  
2140 | take into custody the person named in the certificate and  
2141 | deliver him or her to the appropriate, or nearest, facility  
2142 | within the designated receiving system pursuant to s. 394.462  
2143 | for involuntary examination. The law enforcement officer shall  
2144 | execute a written report detailing the circumstances under which  
2145 | the person was taken into custody. The report and certificate  
2146 | shall be made a part of the patient's clinical record. Any  
2147 | facility accepting the patient based on this certificate must  
2148 | send a copy of the certificate to the department within 5  
2149 | working days. The document may be submitted electronically  
2150 | through existing data systems, if applicable.

2151  
2152 When sending the order, report, or certificate to the  
2153 department, a facility shall, at a minimum, provide information  
2154 about which action was taken regarding the patient under  
2155 paragraph (g), which information shall also be made a part of  
2156 the patient's clinical record.

2157 (f) A patient shall be examined by a physician, physician  
2158 assistant, or ~~a~~ clinical psychologist, or by a psychiatric nurse  
2159 performing within the framework of an established protocol with  
2160 a psychiatrist, at a facility without unnecessary delay to  
2161 determine if the criteria for involuntary services are met.  
2162 Emergency treatment may be provided upon the order of a  
2163 physician if the physician determines that such treatment is  
2164 necessary for the safety of the patient or others. The patient  
2165 may not be released by the receiving facility or its contractor  
2166 without the documented approval of a psychiatrist or a clinical  
2167 psychologist or, if the receiving facility is owned or operated  
2168 by a hospital or health system, the release may also be approved  
2169 by a psychiatric nurse performing within the framework of an  
2170 established protocol with a psychiatrist, or an attending  
2171 emergency department physician with experience in the diagnosis  
2172 and treatment of mental illness after completion of an  
2173 involuntary examination pursuant to this subsection. A  
2174 psychiatric nurse may not approve the release of a patient if  
2175 the involuntary examination was initiated by a psychiatrist

2176 unless the release is approved by the initiating psychiatrist.

2177 Section 27. Paragraph (b) of subsection (2) of section  
2178 395.0191, Florida Statutes, is amended to read:

2179 395.0191 Staff membership and clinical privileges.—

2180 (2)

2181 (b) An advanced practice registered nurse who is certified  
2182 as a registered nurse anesthetist licensed under part I of  
2183 chapter 464 shall administer anesthesia under the onsite medical  
2184 direction of a professional licensed under chapter 458, chapter  
2185 459, or chapter 466, and in accordance with an established  
2186 protocol approved by the medical staff. The medical direction  
2187 shall specifically address the needs of the individual patient.

2188 This paragraph does not apply to a certified registered nurse  
2189 anesthetist registered to engage in autonomous practice under s.  
2190 464.0123.

2191 Section 28. Subsection (3) of section 395.602, Florida  
2192 Statutes, is amended to read:

2193 395.602 Rural hospitals.—

2194 (3) USE OF FUNDS.—It is the intent of the Legislature that  
2195 funds as appropriated shall be utilized by the department for  
2196 the purpose of increasing the number of primary care physicians,  
2197 autonomous physician assistants, physician assistants, certified  
2198 nurse midwives, nurse practitioners, and nurses in rural areas,  
2199 either through the Medical Education Reimbursement and Loan  
2200 Repayment Program as defined by s. 1009.65 or through a federal

2201 loan repayment program which requires state matching funds. The  
2202 department may use funds appropriated for the Medical Education  
2203 Reimbursement and Loan Repayment Program as matching funds for  
2204 federal loan repayment programs for health care personnel, such  
2205 as that authorized in Pub. L. No. 100-177, s. 203. If the  
2206 department receives federal matching funds, the department shall  
2207 only implement the federal program. Reimbursement through either  
2208 program shall be limited to:

2209 (a) Primary care physicians, autonomous physician  
2210 assistants, physician assistants, certified nurse midwives,  
2211 nurse practitioners, and nurses employed by or affiliated with  
2212 rural hospitals, as defined in this act; and

2213 (b) Primary care physicians, autonomous physician  
2214 assistants, physician assistants, certified nurse midwives,  
2215 nurse practitioners, and nurses employed by or affiliated with  
2216 rural area health education centers, as defined in this section.  
2217 These personnel shall practice:

2218 1. In a county with a population density of no greater  
2219 than 100 persons per square mile; or

2220 2. Within the boundaries of a hospital tax district which  
2221 encompasses a population of no greater than 100 persons per  
2222 square mile.

2223  
2224 If the department administers a federal loan repayment program,  
2225 priority shall be given to obligating state and federal matching

2226 funds pursuant to paragraphs (a) and (b). The department may use  
 2227 federal matching funds in other health workforce shortage areas  
 2228 and medically underserved areas in the state for loan repayment  
 2229 programs for primary care physicians, autonomous physician  
 2230 assistants, physician assistants, certified nurse midwives,  
 2231 nurse practitioners, and nurses who are employed by publicly  
 2232 financed health care programs that serve medically indigent  
 2233 persons.

2234 Section 29. Paragraph (a) of subsection (2) of section  
 2235 397.501, Florida Statutes, is amended to read:

2236 397.501 Rights of individuals.—Individuals receiving  
 2237 substance abuse services from any service provider are  
 2238 guaranteed protection of the rights specified in this section,  
 2239 unless otherwise expressly provided, and service providers must  
 2240 ensure the protection of such rights.

2241 (2) RIGHT TO NONDISCRIMINATORY SERVICES.—

2242 (a) Service providers may not deny an individual access to  
 2243 substance abuse services solely on the basis of race, gender,  
 2244 ethnicity, age, sexual preference, human immunodeficiency virus  
 2245 status, prior service departures against medical advice,  
 2246 disability, or number of relapse episodes. Service providers may  
 2247 not deny an individual who takes medication prescribed by a  
 2248 physician, autonomous physician assistant, physician assistant,  
 2249 or advanced practice registered nurse access to substance abuse  
 2250 services solely on that basis. Service providers who receive

2251 state funds to provide substance abuse services may not, if  
2252 space and sufficient state resources are available, deny access  
2253 to services based solely on inability to pay.

2254 Section 30. Section 397.679, Florida Statutes, is amended  
2255 to read:

2256 397.679 Emergency admission; circumstances justifying.—A  
2257 person who meets the criteria for involuntary admission in s.  
2258 397.675 may be admitted to a hospital or to a licensed  
2259 detoxification facility or addictions receiving facility for  
2260 emergency assessment and stabilization, or to a less intensive  
2261 component of a licensed service provider for assessment only,  
2262 upon receipt by the facility of a certificate by a physician, an  
2263 autonomous physician assistant, an advanced practice registered  
2264 nurse, a psychiatric nurse, a clinical psychologist, a clinical  
2265 social worker, a marriage and family therapist, a mental health  
2266 counselor, a physician assistant working under the scope of  
2267 practice of the supervising physician, or a master's-level-  
2268 certified addictions professional for substance abuse services,  
2269 if the certificate is specific to substance abuse impairment,  
2270 and the completion of an application for emergency admission.

2271 Section 31. Subsection (1) of section 397.6793, Florida  
2272 Statutes, is amended to read:

2273 397.6793 Professional's certificate for emergency  
2274 admission.—

2275 (1) A physician, a clinical psychologist, an autonomous

2276 physician assistant, a physician assistant working under the  
2277 scope of practice of the supervising physician, a psychiatric  
2278 nurse, an advanced practice registered nurse, a mental health  
2279 counselor, a marriage and family therapist, a master's-level-  
2280 certified addictions professional for substance abuse services,  
2281 or a clinical social worker may execute a professional's  
2282 certificate for emergency admission. The professional's  
2283 certificate must include the name of the person to be admitted,  
2284 the relationship between the person and the professional  
2285 executing the certificate, the relationship between the  
2286 applicant and the professional, any relationship between the  
2287 professional and the licensed service provider, a statement that  
2288 the person has been examined and assessed within the preceding 5  
2289 days after the application date, and factual allegations with  
2290 respect to the need for emergency admission, including:

2291 (a) The reason for the belief that the person is substance  
2292 abuse impaired;

2293 (b) The reason for the belief that because of such  
2294 impairment the person has lost the power of self-control with  
2295 respect to substance abuse; and

2296 (c)1. The reason for the belief that, without care or  
2297 treatment, the person is likely to suffer from neglect or refuse  
2298 to care for himself or herself; that such neglect or refusal  
2299 poses a real and present threat of substantial harm to his or  
2300 her well-being; and that it is not apparent that such harm may



2301 | be avoided through the help of willing family members or friends  
 2302 | or the provision of other services, or there is substantial  
 2303 | likelihood that the person has inflicted or, unless admitted, is  
 2304 | likely to inflict, physical harm on himself, herself, or  
 2305 | another; or

2306 |         2. The reason for the belief that the person's refusal to  
 2307 | voluntarily receive care is based on judgment so impaired by  
 2308 | reason of substance abuse that the person is incapable of  
 2309 | appreciating his or her need for care and of making a rational  
 2310 | decision regarding his or her need for care.

2311 |         Section 32. Subsection (8) of section 400.021, Florida  
 2312 | Statutes, is amended to read:

2313 |             400.021 Definitions.—When used in this part, unless the  
 2314 | context otherwise requires, the term:

2315 |             (8) "Geriatric outpatient clinic" means a site for  
 2316 | providing outpatient health care to persons 60 years of age or  
 2317 | older, which is staffed by a registered nurse, a physician  
 2318 | assistant, or a licensed practical nurse under the direct  
 2319 | supervision of a registered nurse, advanced practice registered  
 2320 | nurse, physician assistant, autonomous physician assistant, or  
 2321 | physician.

2322 |         Section 33. Subsection (3) of section 400.172, Florida  
 2323 | Statutes, is amended to read:

2324 |             400.172 Respite care provided in nursing home facilities.—

2325 |             (3) A prospective respite care resident must provide

2326 | medical information from a physician, autonomous physician  
 2327 | assistant, physician assistant, or nurse practitioner and any  
 2328 | other information provided by the primary caregiver required by  
 2329 | the facility before or when the person is admitted to receive  
 2330 | respite care. The medical information must include a physician's  
 2331 | order for respite care and proof of a physical examination by a  
 2332 | licensed physician, autonomous physician assistant, physician  
 2333 | assistant, or nurse practitioner. The physician's order and  
 2334 | physical examination may be used to provide intermittent respite  
 2335 | care for up to 12 months after the date the order is written.

2336 |         Section 34. Subsection (2) of section 400.487, Florida  
 2337 | Statutes, is amended to read:

2338 |             400.487 Home health service agreements; physician's,  
 2339 | physician assistant's, autonomous physician assistant's, and  
 2340 | advanced practice registered nurse's treatment orders; patient  
 2341 | assessment; establishment and review of plan of care; provision  
 2342 | of services; orders not to resuscitate.—

2343 |             (2) When required by ~~the provisions of~~ chapter 464; part  
 2344 | I, part III, or part V of chapter 468; or chapter 486, the  
 2345 | attending physician, autonomous physician assistant, physician  
 2346 | assistant, or advanced practice registered nurse, acting within  
 2347 | his or her respective scope of practice, shall establish  
 2348 | treatment orders for a patient who is to receive skilled care.  
 2349 | The treatment orders must be signed by the physician, autonomous  
 2350 | physician assistant, physician assistant, or advanced practice

2351 registered nurse before a claim for payment for the skilled  
2352 services is submitted by the home health agency. If the claim is  
2353 submitted to a managed care organization, the treatment orders  
2354 must be signed within the time allowed under the provider  
2355 agreement. The treatment orders shall be reviewed, as frequently  
2356 as the patient's illness requires, by the physician, autonomous  
2357 physician assistant, physician assistant, or advanced practice  
2358 registered nurse in consultation with the home health agency.

2359 Section 35. Paragraph (a) of subsection (13) of section  
2360 400.506, Florida Statutes, is amended to read:

2361 400.506 Licensure of nurse registries; requirements;  
2362 penalties.—

2363 (13) All persons referred for contract in private  
2364 residences by a nurse registry must comply with the following  
2365 requirements for a plan of treatment:

2366 (a) When, in accordance with the privileges and  
2367 restrictions imposed upon a nurse under part I of chapter 464,  
2368 the delivery of care to a patient is under the direction or  
2369 supervision of a physician or when a physician is responsible  
2370 for the medical care of the patient, a medical plan of treatment  
2371 must be established for each patient receiving care or treatment  
2372 provided by a licensed nurse in the home. The original medical  
2373 plan of treatment must be timely signed by the physician,  
2374 autonomous physician assistant, physician assistant, or advanced  
2375 practice registered nurse, acting within his or her respective

2376 scope of practice, and reviewed in consultation with the  
2377 licensed nurse at least every 2 months. Any additional order or  
2378 change in orders must be obtained from the physician, autonomous  
2379 physician assistant, physician assistant, or advanced practice  
2380 registered nurse and reduced to writing and timely signed by the  
2381 physician, autonomous physician assistant, physician assistant,  
2382 or advanced practice registered nurse. The delivery of care  
2383 under a medical plan of treatment must be substantiated by the  
2384 appropriate nursing notes or documentation made by the nurse in  
2385 compliance with nursing practices established under part I of  
2386 chapter 464.

2387 Section 36. Subsection (5) and paragraph (b) of subsection  
2388 (7) of section 400.9973, Florida Statutes, are amended to read:

2389 400.9973 Client admission, transfer, and discharge.—

2390 (5) A client admitted to a transitional living facility  
2391 must be admitted upon prescription by a licensed physician,  
2392 autonomous physician assistant, physician assistant, or advanced  
2393 practice registered nurse and must remain under the care of a  
2394 licensed physician, autonomous physician assistant, physician  
2395 assistant, or advanced practice registered nurse for the  
2396 duration of the client's stay in the facility.

2397 (7) A person may not be admitted to a transitional living  
2398 facility if the person:

2399 (b) Is a danger to himself or herself or others as  
2400 determined by a physician, autonomous physician assistant,

2401 physician assistant, advanced practice registered nurse, or a  
 2402 mental health practitioner licensed under chapter 490 or chapter  
 2403 491, unless the facility provides adequate staffing and support  
 2404 to ensure patient safety;

2405 Section 37. Paragraphs (a) and (b) of subsection (2) of  
 2406 section 400.9974, Florida Statutes, are amended to read:

2407 400.9974 Client comprehensive treatment plans; client  
 2408 services.—

2409 (2) The comprehensive treatment plan must include:

2410 (a) Orders obtained from the physician, autonomous  
 2411 physician assistant, physician assistant, or advanced practice  
 2412 registered nurse and the client's diagnosis, medical history,  
 2413 physical examination, and rehabilitative or restorative needs.

2414 (b) A preliminary nursing evaluation, including orders for  
 2415 immediate care provided by the physician, autonomous physician  
 2416 assistant, physician assistant, or advanced practice registered  
 2417 nurse, which shall be completed when the client is admitted.

2418 Section 38. Section 400.9976, Florida Statutes, is amended  
 2419 to read:

2420 400.9976 Administration of medication.—

2421 (1) An individual medication administration record must be  
 2422 maintained for each client. A dose of medication, including a  
 2423 self-administered dose, shall be properly recorded in the  
 2424 client's record. A client who self-administers medication shall  
 2425 be given a pill organizer. Medication must be placed in the pill

2426 organizer by a nurse. A nurse shall document the date and time  
2427 that medication is placed into each client's pill organizer. All  
2428 medications must be administered in compliance with orders of a  
2429 physician, autonomous physician assistant, physician assistant,  
2430 or advanced practice registered nurse.

2431 (2) If an interdisciplinary team determines that self-  
2432 administration of medication is an appropriate objective, and if  
2433 the physician, autonomous physician assistant, physician  
2434 assistant, or advanced practice registered nurse does not  
2435 specify otherwise, the client must be instructed by the  
2436 physician, autonomous physician assistant, physician assistant,  
2437 or advanced practice registered nurse to self-administer his or  
2438 her medication without the assistance of a staff person. All  
2439 forms of self-administration of medication, including  
2440 administration orally, by injection, and by suppository, shall  
2441 be included in the training. The client's physician, autonomous  
2442 physician assistant, physician assistant, or advanced practice  
2443 registered nurse must be informed of the interdisciplinary  
2444 team's decision that self-administration of medication is an  
2445 objective for the client. A client may not self-administer  
2446 medication until he or she demonstrates the competency to take  
2447 the correct medication in the correct dosage at the correct  
2448 time, to respond to missed doses, and to contact the appropriate  
2449 person with questions.

2450 (3) Medication administration discrepancies and adverse

2451 drug reactions must be recorded and reported immediately to a  
2452 physician, autonomous physician assistant, physician assistant,  
2453 or advanced practice registered nurse.

2454 Section 39. Subsections (2) through (5) of section  
2455 400.9979, Florida Statutes, are amended to read:

2456 400.9979 Restraint and seclusion; client safety.—

2457 (2) The use of physical restraints must be ordered and  
2458 documented by a physician, autonomous physician assistant,  
2459 physician assistant, or advanced practice registered nurse and  
2460 must be consistent with the policies and procedures adopted by  
2461 the facility. The client or, if applicable, the client's  
2462 representative shall be informed of the facility's physical  
2463 restraint policies and procedures when the client is admitted.

2464 (3) The use of chemical restraints shall be limited to  
2465 prescribed dosages of medications as ordered by a physician,  
2466 autonomous physician assistant, physician assistant, or advanced  
2467 practice registered nurse and must be consistent with the  
2468 client's diagnosis and the policies and procedures adopted by  
2469 the facility. The client and, if applicable, the client's  
2470 representative shall be informed of the facility's chemical  
2471 restraint policies and procedures when the client is admitted.

2472 (4) Based on the assessment by a physician, autonomous  
2473 physician assistant, physician assistant, or advanced practice  
2474 registered nurse, if a client exhibits symptoms that present an  
2475 immediate risk of injury or death to himself or herself or

2476 others, a physician, physician assistant, or advanced practice  
2477 registered nurse may issue an emergency treatment order to  
2478 immediately administer rapid-response psychotropic medications  
2479 or other chemical restraints. Each emergency treatment order  
2480 must be documented and maintained in the client's record.

2481 (a) An emergency treatment order is not effective for more  
2482 than 24 hours.

2483 (b) Whenever a client is medicated under this subsection,  
2484 the client's representative or a responsible party and the  
2485 client's physician, autonomous physician assistant, physician  
2486 assistant, or advanced practice registered nurse shall be  
2487 notified as soon as practicable.

2488 (5) A client who is prescribed and receives a medication  
2489 that can serve as a chemical restraint for a purpose other than  
2490 an emergency treatment order must be evaluated by his or her  
2491 physician, autonomous physician assistant, physician assistant,  
2492 or advanced practice registered nurse at least monthly to  
2493 assess:

2494 (a) The continued need for the medication.

2495 (b) The level of the medication in the client's blood.

2496 (c) The need for adjustments to the prescription.

2497 Section 40. Subsections (1) and (2) of section 401.445,  
2498 Florida Statutes, are amended to read:

2499 401.445 Emergency examination and treatment of  
2500 incapacitated persons.—



2501           (1) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in  
 2502 this state against any emergency medical technician, paramedic,  
 2503 or physician as defined in this chapter, any advanced practice  
 2504 registered nurse licensed under s. 464.012, or any autonomous  
 2505 physician assistant or physician assistant registered or  
 2506 licensed under s. 458.347 or s. 459.022, or any person acting  
 2507 under the direct medical supervision of a physician, in an  
 2508 action brought for examining or treating a patient without his  
 2509 or her informed consent if:

2510           (a) The patient at the time of examination or treatment is  
 2511 intoxicated, under the influence of drugs, or otherwise  
 2512 incapable of providing informed consent as provided in s.  
 2513 766.103;

2514           (b) The patient at the time of examination or treatment is  
 2515 experiencing an emergency medical condition; and

2516           (c) The patient would reasonably, under all the  
 2517 surrounding circumstances, undergo such examination, treatment,  
 2518 or procedure if he or she were advised by the emergency medical  
 2519 technician, paramedic, physician, advanced practice registered  
 2520 nurse, autonomous physician assistant, or physician assistant in  
 2521 accordance with s. 766.103(3).

2522  
 2523 Examination and treatment provided under this subsection shall  
 2524 be limited to reasonable examination of the patient to determine  
 2525 the medical condition of the patient and treatment reasonably

2526 necessary to alleviate the emergency medical condition or to  
2527 stabilize the patient.

2528 (2) In examining and treating a person who is apparently  
2529 intoxicated, under the influence of drugs, or otherwise  
2530 incapable of providing informed consent, the emergency medical  
2531 technician, paramedic, physician, advanced practice registered  
2532 nurse, autonomous physician assistant, or physician assistant,  
2533 or any person acting under the direct medical supervision of a  
2534 physician, shall proceed wherever possible with the consent of  
2535 the person. If the person reasonably appears to be incapacitated  
2536 and refuses his or her consent, the person may be examined,  
2537 treated, or taken to a hospital or other appropriate treatment  
2538 resource if he or she is in need of emergency attention, without  
2539 his or her consent, but unreasonable force shall not be used.

2540 Section 41. Subsection (18) of section 409.906, Florida  
2541 Statutes, is amended to read:

2542 409.906 Optional Medicaid services.—Subject to specific  
2543 appropriations, the agency may make payments for services which  
2544 are optional to the state under Title XIX of the Social Security  
2545 Act and are furnished by Medicaid providers to recipients who  
2546 are determined to be eligible on the dates on which the services  
2547 were provided. Any optional service that is provided shall be  
2548 provided only when medically necessary and in accordance with  
2549 state and federal law. Optional services rendered by providers  
2550 in mobile units to Medicaid recipients may be restricted or

2551 prohibited by the agency. Nothing in this section shall be  
2552 construed to prevent or limit the agency from adjusting fees,  
2553 reimbursement rates, lengths of stay, number of visits, or  
2554 number of services, or making any other adjustments necessary to  
2555 comply with the availability of moneys and any limitations or  
2556 directions provided for in the General Appropriations Act or  
2557 chapter 216. If necessary to safeguard the state's systems of  
2558 providing services to elderly and disabled persons and subject  
2559 to the notice and review provisions of s. 216.177, the Governor  
2560 may direct the Agency for Health Care Administration to amend  
2561 the Medicaid state plan to delete the optional Medicaid service  
2562 known as "Intermediate Care Facilities for the Developmentally  
2563 Disabled." Optional services may include:

2564 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for  
2565 all services provided to a recipient by an autonomous physician  
2566 assistant or a physician assistant registered or licensed under  
2567 s. 458.347 or s. 459.022. Reimbursement for such services must  
2568 be not less than 80 percent of the reimbursement that would be  
2569 paid to a physician who provided the same services.

2570 Section 42. Paragraph (m) of subsection (3) of section  
2571 409.908, Florida Statutes, is amended to read:

2572 409.908 Reimbursement of Medicaid providers.—Subject to  
2573 specific appropriations, the agency shall reimburse Medicaid  
2574 providers, in accordance with state and federal law, according  
2575 to methodologies set forth in the rules of the agency and in

2576 policy manuals and handbooks incorporated by reference therein.  
 2577 These methodologies may include fee schedules, reimbursement  
 2578 methods based on cost reporting, negotiated fees, competitive  
 2579 bidding pursuant to s. 287.057, and other mechanisms the agency  
 2580 considers efficient and effective for purchasing services or  
 2581 goods on behalf of recipients. If a provider is reimbursed based  
 2582 on cost reporting and submits a cost report late and that cost  
 2583 report would have been used to set a lower reimbursement rate  
 2584 for a rate semester, then the provider's rate for that semester  
 2585 shall be retroactively calculated using the new cost report, and  
 2586 full payment at the recalculated rate shall be effected  
 2587 retroactively. Medicare-granted extensions for filing cost  
 2588 reports, if applicable, shall also apply to Medicaid cost  
 2589 reports. Payment for Medicaid compensable services made on  
 2590 behalf of Medicaid eligible persons is subject to the  
 2591 availability of moneys and any limitations or directions  
 2592 provided for in the General Appropriations Act or chapter 216.  
 2593 Further, nothing in this section shall be construed to prevent  
 2594 or limit the agency from adjusting fees, reimbursement rates,  
 2595 lengths of stay, number of visits, or number of services, or  
 2596 making any other adjustments necessary to comply with the  
 2597 availability of moneys and any limitations or directions  
 2598 provided for in the General Appropriations Act, provided the  
 2599 adjustment is consistent with legislative intent.

2600 (3) Subject to any limitations or directions provided for

2601 in the General Appropriations Act, the following Medicaid  
 2602 services and goods may be reimbursed on a fee-for-service basis.  
 2603 For each allowable service or goods furnished in accordance with  
 2604 Medicaid rules, policy manuals, handbooks, and state and federal  
 2605 law, the payment shall be the amount billed by the provider, the  
 2606 provider's usual and customary charge, or the maximum allowable  
 2607 fee established by the agency, whichever amount is less, with  
 2608 the exception of those services or goods for which the agency  
 2609 makes payment using a methodology based on capitation rates,  
 2610 average costs, or negotiated fees.

2611 (m) Autonomous physician assistant and physician assistant  
 2612 services.

2613 Section 43. Paragraphs (c) through (cc) of subsection (1)  
 2614 of section 409.973, Florida Statutes, are redesignated as  
 2615 paragraphs (d) through (dd), respectively, and a new paragraph  
 2616 (c) is added to that subsection to read:

2617 409.973 Benefits.—

2618 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a  
 2619 minimum, the following services:

2620 (c) Autonomous physician assistant services.

2621 Section 44. Subsections (2), (4), and (5) of section  
 2622 429.26, Florida Statutes, are amended to read:

2623 429.26 Appropriateness of placements; examinations of  
 2624 residents.—

2625 (2) A physician, autonomous physician assistant, physician

2626 assistant, or nurse practitioner who is employed by an assisted  
2627 living facility to provide an initial examination for admission  
2628 purposes may not have financial interest in the facility.

2629 (4) If possible, each resident shall have been examined by  
2630 a licensed physician, an autonomous physician assistant, a  
2631 licensed physician assistant, or a licensed nurse practitioner  
2632 within 60 days before admission to the facility. The signed and  
2633 completed medical examination report shall be submitted to the  
2634 owner or administrator of the facility who shall use the  
2635 information contained therein to assist in the determination of  
2636 the appropriateness of the resident's admission and continued  
2637 stay in the facility. The medical examination report shall  
2638 become a permanent part of the record of the resident at the  
2639 facility and shall be made available to the agency during  
2640 inspection or upon request. An assessment that has been  
2641 completed through the Comprehensive Assessment and Review for  
2642 Long-Term Care Services (CARES) Program fulfills the  
2643 requirements for a medical examination under this subsection and  
2644 s. 429.07(3)(b)6.

2645 (5) Except as provided in s. 429.07, if a medical  
2646 examination has not been completed within 60 days before the  
2647 admission of the resident to the facility, a licensed physician,  
2648 a registered autonomous physician assistant, a licensed  
2649 physician assistant, or a licensed nurse practitioner shall  
2650 examine the resident and complete a medical examination form

2651 provided by the agency within 30 days following the admission to  
2652 the facility to enable the facility owner or administrator to  
2653 determine the appropriateness of the admission. The medical  
2654 examination form shall become a permanent part of the record of  
2655 the resident at the facility and shall be made available to the  
2656 agency during inspection by the agency or upon request.

2657 Section 45. Paragraph (a) of subsection (2) and paragraph  
2658 (a) of subsection (7) of section 429.918, Florida Statutes, are  
2659 amended to read:

2660 429.918 Licensure designation as a specialized Alzheimer's  
2661 services adult day care center.—

2662 (2) As used in this section, the term:

2663 (a) "ADRD participant" means a participant who has a  
2664 documented diagnosis of Alzheimer's disease or a dementia-  
2665 related disorder (ADRD) from a licensed physician, a registered  
2666 autonomous physician assistant, a licensed physician assistant,  
2667 or a licensed advanced practice registered nurse.

2668 (7) (a) An ADRD participant admitted to an adult day care  
2669 center having a license designated under this section, or the  
2670 caregiver when applicable, must:

2671 1. Require ongoing supervision to maintain the highest  
2672 level of medical or custodial functioning and have a  
2673 demonstrated need for a responsible party to oversee his or her  
2674 care.

2675 2. Not actively demonstrate aggressive behavior that

2676 places himself, herself, or others at risk of harm.

2677 3. Provide the following medical documentation signed by a  
2678 licensed physician, a registered autonomous physician assistant,  
2679 a licensed physician assistant, or a licensed advanced practice  
2680 registered nurse:

2681 a. Any physical, health, or emotional conditions that  
2682 require medical care.

2683 b. A listing of the ADRD participant's current prescribed  
2684 and over-the-counter medications and dosages, diet restrictions,  
2685 mobility restrictions, and other physical limitations.

2686 4. Provide documentation signed by a health care provider  
2687 licensed in this state which indicates that the ADRD participant  
2688 is free of the communicable form of tuberculosis and free of  
2689 signs and symptoms of other communicable diseases.

2690 Section 46. Paragraph (e) of subsection (5) of section  
2691 440.102, Florida Statutes, is amended to read:

2692 440.102 Drug-free workplace program requirements.—The  
2693 following provisions apply to a drug-free workplace program  
2694 implemented pursuant to law or to rules adopted by the Agency  
2695 for Health Care Administration:

2696 (5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen  
2697 collection and testing for drugs under this section shall be  
2698 performed in accordance with the following procedures:

2699 (e) A specimen for a drug test may be taken or collected  
2700 by any of the following persons:



2701 1. A physician, an autonomous physician assistant, a  
 2702 physician assistant, a registered professional nurse, a licensed  
 2703 practical nurse, or a nurse practitioner or a certified  
 2704 paramedic who is present at the scene of an accident for the  
 2705 purpose of rendering emergency medical service or treatment.

2706 2. A qualified person employed by a licensed or certified  
 2707 laboratory as described in subsection (9).

2708 Section 47. Paragraphs (a), (i), (o), and (r) of  
 2709 subsection (3) and paragraph (g) of subsection (5) of section  
 2710 456.053, Florida Statutes, are amended to read:

2711 456.053 Financial arrangements between referring health  
 2712 care providers and providers of health care services.—

2713 (3) DEFINITIONS.—For the purpose of this section, the  
 2714 word, phrase, or term:

2715 (a) "Board" means any of the following boards relating to  
 2716 the respective professions: the Board of Medicine as created in  
 2717 s. 458.307; the Board of Osteopathic Medicine as created in s.  
 2718 459.004; the Board of Chiropractic Medicine as created in s.  
 2719 460.404; the Board of Podiatric Medicine as created in s.  
 2720 461.004; the Board of Optometry as created in s. 463.003; the  
 2721 Board of Nursing as created in s. 464.004; the Board of Pharmacy  
 2722 as created in s. 465.004; and the Board of Dentistry as created  
 2723 in s. 466.004.

2724 (i) "Health care provider" means a ~~any~~ physician licensed  
 2725 under chapter 458, chapter 459, chapter 460, or chapter 461; an

2726 autonomous physician assistant registered under chapter 458 or  
2727 chapter 459; an advanced practice registered nurse registered to  
2728 engage in autonomous practice under s. 464.0123;~~7~~ or any health  
2729 care provider licensed under chapter 463 or chapter 466.

2730 (o) "Referral" means any referral of a patient by a health  
2731 care provider for health care services, including, without  
2732 limitation:

2733 1. The forwarding of a patient by a health care provider  
2734 to another health care provider or to an entity which provides  
2735 or supplies designated health services or any other health care  
2736 item or service; or

2737 2. The request or establishment of a plan of care by a  
2738 health care provider, which includes the provision of designated  
2739 health services or other health care item or service.

2740 3. The following orders, recommendations, or plans of care  
2741 shall not constitute a referral by a health care provider:

2742 a. By a radiologist for diagnostic-imaging services.

2743 b. By a physician specializing in the provision of  
2744 radiation therapy services for such services.

2745 c. By a medical oncologist for drugs and solutions to be  
2746 prepared and administered intravenously to such oncologist's  
2747 patient, as well as for the supplies and equipment used in  
2748 connection therewith to treat such patient for cancer and the  
2749 complications thereof.

2750 d. By a cardiologist for cardiac catheterization services.

2751 e. By a pathologist for diagnostic clinical laboratory  
2752 tests and pathological examination services, if furnished by or  
2753 under the supervision of such pathologist pursuant to a  
2754 consultation requested by another physician.

2755 f. By a health care provider who is the sole provider or  
2756 member of a group practice for designated health services or  
2757 other health care items or services that are prescribed or  
2758 provided solely for such referring health care provider's or  
2759 group practice's own patients, and that are provided or  
2760 performed by or under the direct supervision of such referring  
2761 health care provider or group practice; provided, however, ~~that~~  
2762 ~~effective July 1, 1999,~~ a health care provider ~~physician~~  
2763 ~~licensed pursuant to chapter 458, chapter 459, chapter 460, or~~  
2764 ~~chapter 461~~ may refer a patient to a sole provider or group  
2765 practice for diagnostic imaging services, excluding radiation  
2766 therapy services, for which the sole provider or group practice  
2767 billed both the technical and the professional fee for or on  
2768 behalf of the patient, if the referring health care provider  
2769 does not have an ~~physician has no~~ investment interest in the  
2770 practice. The diagnostic imaging service referred to a group  
2771 practice or sole provider must be a diagnostic imaging service  
2772 normally provided within the scope of practice to the patients  
2773 of the group practice or sole provider. The group practice or  
2774 sole provider may accept no more than 15 percent of their  
2775 patients receiving diagnostic imaging services from outside

2776 referrals, excluding radiation therapy services.

2777 g. By a health care provider for services provided by an  
 2778 ambulatory surgical center licensed under chapter 395.

2779 h. By a urologist for lithotripsy services.

2780 i. By a dentist for dental services performed by an  
 2781 employee of or health care provider who is an independent  
 2782 contractor with the dentist or group practice of which the  
 2783 dentist is a member.

2784 j. By a physician for infusion therapy services to a  
 2785 patient of that physician or a member of that physician's group  
 2786 practice.

2787 k. By a nephrologist for renal dialysis services and  
 2788 supplies, except laboratory services.

2789 l. By a health care provider whose principal professional  
 2790 practice consists of treating patients in their private  
 2791 residences for services to be rendered in such private  
 2792 residences, except for services rendered by a home health agency  
 2793 licensed under chapter 400. For purposes of this sub-  
 2794 subparagraph, the term "private residences" includes patients'  
 2795 private homes, independent living centers, and assisted living  
 2796 facilities, but does not include skilled nursing facilities.

2797 m. By a health care provider for sleep-related testing.

2798 (r) "Sole provider" means one health care provider  
 2799 licensed under chapter 458, chapter 459, chapter 460, or chapter  
 2800 461, or registered under s. 464.0123, who maintains a separate

2801 | medical office and a medical practice separate from any other  
 2802 | health care provider and who bills for his or her services  
 2803 | separately from the services provided by any other health care  
 2804 | provider. A sole provider shall not share overhead expenses or  
 2805 | professional income with any other person or group practice.

2806 | (5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as  
 2807 | provided in this section:

2808 | (g) A violation of this section by a health care provider  
 2809 | shall constitute grounds for disciplinary action to be taken by  
 2810 | the applicable board pursuant to s. 458.331(2), s. 459.015(2),  
 2811 | s. 460.413(2), s. 461.013(2), s. 463.016(2), s. 464.018, or s.  
 2812 | 466.028(2). Any hospital licensed under chapter 395 found in  
 2813 | violation of this section shall be subject to s. 395.0185(2).

2814 | Section 48. Subsection (7) of section 456.072, Florida  
 2815 | Statutes, is amended to read:

2816 | 456.072 Grounds for discipline; penalties; enforcement.—

2817 | (7) Notwithstanding subsection (2), upon a finding that a  
 2818 | physician or autonomous physician assistant has prescribed or  
 2819 | dispensed a controlled substance, or caused a controlled  
 2820 | substance to be prescribed or dispensed, in a manner that  
 2821 | violates the standard of practice set forth in s. 458.331(1)(g)  
 2822 | or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s.  
 2823 | 466.028(1)(p) or (x), or that an advanced practice registered  
 2824 | nurse has prescribed or dispensed a controlled substance, or  
 2825 | caused a controlled substance to be prescribed or dispensed, in

2826 a manner that violates the standard of practice set forth in s.  
 2827 464.018(1)(n) or (p)6., the physician, autonomous physician  
 2828 assistant, or advanced practice registered nurse shall be  
 2829 suspended for a period of not less than 6 months and pay a fine  
 2830 of not less than \$10,000 per count. Repeated violations shall  
 2831 result in increased penalties.

2832 Section 49. Paragraph (h) of subsection (1) and subsection  
 2833 (2) of section 456.44, Florida Statutes, are amended to read:

2834 456.44 Controlled substance prescribing.—

2835 (1) DEFINITIONS.—As used in this section, the term:

2836 (h) "Registrant" means a physician, an autonomous  
 2837 physician assistant, a physician assistant, or an advanced  
 2838 practice registered nurse who meets the requirements of  
 2839 subsection (2).

2840 (2) REGISTRATION.—A physician licensed under chapter 458,  
 2841 chapter 459, chapter 461, or chapter 466, an autonomous  
 2842 physician assistant or a physician assistant registered or  
 2843 licensed under chapter 458 or chapter 459, or an advanced  
 2844 practice registered nurse licensed under part I of chapter 464  
 2845 who prescribes any controlled substance, listed in Schedule II,  
 2846 Schedule III, or Schedule IV as defined in s. 893.03, for the  
 2847 treatment of chronic nonmalignant pain, must:

2848 (a) Designate himself or herself as a controlled substance  
 2849 prescribing practitioner on his or her practitioner profile.

2850 (b) Comply with the requirements of this section and

2851 applicable board rules.

2852 Section 50. Paragraph (c) of subsection (3) of section  
2853 458.3265, Florida Statutes, is amended to read:

2854 458.3265 Pain-management clinics.—

2855 (3) PHYSICIAN RESPONSIBILITIES.—These responsibilities  
2856 apply to any physician who provides professional services in a  
2857 pain-management clinic that is required to be registered in  
2858 subsection (1).

2859 (c) A physician, an autonomous physician assistant, a  
2860 physician assistant, or an advanced practice registered nurse  
2861 must perform a physical examination of a patient on the same day  
2862 that the physician prescribes a controlled substance to a  
2863 patient at a pain-management clinic. If the physician prescribes  
2864 more than a 72-hour dose of controlled substances for the  
2865 treatment of chronic nonmalignant pain, the physician must  
2866 document in the patient's record the reason for prescribing that  
2867 quantity.

2868 Section 51. Paragraph (ii) of subsection (1) and  
2869 subsection (10) of section 458.331, Florida Statutes, are  
2870 amended to read:

2871 458.331 Grounds for disciplinary action; action by the  
2872 board and department.—

2873 (1) The following acts constitute grounds for denial of a  
2874 license or disciplinary action, as specified in s. 456.072(2):

2875 (ii) Failing to report to the department any licensee

2876 | under this chapter or under chapter 459 who the physician,  
2877 | autonomous physician assistant, or physician assistant knows has  
2878 | violated the grounds for disciplinary action set out in the law  
2879 | under which that person is licensed and who provides health care  
2880 | services in a facility licensed under chapter 395, or a health  
2881 | maintenance organization certificated under part I of chapter  
2882 | 641, in which the physician, autonomous physician assistant, or  
2883 | physician assistant also provides services.

2884 |       (10) A probable cause panel convened to consider  
2885 | disciplinary action against an autonomous physician assistant or  
2886 | a physician assistant alleged to have violated s. 456.072 or  
2887 | this section must include one physician assistant. The physician  
2888 | assistant must hold a valid license to practice as a physician  
2889 | assistant in this state and be appointed to the panel by the  
2890 | Council of Physician Assistants. The physician assistant may  
2891 | hear only cases involving disciplinary actions against a  
2892 | physician assistant. If the appointed physician assistant is not  
2893 | present at the disciplinary hearing, the panel may consider the  
2894 | matter and vote on the case in the absence of the physician  
2895 | assistant. The training requirements set forth in s. 458.307(4)  
2896 | do not apply to the appointed physician assistant. Rules need  
2897 | not be adopted to implement this subsection.

2898 |       Section 52. Paragraph (c) of subsection (3) of section  
2899 | 459.0137, Florida Statutes, is amended to read:

2900 |       459.0137 Pain-management clinics.—



2901 (3) PHYSICIAN RESPONSIBILITIES.—These responsibilities  
 2902 apply to any osteopathic physician who provides professional  
 2903 services in a pain-management clinic that is required to be  
 2904 registered in subsection (1).

2905 (c) An osteopathic physician, an autonomous physician  
 2906 assistant, a physician assistant, or an advanced practice  
 2907 registered nurse must perform a physical examination of a  
 2908 patient on the same day that the physician prescribes a  
 2909 controlled substance to a patient at a pain-management clinic.  
 2910 If the osteopathic physician prescribes more than a 72-hour dose  
 2911 of controlled substances for the treatment of chronic  
 2912 nonmalignant pain, the osteopathic physician must document in  
 2913 the patient's record the reason for prescribing that quantity.

2914 Section 53. Paragraph (11) of subsection (1) and  
 2915 subsection (10) of section 459.015, Florida Statutes, are  
 2916 amended to read:

2917 459.015 Grounds for disciplinary action; action by the  
 2918 board and department.—

2919 (1) The following acts constitute grounds for denial of a  
 2920 license or disciplinary action, as specified in s. 456.072(2):

2921 (11) Failing to report to the department any licensee  
 2922 under chapter 458 or under this chapter who the osteopathic  
 2923 physician, autonomous physician assistant, or physician  
 2924 assistant knows has violated the grounds for disciplinary action  
 2925 set out in the law under which that person is licensed and who

2926 provides health care services in a facility licensed under  
 2927 chapter 395, or a health maintenance organization certificated  
 2928 under part I of chapter 641, in which the osteopathic physician,  
 2929 autonomous physician assistant, or physician assistant also  
 2930 provides services.

2931 (10) A probable cause panel convened to consider  
 2932 disciplinary action against an autonomous physician assistant or  
 2933 a physician assistant alleged to have violated s. 456.072 or  
 2934 this section must include one physician assistant. The physician  
 2935 assistant must hold a valid license to practice as a physician  
 2936 assistant in this state and be appointed to the panel by the  
 2937 Council of Physician Assistants. The physician assistant may  
 2938 hear only cases involving disciplinary actions against a  
 2939 physician assistant. If the appointed physician assistant is not  
 2940 present at the disciplinary hearing, the panel may consider the  
 2941 matter and vote on the case in the absence of the physician  
 2942 assistant. The training requirements set forth in s. 458.307(4)  
 2943 do not apply to the appointed physician assistant. Rules need  
 2944 not be adopted to implement this subsection.

2945 Section 54. Subsection (17) of section 464.003, Florida  
 2946 Statutes, is amended to read:

2947 464.003 Definitions.—As used in this part, the term:

2948 (17) "Practice of practical nursing" means the performance  
 2949 of selected acts, including the administration of treatments and  
 2950 medications, in the care of the ill, injured, or infirm; the

2951 promotion of wellness, maintenance of health, and prevention of  
 2952 illness of others under the direction of a registered nurse, a  
 2953 licensed physician, a licensed osteopathic physician, a licensed  
 2954 podiatric physician, a registered autonomous physician  
 2955 assistant, or a licensed dentist; and the teaching of general  
 2956 principles of health and wellness to the public and to students  
 2957 other than nursing students. A practical nurse is responsible  
 2958 and accountable for making decisions that are based upon the  
 2959 individual's educational preparation and experience in nursing.

2960 Section 55. Paragraph (a) of subsection (4) of section  
 2961 464.0205, Florida Statutes, is amended to read:

2962 464.0205 Retired volunteer nurse certificate.—

2963 (4) A retired volunteer nurse receiving certification from  
 2964 the board shall:

2965 (a) Work under the direct supervision of the director of a  
 2966 county health department, a physician working under a limited  
 2967 license issued pursuant to s. 458.317 or s. 459.0075, a  
 2968 physician or an autonomous physician assistant licensed or  
 2969 registered under chapter 458 or chapter 459, an advanced  
 2970 practice registered nurse licensed under s. 464.012, or a  
 2971 registered nurse licensed under s. 464.008 or s. 464.009.

2972 Section 56. Paragraph (b) of subsection (1) of section  
 2973 480.0475, Florida Statutes, is amended to read:

2974 480.0475 Massage establishments; prohibited practices.—

2975 (1) A person may not operate a massage establishment

2976 | between the hours of midnight and 5 a.m. This subsection does  
 2977 | not apply to a massage establishment:

2978 |         (b) In which every massage performed between the hours of  
 2979 | midnight and 5 a.m. is performed by a massage therapist acting  
 2980 | under the prescription of a physician, autonomous physician  
 2981 | assistant, or physician assistant licensed or registered under  
 2982 | chapter 458;~~7~~ an osteopathic physician, autonomous physician  
 2983 | assistant, or physician assistant licensed or registered under  
 2984 | chapter 459;~~7~~ a chiropractic physician licensed under chapter  
 2985 | 460;~~7~~ a podiatric physician licensed under chapter 461;~~7~~ an  
 2986 | advanced practice registered nurse licensed under part I of  
 2987 | chapter 464;~~7~~ or a dentist licensed under chapter 466; or

2988 |         Section 57. Subsection (2) of section 493.6108, Florida  
 2989 | Statutes, is amended to read:

2990 |             493.6108 Investigation of applicants by Department of  
 2991 | Agriculture and Consumer Services.—

2992 |         (2) In addition to subsection (1), the department shall  
 2993 | make an investigation of the general physical fitness of the  
 2994 | Class "G" applicant to bear a weapon or firearm. Determination  
 2995 | of physical fitness shall be certified by a physician,  
 2996 | autonomous physician assistant, or physician assistant currently  
 2997 | licensed or registered under ~~pursuant to~~ chapter 458, chapter  
 2998 | 459, or any similar law of another state or authorized to act as  
 2999 | a licensed physician by a federal agency or department or by an  
 3000 | advanced practice registered nurse currently licensed pursuant

3001 to chapter 464. Such certification shall be submitted on a form  
 3002 provided by the department.

3003 Section 58. Subsection (1) of section 626.9707, Florida  
 3004 Statutes, is amended to read:

3005 626.9707 Disability insurance; discrimination on basis of  
 3006 sickle-cell trait prohibited.—

3007 (1) An ~~No~~ insurer authorized to transact insurance in this  
 3008 state may not ~~shall~~ refuse to issue and deliver in this state  
 3009 any policy of disability insurance, whether such policy is  
 3010 defined as individual, group, blanket, franchise, industrial, or  
 3011 otherwise, which is currently being issued for delivery in this  
 3012 state and which affords benefits and coverage for any medical  
 3013 treatment or service authorized and permitted to be furnished by  
 3014 a hospital, a clinic, a health clinic, a neighborhood health  
 3015 clinic, a health maintenance organization, a physician, an  
 3016 autonomous physician assistant, a physician ~~physician's~~  
 3017 assistant, an advanced practice registered nurse ~~practitioner,~~  
 3018 or a medical service facility or personnel solely because the  
 3019 person to be insured has the sickle-cell trait.

3020 Section 59. Paragraph (b) of subsection (1) of section  
 3021 627.357, Florida Statutes, is amended to read:

3022 627.357 Medical malpractice self-insurance.—

3023 (1) DEFINITIONS.—As used in this section, the term:

3024 (b) "Health care provider" means any:

3025 1. Hospital licensed under chapter 395.

- 3026           2. Physician, autonomous physician assistant ~~licensed~~, or  
 3027 physician assistant registered or licensed, under chapter 458.
- 3028           3. Osteopathic physician, autonomous physician assistant,  
 3029 or physician assistant registered or licensed under chapter 459.
- 3030           4. Podiatric physician licensed under chapter 461.
- 3031           5. Health maintenance organization certificated under part  
 3032 I of chapter 641.
- 3033           6. Ambulatory surgical center licensed under chapter 395.
- 3034           7. Chiropractic physician licensed under chapter 460.
- 3035           8. Psychologist licensed under chapter 490.
- 3036           9. Optometrist licensed under chapter 463.
- 3037           10. Dentist licensed under chapter 466.
- 3038           11. Pharmacist licensed under chapter 465.
- 3039           12. Registered nurse, licensed practical nurse, or  
 3040 advanced practice registered nurse licensed or registered under  
 3041 part I of chapter 464.
- 3042           13. Other medical facility.
- 3043           14. Professional association, partnership, corporation,  
 3044 joint venture, or other association established by the  
 3045 individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9.,  
 3046 10., 11., and 12. for professional activity.
- 3047           Section 60. Paragraph (a) of subsection (1) of section  
 3048 627.736, Florida Statutes, is amended to read:
- 3049           627.736 Required personal injury protection benefits;  
 3050 exclusions; priority; claims.—

3051 (1) REQUIRED BENEFITS.—An insurance policy complying with  
3052 the security requirements of s. 627.733 must provide personal  
3053 injury protection to the named insured, relatives residing in  
3054 the same household, persons operating the insured motor vehicle,  
3055 passengers in the motor vehicle, and other persons struck by the  
3056 motor vehicle and suffering bodily injury while not an occupant  
3057 of a self-propelled vehicle, subject to subsection (2) and  
3058 paragraph (4) (e), to a limit of \$10,000 in medical and  
3059 disability benefits and \$5,000 in death benefits resulting from  
3060 bodily injury, sickness, disease, or death arising out of the  
3061 ownership, maintenance, or use of a motor vehicle as follows:

3062 (a) Medical benefits.—Eighty percent of all reasonable  
3063 expenses for medically necessary medical, surgical, X-ray,  
3064 dental, and rehabilitative services, including prosthetic  
3065 devices and medically necessary ambulance, hospital, and nursing  
3066 services if the individual receives initial services and care  
3067 pursuant to subparagraph 1. within 14 days after the motor  
3068 vehicle accident. The medical benefits provide reimbursement  
3069 only for:

3070 1. Initial services and care that are lawfully provided,  
3071 supervised, ordered, or prescribed by a physician or an  
3072 autonomous physician assistant licensed or registered under  
3073 chapter 458 or chapter 459, a dentist licensed under chapter  
3074 466, ~~or~~ a chiropractic physician licensed under chapter 460, or  
3075 an advanced practice registered nurse registered to engage in

3076 autonomous practice under s. 464.0123 or that are provided in a  
3077 hospital or in a facility that owns, or is wholly owned by, a  
3078 hospital. Initial services and care may also be provided by a  
3079 person or entity licensed under part III of chapter 401 which  
3080 provides emergency transportation and treatment.

3081 2. Upon referral by a provider described in subparagraph  
3082 1., followup services and care consistent with the underlying  
3083 medical diagnosis rendered pursuant to subparagraph 1. which may  
3084 be provided, supervised, ordered, or prescribed only by a  
3085 physician or an autonomous physician assistant licensed or  
3086 registered under chapter 458 or chapter 459, a chiropractic  
3087 physician licensed under chapter 460, a dentist licensed under  
3088 chapter 466, or an advanced practice registered nurse registered  
3089 to engage in autonomous practice under s. 464.0123, or, to the  
3090 extent permitted by applicable law and under the supervision of  
3091 such physician, osteopathic physician, chiropractic physician,  
3092 or dentist, by a physician assistant licensed under chapter 458  
3093 or chapter 459 or an advanced practice registered nurse licensed  
3094 under chapter 464. Followup services and care may also be  
3095 provided by the following persons or entities:

3096 a. A hospital or ambulatory surgical center licensed under  
3097 chapter 395.

3098 b. An entity wholly owned by one or more physicians or  
3099 autonomous physician assistants licensed or registered under  
3100 chapter 458 or chapter 459, chiropractic physicians licensed



3101 | under chapter 460, advanced practice registered nurses  
 3102 | registered to engage in autonomous practice under s. 464.0123,  
 3103 | or dentists licensed under chapter 466 or by such practitioners  
 3104 | and the spouse, parent, child, or sibling of such practitioners.

3105 |       c. An entity that owns or is wholly owned, directly or  
 3106 | indirectly, by a hospital or hospitals.

3107 |       d. A physical therapist licensed under chapter 486, based  
 3108 | upon a referral by a provider described in this subparagraph.

3109 |       e. A health care clinic licensed under part X of chapter  
 3110 | 400 which is accredited by an accrediting organization whose  
 3111 | standards incorporate comparable regulations required by this  
 3112 | state, or

3113 |           (I) Has a medical director licensed under chapter 458,  
 3114 | chapter 459, or chapter 460;

3115 |           (II) Has been continuously licensed for more than 3 years  
 3116 | or is a publicly traded corporation that issues securities  
 3117 | traded on an exchange registered with the United States  
 3118 | Securities and Exchange Commission as a national securities  
 3119 | exchange; and

3120 |           (III) Provides at least four of the following medical  
 3121 | specialties:

3122 |               (A) General medicine.

3123 |               (B) Radiography.

3124 |               (C) Orthopedic medicine.

3125 |               (D) Physical medicine.

3126 (E) Physical therapy.

3127 (F) Physical rehabilitation.

3128 (G) Prescribing or dispensing outpatient prescription  
 3129 medication.

3130 (H) Laboratory services.

3131 3. Reimbursement for services and care provided in  
 3132 subparagraph 1. or subparagraph 2. up to \$10,000 if a physician  
 3133 licensed under chapter 458 or chapter 459, a dentist licensed  
 3134 under chapter 466, an autonomous physician assistant or a  
 3135 physician assistant registered or licensed under chapter 458 or  
 3136 chapter 459, or an advanced practice registered nurse licensed  
 3137 under chapter 464 has determined that the injured person had an  
 3138 emergency medical condition.

3139 4. Reimbursement for services and care provided in  
 3140 subparagraph 1. or subparagraph 2. is limited to \$2,500 if a  
 3141 provider listed in subparagraph 1. or subparagraph 2. determines  
 3142 that the injured person did not have an emergency medical  
 3143 condition.

3144 5. Medical benefits do not include massage as defined in  
 3145 s. 480.033 or acupuncture as defined in s. 457.102, regardless  
 3146 of the person, entity, or licensee providing massage or  
 3147 acupuncture, and a licensed massage therapist or licensed  
 3148 acupuncturist may not be reimbursed for medical benefits under  
 3149 this section.

3150 6. The Financial Services Commission shall adopt by rule

3151 the form that must be used by an insurer and a health care  
3152 provider specified in sub-subparagraph 2.b., sub-subparagraph  
3153 2.c., or sub-subparagraph 2.e. to document that the health care  
3154 provider meets the criteria of this paragraph. Such rule must  
3155 include a requirement for a sworn statement or affidavit.

3156

3157 Only insurers writing motor vehicle liability insurance in this  
3158 state may provide the required benefits of this section, and  
3159 such insurer may not require the purchase of any other motor  
3160 vehicle coverage other than the purchase of property damage  
3161 liability coverage as required by s. 627.7275 as a condition for  
3162 providing such benefits. Insurers may not require that property  
3163 damage liability insurance in an amount greater than \$10,000 be  
3164 purchased in conjunction with personal injury protection. Such  
3165 insurers shall make benefits and required property damage  
3166 liability insurance coverage available through normal marketing  
3167 channels. An insurer writing motor vehicle liability insurance  
3168 in this state who fails to comply with such availability  
3169 requirement as a general business practice violates part IX of  
3170 chapter 626, and such violation constitutes an unfair method of  
3171 competition or an unfair or deceptive act or practice involving  
3172 the business of insurance. An insurer committing such violation  
3173 is subject to the penalties provided under that part, as well as  
3174 those provided elsewhere in the insurance code.

3175 Section 61. Subsection (5) of section 633.412, Florida

3176 Statutes, is amended to read:

3177       633.412 Firefighters; qualifications for certification.—A  
3178 person applying for certification as a firefighter must:

3179       (5) Be in good physical condition as determined by a  
3180 medical examination given by a physician, surgeon, or autonomous  
3181 physician assistant or physician assistant licensed or  
3182 registered under ~~to practice in the state pursuant to~~ chapter  
3183 458; an osteopathic physician, surgeon, autonomous physician  
3184 assistant, or physician assistant licensed or registered under  
3185 ~~to practice in the state pursuant to~~ chapter 459; or an advanced  
3186 practice registered nurse licensed under ~~to practice in the~~  
3187 ~~state pursuant to~~ chapter 464. Such examination may include, but  
3188 need not be limited to, the National Fire Protection Association  
3189 Standard 1582. A medical examination evidencing good physical  
3190 condition shall be submitted to the division, on a form as  
3191 provided by rule, before an individual is eligible for admission  
3192 into a course under s. 633.408.

3193       Section 62. Subsection (8) of section 641.495, Florida  
3194 Statutes, is amended to read:

3195       641.495 Requirements for issuance and maintenance of  
3196 certificate.—

3197       (8) Each organization's contracts, certificates, and  
3198 subscriber handbooks shall contain a provision, if applicable,  
3199 disclosing that, for certain types of described medical  
3200 procedures, services may be provided by autonomous physician

3201 assistants, physician assistants, advanced practice registered  
 3202 nurses ~~nurse practitioners~~, or other individuals who are not  
 3203 licensed physicians.

3204 Section 63. Subsection (1) of section 744.2006, Florida  
 3205 Statutes, is amended to read:

3206 744.2006 Office of Public and Professional Guardians;  
 3207 appointment, notification.—

3208 (1) The executive director of the Office of Public and  
 3209 Professional Guardians, after consultation with the chief judge  
 3210 and other circuit judges within the judicial circuit and with  
 3211 appropriate advocacy groups and individuals and organizations  
 3212 who are knowledgeable about the needs of incapacitated persons,  
 3213 may establish, within a county in the judicial circuit or within  
 3214 the judicial circuit, one or more offices of public guardian and  
 3215 if so established, shall create a list of persons best qualified  
 3216 to serve as the public guardian, who have been investigated  
 3217 pursuant to s. 744.3135. The public guardian must have knowledge  
 3218 of the legal process and knowledge of social services available  
 3219 to meet the needs of incapacitated persons. The public guardian  
 3220 shall maintain a staff or contract with professionally qualified  
 3221 individuals to carry out the guardianship functions, including  
 3222 an attorney who has experience in probate areas and another  
 3223 person who has a master's degree in social work, or a  
 3224 gerontologist, psychologist, autonomous physician assistant,  
 3225 advanced practice registered nurse, or registered nurse, ~~or~~

3226 ~~nurse practitioner~~. A public guardian that is a nonprofit  
3227 corporate guardian under s. 744.309(5) must receive tax-exempt  
3228 status from the United States Internal Revenue Service.

3229 Section 64. Paragraph (a) of subsection (3) of section  
3230 744.331, Florida Statutes, is amended to read:

3231 744.331 Procedures to determine incapacity.—

3232 (3) EXAMINING COMMITTEE.—

3233 (a) Within 5 days after a petition for determination of  
3234 incapacity has been filed, the court shall appoint an examining  
3235 committee consisting of three members. One member must be a  
3236 psychiatrist or other physician. The remaining members must be  
3237 either a psychologist, a gerontologist, a ~~another~~ psychiatrist,  
3238 a ~~or other~~ physician, an autonomous physician assistant, a  
3239 physician assistant, an advanced practice registered nurse, a  
3240 registered nurse, ~~nurse practitioner~~, a licensed social worker,  
3241 a person with an advanced degree in gerontology from an  
3242 accredited institution of higher education, or any other person  
3243 who by knowledge, skill, experience, training, or education may,  
3244 in the court's discretion, advise the court in the form of an  
3245 expert opinion. One of three members of the committee must have  
3246 knowledge of the type of incapacity alleged in the petition.  
3247 Unless good cause is shown, the attending or family physician  
3248 may not be appointed to the committee. If the attending or  
3249 family physician is available for consultation, the committee  
3250 must consult with the physician. Members of the examining

3251 committee may not be related to or associated with one another,  
3252 with the petitioner, with counsel for the petitioner or the  
3253 proposed guardian, or with the person alleged to be totally or  
3254 partially incapacitated. A member may not be employed by any  
3255 private or governmental agency that has custody of, or  
3256 furnishes, services or subsidies, directly or indirectly, to the  
3257 person or the family of the person alleged to be incapacitated  
3258 or for whom a guardianship is sought. A petitioner may not serve  
3259 as a member of the examining committee. Members of the examining  
3260 committee must be able to communicate, either directly or  
3261 through an interpreter, in the language that the alleged  
3262 incapacitated person speaks or to communicate in a medium  
3263 understandable to the alleged incapacitated person if she or he  
3264 is able to communicate. The clerk of the court shall send notice  
3265 of the appointment to each person appointed no later than 3 days  
3266 after the court's appointment.

3267 Section 65. Paragraph (b) of subsection (1) of section  
3268 744.3675, Florida Statutes, is amended to read:

3269 744.3675 Annual guardianship plan.—Each guardian of the  
3270 person must file with the court an annual guardianship plan  
3271 which updates information about the condition of the ward. The  
3272 annual plan must specify the current needs of the ward and how  
3273 those needs are proposed to be met in the coming year.

3274 (1) Each plan for an adult ward must, if applicable,  
3275 include:

3276 (b) Information concerning the medical and mental health  
 3277 conditions and treatment and rehabilitation needs of the ward,  
 3278 including:

3279 1. A resume of any professional medical treatment given to  
 3280 the ward during the preceding year.

3281 2. The report of a physician, autonomous physician  
 3282 assistant, physician assistant, or advanced practice registered  
 3283 nurse who examined the ward no more than 90 days before the  
 3284 beginning of the applicable reporting period. The report must  
 3285 contain an evaluation of the ward's condition and a statement of  
 3286 the current level of capacity of the ward.

3287 3. The plan for providing medical, mental health, and  
 3288 rehabilitative services in the coming year.

3289 Section 66. Subsection (3) of section 766.103, Florida  
 3290 Statutes, is amended to read:

3291 766.103 Florida Medical Consent Law.—

3292 (3) ~~No Recovery is not shall be~~ allowed in any court in  
 3293 this state against any physician licensed under chapter 458,  
 3294 osteopathic physician licensed under chapter 459, chiropractic  
 3295 physician licensed under chapter 460, podiatric physician  
 3296 licensed under chapter 461, dentist licensed under chapter 466,  
 3297 advanced practice registered nurse licensed under s. 464.012,  
 3298 autonomous physician assistant registered under chapter 458 or  
 3299 chapter 459, or physician assistant licensed under s. 458.347 or  
 3300 s. 459.022 in an action brought for treating, examining, or



3301 | operating on a patient without his or her informed consent when:

3302 |       (a)1. The action of the physician, osteopathic physician,  
 3303 | chiropractic physician, podiatric physician, dentist, advanced  
 3304 | practice registered nurse, autonomous physician assistant, or  
 3305 | physician assistant in obtaining the consent of the patient or  
 3306 | another person authorized to give consent for the patient was in  
 3307 | accordance with an accepted standard of medical practice among  
 3308 | members of the medical profession with similar training and  
 3309 | experience in the same or similar medical community as that of  
 3310 | the person treating, examining, or operating on the patient for  
 3311 | whom the consent is obtained; and

3312 |       2. A reasonable individual, from the information provided  
 3313 | by the physician, osteopathic physician, chiropractic physician,  
 3314 | podiatric physician, dentist, advanced practice registered  
 3315 | nurse, autonomous physician assistant, or physician assistant,  
 3316 | under the circumstances, would have a general understanding of  
 3317 | the procedure, the medically acceptable alternative procedures  
 3318 | or treatments, and the substantial risks and hazards inherent in  
 3319 | the proposed treatment or procedures, which are recognized among  
 3320 | other physicians, osteopathic physicians, chiropractic  
 3321 | physicians, podiatric physicians, or dentists in the same or  
 3322 | similar community who perform similar treatments or procedures;  
 3323 | or

3324 |       (b) The patient would reasonably, under all the  
 3325 | surrounding circumstances, have undergone such treatment or

3326 procedure had he or she been advised by the physician,  
3327 osteopathic physician, chiropractic physician, podiatric  
3328 physician, dentist, advanced practice registered nurse,  
3329 autonomous physician assistant, or physician assistant in  
3330 accordance with ~~the provisions of~~ paragraph (a).

3331 Section 67. Paragraph (b) of subsection (1) and paragraph  
3332 (e) of subsection (2) of section 766.105, Florida Statutes, are  
3333 amended to read:

3334 766.105 Florida Patient's Compensation Fund.—

3335 (1) DEFINITIONS.—The following definitions apply in the  
3336 interpretation and enforcement of this section:

3337 (b) The term "health care provider" means any:

3338 1. Hospital licensed under chapter 395.

3339 2. Physician, autonomous physician assistant, or physician  
3340 assistant licensed or registered under chapter 458.

3341 3. Osteopathic physician, autonomous physician assistant,  
3342 or physician assistant licensed or registered under chapter 459.

3343 4. Podiatric physician licensed under chapter 461.

3344 5. Health maintenance organization certificated under part  
3345 I of chapter 641.

3346 6. Ambulatory surgical center licensed under chapter 395.

3347 7. "Other medical facility" as defined in paragraph (c).

3348 8. Professional association, partnership, corporation,  
3349 joint venture, or other association by the individuals set forth  
3350 in subparagraphs 2., 3., and 4. for professional activity.

3351 (2) COVERAGE.—

3352 (e) The coverage afforded by the fund for a participating  
 3353 hospital or ambulatory surgical center shall apply to the  
 3354 officers, trustees, volunteer workers, trainees, committee  
 3355 members (including physicians, osteopathic physicians, podiatric  
 3356 physicians, and dentists), and employees of the hospital or  
 3357 ambulatory surgical center, other than employed physicians  
 3358 licensed under chapter 458, autonomous physician assistants or  
 3359 physician assistants registered or licensed under chapter 458 or  
 3360 chapter 459, osteopathic physicians licensed under chapter 459,  
 3361 dentists licensed under chapter 466, and podiatric physicians  
 3362 licensed under chapter 461. However, the coverage afforded by  
 3363 the fund for a participating hospital shall apply to house  
 3364 physicians, interns, employed physician residents in a resident  
 3365 training program, or physicians performing purely administrative  
 3366 duties for the participating hospitals other than the treatment  
 3367 of patients. This coverage shall apply to the hospital or  
 3368 ambulatory surgical center and those included in this subsection  
 3369 as one health care provider.

3370 Section 68. Paragraph (d) of subsection (3) of section  
 3371 766.1115, Florida Statutes, is amended to read:

3372 766.1115 Health care providers; creation of agency  
 3373 relationship with governmental contractors.—

3374 (3) DEFINITIONS.—As used in this section, the term:

3375 (d) "Health care provider" or "provider" means:

- 3376 | 1. A birth center licensed under chapter 383.
- 3377 | 2. An ambulatory surgical center licensed under chapter
- 3378 | 395.
- 3379 | 3. A hospital licensed under chapter 395.
- 3380 | 4. A physician, autonomous physician assistant, or
- 3381 | physician assistant licensed or registered under chapter 458.
- 3382 | 5. An osteopathic physician, autonomous physician
- 3383 | assistant, or ~~osteopathic~~ physician assistant licensed or
- 3384 | registered under chapter 459.
- 3385 | 6. A chiropractic physician licensed under chapter 460.
- 3386 | 7. A podiatric physician licensed under chapter 461.
- 3387 | 8. A registered nurse, nurse midwife, licensed practical
- 3388 | nurse, or advanced practice registered nurse licensed or
- 3389 | registered under part I of chapter 464 or any facility which
- 3390 | employs nurses licensed or registered under part I of chapter
- 3391 | 464 to supply all or part of the care delivered under this
- 3392 | section.
- 3393 | 9. A midwife licensed under chapter 467.
- 3394 | 10. A health maintenance organization certificated under
- 3395 | part I of chapter 641.
- 3396 | 11. A health care professional association and its
- 3397 | employees or a corporate medical group and its employees.
- 3398 | 12. Any other medical facility the primary purpose of
- 3399 | which is to deliver human medical diagnostic services or which
- 3400 | delivers nonsurgical human medical treatment, and which includes

3401 an office maintained by a provider.

3402 13. A dentist or dental hygienist licensed under chapter  
3403 466.

3404 14. A free clinic that delivers only medical diagnostic  
3405 services or nonsurgical medical treatment free of charge to all  
3406 low-income recipients.

3407 15. Any other health care professional, practitioner,  
3408 provider, or facility under contract with a governmental  
3409 contractor, including a student enrolled in an accredited  
3410 program that prepares the student for licensure as any one of  
3411 the professionals listed in subparagraphs 4.-9.

3412  
3413 The term includes any nonprofit corporation qualified as exempt  
3414 from federal income taxation under s. 501(a) of the Internal  
3415 Revenue Code, and described in s. 501(c) of the Internal Revenue  
3416 Code, which delivers health care services provided by licensed  
3417 professionals listed in this paragraph, any federally funded  
3418 community health center, and any volunteer corporation or  
3419 volunteer health care provider that delivers health care  
3420 services.

3421 Section 69. Subsection (1) of section 766.1116, Florida  
3422 Statutes, is amended to read:

3423 766.1116 Health care practitioner; waiver of license  
3424 renewal fees and continuing education requirements.—

3425 (1) As used in this section, the term "health care

3426 practitioner" means a physician, autonomous physician assistant,  
 3427 or physician assistant licensed or registered under chapter 458;  
 3428 an osteopathic physician, autonomous physician assistant, or  
 3429 physician assistant licensed or registered under chapter 459; a  
 3430 chiropractic physician licensed under chapter 460; a podiatric  
 3431 physician licensed under chapter 461; an advanced practice  
 3432 registered nurse, registered nurse, or licensed practical nurse  
 3433 licensed under part I of chapter 464; a dentist or dental  
 3434 hygienist licensed under chapter 466; or a midwife licensed  
 3435 under chapter 467, who participates as a health care provider  
 3436 under s. 766.1115.

3437 Section 70. Paragraph (c) of subsection (1) of section  
 3438 766.118, Florida Statutes, is amended to read:

3439 766.118 Determination of noneconomic damages.—

3440 (1) DEFINITIONS.—As used in this section, the term:

3441 (c) "Practitioner" means any person licensed or registered  
 3442 under chapter 458, chapter 459, chapter 460, chapter 461,  
 3443 chapter 462, chapter 463, chapter 466, chapter 467, chapter 486,  
 3444 ~~or~~ s. 464.012, or s. 464.0123. "Practitioner" also means any  
 3445 association, corporation, firm, partnership, or other business  
 3446 entity under which such practitioner practices or any employee  
 3447 of such practitioner or entity acting in the scope of his or her  
 3448 employment. For the purpose of determining the limitations on  
 3449 noneconomic damages set forth in this section, the term  
 3450 "practitioner" includes any person or entity for whom a

3451 practitioner is vicariously liable and any person or entity  
 3452 whose liability is based solely on such person or entity being  
 3453 vicariously liable for the actions of a practitioner.

3454 Section 71. Subsection (3) of section 768.135, Florida  
 3455 Statutes, is amended to read:

3456 768.135 Volunteer team physicians; immunity.—

3457 (3) A practitioner licensed or registered under chapter  
 3458 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 who  
 3459 gratuitously and in good faith conducts an evaluation pursuant  
 3460 to s. 1006.20(2)(c) is not liable for any civil damages arising  
 3461 from that evaluation unless the evaluation was conducted in a  
 3462 wrongful manner.

3463 Section 72. Subsection (5) of section 794.08, Florida  
 3464 Statutes, is amended to read:

3465 794.08 Female genital mutilation.—

3466 (5) This section does not apply to procedures performed by  
 3467 or under the direction of a physician licensed under chapter  
 3468 458, an osteopathic physician licensed under chapter 459, a  
 3469 registered nurse licensed under part I of chapter 464, a  
 3470 practical nurse licensed under part I of chapter 464, an  
 3471 advanced practice registered nurse licensed under part I of  
 3472 chapter 464, a midwife licensed under chapter 467, or an  
 3473 autonomous physician assistant or a physician assistant  
 3474 registered or licensed under chapter 458 or chapter 459 when  
 3475 necessary to preserve the physical health of a female person.

3476 | This section also does not apply to any autopsy or limited  
 3477 | dissection conducted pursuant to chapter 406.

3478 |       Section 73. Subsection (23) of section 893.02, Florida  
 3479 | Statutes, is amended to read:

3480 |           893.02 Definitions.—The following words and phrases as  
 3481 | used in this chapter shall have the following meanings, unless  
 3482 | the context otherwise requires:

3483 |           (23) "Practitioner" means a physician licensed under  
 3484 | chapter 458, a dentist licensed under chapter 466, a  
 3485 | veterinarian licensed under chapter 474, an osteopathic  
 3486 | physician licensed under chapter 459, an advanced practice  
 3487 | registered nurse licensed under chapter 464, a naturopath  
 3488 | licensed under chapter 462, a certified optometrist licensed  
 3489 | under chapter 463, a psychiatric nurse as defined in s. 394.455,  
 3490 | a podiatric physician licensed under chapter 461, an autonomous  
 3491 | physician assistant registered under chapter 458 or chapter 459,  
 3492 | or a physician assistant licensed under chapter 458 or chapter  
 3493 | 459, provided such practitioner holds a valid federal controlled  
 3494 | substance registry number.

3495 |       Section 74. Subsection (6) of section 943.13, Florida  
 3496 | Statutes, is amended to read:

3497 |           943.13 Officers' minimum qualifications for employment or  
 3498 | appointment.—On or after October 1, 1984, any person employed or  
 3499 | appointed as a full-time, part-time, or auxiliary law  
 3500 | enforcement officer or correctional officer; on or after October



3501 1, 1986, any person employed as a full-time, part-time, or  
3502 auxiliary correctional probation officer; and on or after  
3503 October 1, 1986, any person employed as a full-time, part-time,  
3504 or auxiliary correctional officer by a private entity under  
3505 contract to the Department of Corrections, to a county  
3506 commission, or to the Department of Management Services shall:

3507 (6) Have passed a physical examination by a licensed  
3508 physician, registered autonomous physician assistant, licensed  
3509 physician assistant, or licensed advanced practice registered  
3510 nurse, based on specifications established by the commission. In  
3511 order to be eligible for the presumption set forth in s. 112.18  
3512 while employed with an employing agency, a law enforcement  
3513 officer, correctional officer, or correctional probation officer  
3514 must have successfully passed the physical examination required  
3515 by this subsection upon entering into service as a law  
3516 enforcement officer, correctional officer, or correctional  
3517 probation officer with the employing agency, which examination  
3518 must have failed to reveal any evidence of tuberculosis, heart  
3519 disease, or hypertension. A law enforcement officer,  
3520 correctional officer, or correctional probation officer may not  
3521 use a physical examination from a former employing agency for  
3522 purposes of claiming the presumption set forth in s. 112.18  
3523 against the current employing agency.

3524 Section 75. Subsection (2) of section 945.603, Florida  
3525 Statutes, is amended to read:

3526           945.603 Powers and duties of authority.—The purpose of the  
 3527 authority is to assist in the delivery of health care services  
 3528 for inmates in the Department of Corrections by advising the  
 3529 Secretary of Corrections on the professional conduct of primary,  
 3530 convalescent, dental, and mental health care and the management  
 3531 of costs consistent with quality care, by advising the Governor  
 3532 and the Legislature on the status of the Department of  
 3533 Corrections' health care delivery system, and by assuring that  
 3534 adequate standards of physical and mental health care for  
 3535 inmates are maintained at all Department of Corrections  
 3536 institutions. For this purpose, the authority has the authority  
 3537 to:

3538           (2) Review and make recommendations regarding health care  
 3539 for the delivery of health care services including, but not  
 3540 limited to, acute hospital-based services and facilities,  
 3541 primary and tertiary care services, ancillary and clinical  
 3542 services, dental services, mental health services, intake and  
 3543 screening services, medical transportation services, and the use  
 3544 of nurse practitioner, autonomous physician assistant, and  
 3545 physician assistant personnel to act as physician extenders as  
 3546 these relate to inmates in the Department of Corrections.

3547           Section 76. Paragraph (n) of subsection (1) of section  
 3548 948.03, Florida Statutes, is amended to read:

3549           948.03 Terms and conditions of probation.—

3550           (1) The court shall determine the terms and conditions of

3551 probation. Conditions specified in this section do not require  
3552 oral pronouncement at the time of sentencing and may be  
3553 considered standard conditions of probation. These conditions  
3554 may include among them the following, that the probationer or  
3555 offender in community control shall:

3556 (n) Be prohibited from using intoxicants to excess or  
3557 possessing any drugs or narcotics unless prescribed by a  
3558 physician, an advanced practice registered nurse, an autonomous  
3559 physician assistant, or a physician assistant. The probationer  
3560 or community controllee may not knowingly visit places where  
3561 intoxicants, drugs, or other dangerous substances are unlawfully  
3562 sold, dispensed, or used.

3563 Section 77. Subsection (34) of section 984.03, Florida  
3564 Statutes, is amended to read:

3565 984.03 Definitions.—When used in this chapter, the term:

3566 (34) "Licensed health care professional" means a physician  
3567 licensed under chapter 458, an osteopathic physician licensed  
3568 under chapter 459, a nurse licensed under part I of chapter 464,  
3569 an autonomous physician assistant or a physician assistant  
3570 registered or licensed under chapter 458 or chapter 459, or a  
3571 dentist licensed under chapter 466.

3572 Section 78. Subsection (30) of section 985.03, Florida  
3573 Statutes, is amended to read:

3574 985.03 Definitions.—As used in this chapter, the term:

3575 (30) "Licensed health care professional" means a physician

3576 licensed under chapter 458, an osteopathic physician licensed  
3577 under chapter 459, a nurse licensed under part I of chapter 464,  
3578 an autonomous physician assistant or a physician assistant  
3579 registered or licensed under chapter 458 or chapter 459, or a  
3580 dentist licensed under chapter 466.

3581 Section 79. Paragraph (i) of subsection (3) of section  
3582 1002.20, Florida Statutes, is amended to read:

3583 1002.20 K-12 student and parent rights.—Parents of public  
3584 school students must receive accurate and timely information  
3585 regarding their child's academic progress and must be informed  
3586 of ways they can help their child to succeed in school. K-12  
3587 students and their parents are afforded numerous statutory  
3588 rights including, but not limited to, the following:

3589 (3) HEALTH ISSUES.—

3590 (i) Epinephrine use and supply.—

3591 1. A student who has experienced or is at risk for life-  
3592 threatening allergic reactions may carry an epinephrine auto-  
3593 injector and self-administer epinephrine by auto-injector while  
3594 in school, participating in school-sponsored activities, or in  
3595 transit to or from school or school-sponsored activities if the  
3596 school has been provided with parental and physician  
3597 authorization. The State Board of Education, in cooperation with  
3598 the Department of Health, shall adopt rules for such use of  
3599 epinephrine auto-injectors that shall include provisions to  
3600 protect the safety of all students from the misuse or abuse of

3601 auto-injectors. A school district, county health department,  
3602 public-private partner, and their employees and volunteers shall  
3603 be indemnified by the parent of a student authorized to carry an  
3604 epinephrine auto-injector for any and all liability with respect  
3605 to the student's use of an epinephrine auto-injector pursuant to  
3606 this paragraph.

3607 2. A public school may purchase a supply of epinephrine  
3608 auto-injectors from a wholesale distributor as defined in s.  
3609 499.003 or may enter into an arrangement with a wholesale  
3610 distributor or manufacturer as defined in s. 499.003 for the  
3611 epinephrine auto-injectors at fair-market, free, or reduced  
3612 prices for use in the event a student has an anaphylactic  
3613 reaction. The epinephrine auto-injectors must be maintained in a  
3614 secure location on the public school's premises. The  
3615 participating school district shall adopt a protocol developed  
3616 by a licensed physician for the administration by school  
3617 personnel who are trained to recognize an anaphylactic reaction  
3618 and to administer an epinephrine auto-injection. The supply of  
3619 epinephrine auto-injectors may be provided to and used by a  
3620 student authorized to self-administer epinephrine by auto-  
3621 injector under subparagraph 1. or trained school personnel.

3622 3. The school district and its employees, agents, and the  
3623 physician who provides the standing protocol for school  
3624 epinephrine auto-injectors are not liable for any injury arising  
3625 from the use of an epinephrine auto-injector administered by

3626 | trained school personnel who follow the adopted protocol and  
 3627 | whose professional opinion is that the student is having an  
 3628 | anaphylactic reaction:

3629 |       a. Unless the trained school personnel's action is willful  
 3630 | and wanton;

3631 |       b. Notwithstanding that the parents or guardians of the  
 3632 | student to whom the epinephrine is administered have not been  
 3633 | provided notice or have not signed a statement acknowledging  
 3634 | that the school district is not liable; and

3635 |       c. Regardless of whether authorization has been given by  
 3636 | the student's parents or guardians or by the student's  
 3637 | physician, autonomous physician assistant, physician ~~physician's~~  
 3638 | assistant, or advanced practice registered nurse.

3639 |       Section 80. Paragraph (b) of subsection (17) of section  
 3640 | 1002.42, Florida Statutes, is amended to read:

3641 |       1002.42 Private schools.—

3642 |       (17) EPINEPHRINE SUPPLY.—

3643 |       (b) The private school and its employees, agents, and the  
 3644 | physician who provides the standing protocol for school  
 3645 | epinephrine auto-injectors are not liable for any injury arising  
 3646 | from the use of an epinephrine auto-injector administered by  
 3647 | trained school personnel who follow the adopted protocol and  
 3648 | whose professional opinion is that the student is having an  
 3649 | anaphylactic reaction:

3650 |       1. Unless the trained school personnel's action is willful

3651 and wanton;

3652 2. Notwithstanding that the parents or guardians of the  
 3653 student to whom the epinephrine is administered have not been  
 3654 provided notice or have not signed a statement acknowledging  
 3655 that the school district is not liable; and

3656 3. Regardless of whether authorization has been given by  
 3657 the student's parents or guardians or by the student's  
 3658 physician, autonomous physician assistant, physician ~~physician's~~  
 3659 assistant, or advanced practice registered nurse.

3660 Section 81. Paragraph (a) of subsection (1) and  
 3661 subsections (4) and (5) of section 1006.062, Florida Statutes,  
 3662 are amended to read:

3663 1006.062 Administration of medication and provision of  
 3664 medical services by district school board personnel.—

3665 (1) Notwithstanding the provisions of the Nurse Practice  
 3666 Act, part I of chapter 464, district school board personnel may  
 3667 assist students in the administration of prescription medication  
 3668 when the following conditions have been met:

3669 (a) Each district school board shall include in its  
 3670 approved school health services plan a procedure to provide  
 3671 training, by a registered nurse, a licensed practical nurse, or  
 3672 an advanced practice registered nurse licensed under chapter 464  
 3673 or by a physician, autonomous physician assistant, or physician  
 3674 assistant licensed or registered under ~~pursuant to~~ chapter 458  
 3675 or chapter 459, ~~or a physician assistant licensed pursuant to~~

3676 ~~chapter 458 or chapter 459~~, to the school personnel designated  
3677 by the school principal to assist students in the administration  
3678 of prescribed medication. Such training may be provided in  
3679 collaboration with other school districts, through contract with  
3680 an education consortium, or by any other arrangement consistent  
3681 with the intent of this subsection.

3682 (4) Nonmedical assistive personnel shall be allowed to  
3683 perform health-related services upon successful completion of  
3684 child-specific training by a registered nurse or advanced  
3685 practice registered nurse licensed under chapter 464 or a  
3686 physician, autonomous physician assistant, or physician  
3687 assistant licensed or registered under ~~pursuant to~~ chapter 458  
3688 or chapter 459, ~~or a physician assistant licensed pursuant to~~  
3689 ~~chapter 458 or chapter 459~~. All procedures shall be monitored  
3690 periodically by a nurse, advanced practice registered nurse,  
3691 autonomous physician assistant, physician assistant, or  
3692 physician, including, but not limited to:

- 3693 (a) Intermittent clean catheterization.  
3694 (b) Gastrostomy tube feeding.  
3695 (c) Monitoring blood glucose.  
3696 (d) Administering emergency injectable medication.

3697 (5) For all other invasive medical services not listed in  
3698 this subsection, a registered nurse or advanced practice  
3699 registered nurse licensed under chapter 464 or a physician,  
3700 autonomous physician assistant, or physician assistant licensed



3701 or registered under ~~pursuant to~~ chapter 458 or chapter 459, ~~or a~~  
3702 ~~physician assistant licensed pursuant to chapter 458 or chapter~~  
3703 ~~459~~ shall determine if nonmedical district school board  
3704 personnel shall be allowed to perform such service.

3705 Section 82. Paragraph (c) of subsection (2) of section  
3706 1006.20, Florida Statutes, is amended to read:

3707 1006.20 Athletics in public K-12 schools.—

3708 (2) ADOPTION OF BYLAWS, POLICIES, OR GUIDELINES.—

3709 (c) The FHSAA shall adopt bylaws that require all students  
3710 participating in interscholastic athletic competition or who are  
3711 candidates for an interscholastic athletic team to  
3712 satisfactorily pass a medical evaluation each year before ~~prior~~  
3713 ~~to~~ participating in interscholastic athletic competition or  
3714 engaging in any practice, tryout, workout, or other physical  
3715 activity associated with the student's candidacy for an  
3716 interscholastic athletic team. Such medical evaluation may be  
3717 administered only by a practitioner licensed or registered under  
3718 chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s.  
3719 464.0123 and in good standing with the practitioner's regulatory  
3720 board. The bylaws shall establish requirements for eliciting a  
3721 student's medical history and performing the medical evaluation  
3722 required under this paragraph, which shall include a physical  
3723 assessment of the student's physical capabilities to participate  
3724 in interscholastic athletic competition as contained in a  
3725 uniform preparticipation physical evaluation and history form.

3726 The evaluation form shall incorporate the recommendations of the  
3727 American Heart Association for participation cardiovascular  
3728 screening and shall provide a place for the signature of the  
3729 practitioner performing the evaluation with an attestation that  
3730 each examination procedure listed on the form was performed by  
3731 the practitioner or by someone under the direct supervision of  
3732 the practitioner. The form shall also contain a place for the  
3733 practitioner to indicate if a referral to another practitioner  
3734 was made in lieu of completion of a certain examination  
3735 procedure. The form shall provide a place for the practitioner  
3736 to whom the student was referred to complete the remaining  
3737 sections and attest to that portion of the examination. The  
3738 preparticipation physical evaluation form shall advise students  
3739 to complete a cardiovascular assessment and shall include  
3740 information concerning alternative cardiovascular evaluation and  
3741 diagnostic tests. Results of such medical evaluation must be  
3742 provided to the school. A student is not eligible to  
3743 participate, as provided in s. 1006.15(3), in any  
3744 interscholastic athletic competition or engage in any practice,  
3745 tryout, workout, or other physical activity associated with the  
3746 student's candidacy for an interscholastic athletic team until  
3747 the results of the medical evaluation have been received and  
3748 approved by the school.

3749 Section 83. Subsection (1) of section 1009.65, Florida  
3750 Statutes, is amended to read:

3751 1009.65 Medical Education Reimbursement and Loan Repayment  
 3752 Program.—

3753 (1) To encourage qualified medical professionals to  
 3754 practice in underserved locations where there are shortages of  
 3755 such personnel, there is established the Medical Education  
 3756 Reimbursement and Loan Repayment Program. The function of the  
 3757 program is to make payments that offset loans and educational  
 3758 expenses incurred by students for studies leading to a medical  
 3759 or nursing degree, medical or nursing licensure, ~~or~~ advanced  
 3760 practice registered nurse licensure, autonomous physician  
 3761 assistant registration, or physician assistant licensure. The  
 3762 following licensed or certified health care professionals are  
 3763 eligible to participate in this program: medical doctors with  
 3764 primary care specialties, doctors of osteopathic medicine with  
 3765 primary care specialties, autonomous physician assistants,  
 3766 physician ~~physician's~~ assistants, licensed practical nurses and  
 3767 registered nurses, and advanced practice registered nurses with  
 3768 primary care specialties such as certified nurse midwives.  
 3769 Primary care medical specialties for physicians include  
 3770 obstetrics, gynecology, general and family practice, internal  
 3771 medicine, pediatrics, and other specialties which may be  
 3772 identified by the Department of Health.

3773 Section 84. For the 2020-2021 fiscal year, 3.5 full-time  
 3774 equivalent positions with associated salary rate of 183,895 are  
 3775 authorized and the sums of \$219,089 in recurring funds and

CS/HB 607

2020

3776 | \$17,716 in nonrecurring funds from the Medical Quality Assurance  
3777 | Trust Fund are appropriated to the Department of Health for the  
3778 | purpose of implementing this act.

3779 | Section 85. 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                                         

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1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Pigman offered the following:

4

5 **Amendment**

6 Remove lines 640-644 and insert:

7 States, at least 2,000 clinical practice hours within the 5  
8 years immediately preceding the submission of the registration  
9 request while practicing as a physician assistant under the  
10 supervision of an allopathic or osteopathic physician who held  
11 an active, unencumbered license issued by any state, the

12

13 Remove line 943 and insert:

14 States, at least 2,000 clinical practice hours within the 5

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 607 (2020)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Pigman offered the following:

4

5 **Amendment**

6 Remove line 1197 and insert:

7 issued by any state, the District of Columbia, or a



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 731 Agency for Health Care Administration  
**SPONSOR(S):** Health Market Reform Subcommittee, Perez  
**TIED BILLS:** IDEN./SIM. **BILLS:** CS/SB 1726

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	11 Y, 1 N, As CS	Guzzo	Calamas
2) Appropriations Committee	24 Y, 3 N	Nobles	Pridgeon
3) Health & Human Services Committee		Guzzo	Calamas

### SUMMARY ANALYSIS

The bill amends various authorizing and licensing statutes for entities regulated by the Agency for Health Care Administration (AHCA), including, nurse registries, home medical equipment providers, health care clinics, nursing homes, assisted living facilities, diagnostic imaging centers, ambulatory surgical centers (ASCs), and home health agencies. Specifically the bill:

- Creates risk-based licensure inspections for nurse registries, home medical equipment providers, and health care clinics to provide AHCA the flexibility to inspect high-performing providers less frequently than poor performers;
- Allows AHCA to conduct extended inspection periods for other high performing providers that are currently required to be inspected biennially, including hospices and adult day care centers;
- Revises a requirement for AHCA to inspect nursing homes with records of poor performance every six months for a two year period, to instead, require AHCA to conduct one additional inspection;
- Creates an exemption to health care clinic licensure for federally certified providers, community mental health center-partial hospitalization programs, portable x-ray providers, and rural health clinics;
- Repeals licensure of multiphasic health testing centers;
- Allows AHCA to issue a provisional license to all regulated providers/facilities;
- Repeals several statutorily mandated annual reports that are obsolete or rarely used, and instead directs AHCA to publish the information online;
- Repeals an unenforceable annual assessment on diagnostic imaging centers and ASCs;
- Updates requirements for approval of comprehensive emergency management plans for newly licensed facilities to create a consistent approval process across all provider types;
- Removes the ability of a health care clinic to submit a surety bond instead of submitting certain documents as proof of financial ability to operate to satisfy initial licensure requirements;
- Removes outdated language relating to certificate of need, to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee;
- Amends the definition of home health agency by removing staffing services to clarify that a home health agency that provides only home health services, but not staffing services, is required to be licensed as a home health agency; and
- Creates an exemption from health care clinic licensure for all Medicaid providers.

The bill strengthens AHCA's authority to conduct retrospective review of Medicaid hospital payments to allow AHCA to recover all overpayments. The bill also strengthens AHCA's ability to collect legal fees for Medicaid cases in which AHCA prevails.

The bill has an indeterminate, but likely insignificant, fiscal impact on AHCA (see fiscal comments). The bill has no fiscal impact to local governments.

Except as otherwise expressly provided, the bill provides an effective date of July 1, 2020



## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### **Agency for Health Care Administration – Division of Health Quality Assurance**

The Division of Health Quality Assurance (HQA), housed within the Agency for Health Care Administration (AHCA), licenses, certifies, and regulates 40 different types of health care providers. In total, HQA regulates more than 48,000 individual providers.<sup>1</sup> Regulated providers include:

- Laboratories performing testing under the Drug-Free Workplace program, s. 440.102(9), F.S.
- Birth centers, ch. 383, F.S.
- Abortion clinics, ch.390, F.S.
- Crisis stabilization units, parts I and IV of ch. 394, F.S.
- Short-term residential treatment facilities, parts I and IV of ch. 394, F.S.
- Residential treatment facilities, as provided under part IV of ch. 394, F.S.
- Residential treatment centers for children and adolescents, part IV of ch. 394, F.S.
- Hospitals, part I of ch. 395, F.S.
- Ambulatory surgical centers, part I of ch. 395, F.S.
- Nursing homes, part II of ch. 400, F.S.
- Assisted living facilities (ALFs), part I of ch. 429, F.S.
- Home health agencies, part III of ch. 400, F.S.
- Nurse registries, part III of ch. 400, F.S.
- Companion services or homemaker services providers, part III of ch. 400, F.S.
- Adult day care centers, part III of ch. 429, F.S.
- Hospices, part IV of ch. 400, F.S.
- Adult family-care homes, part II of ch. 429, F.S.
- Homes for special services, part V of ch. 400, F.S.
- Transitional living facilities, part XI of ch. 400, F.S.
- Prescribed pediatric extended care centers, part VI of ch. 400, F.S.
- Home medical equipment providers, part VII of ch. 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, part VIII of ch. 400, F.S.
- Health care services pools, part IX of ch. 400, F.S.
- Health care clinics, part X of ch. 400, F.S.
- Multiphasic health testing centers, part II of ch. 483, F.S.
- Organ, tissue, and eye procurement organizations, part V of ch. 765, F.S.

Certain health care providers<sup>2</sup> are regulated under part II of ch. 408, F.S., which is the Health Care Licensing Procedures Act (Act), or core licensing statutes. The Act provides uniform licensing procedures and standards for 26 provider types.<sup>3</sup> In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. In the case of conflict between the Act and an individual authorizing statute, the Act prevails.<sup>4</sup>

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<sup>1</sup> Agency for Health Care Administration, *Health Quality Assurance*, 2017, available at <http://ahca.myflorida.com/MCHQ/> (last visited January 31, 2020).

<sup>2</sup> "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.

<sup>3</sup> S. 408.802, F.S.

<sup>4</sup> S. 408.832, F.S.

## Birth Centers

### Current Situation

A birth center is any facility, institution, or place, which is not an ambulatory surgical center or a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.<sup>5</sup> Birth centers are licensed and regulated by AHCA under ch. 383, F.S., and part II of ch. 408, F.S.

AHCA is required to adopt rules establishing minimum standards for birth centers, which ensure:

- Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety;
- Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented; and
- Licensed facilities are established, organized, and operated consistent with established programmatic standards.<sup>6</sup>

Section 383.327, F.S., requires birth centers to submit an annual report to AHCA, the contents of which are to be prescribed by AHCA rule. Current law does not expressly authorize AHCA to adopt rules to change the frequency for submission of the report. Rule 59A-11.019, F.A.C., requires birth centers to submit the annual report using an electronic form, which includes reportable data fields on:

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reason for the transfer, whether it occurred intrapartum or postpartum, and the length of the hospital stay;
- Newborn transfers, including the reason for the transfer, birth weight, days in hospital, and APGAR score<sup>7</sup> at five and ten minutes;
- Newborn deaths; and
- Stillborn/Fetal deaths.<sup>8</sup>

### Effect of the Bill

The bill amends s. 383.327, F.S., to remove the statutory requirement for the report to be submitted annually. Instead, the bill authorizes AHCA to adopt rules to establish the frequency at which the report is submitted. According to AHCA, this will allow the Agency to change the annual reporting requirement in AHCA rule to require more frequent submission.<sup>9</sup>

Birth centers are also required to immediately report each maternal death, newborn death, and stillbirth to the medical examiner. However, current law does not require birth centers to immediately report such deaths to AHCA. The bill requires birth centers to immediately report to AHCA each maternal death, newborn death, and stillbirth.

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<sup>5</sup> S. 383.302(2), F.S. Section 383.302(8), F.S.

<sup>6</sup> Section 383.309, F.S.; The minimum standards for birth centers are contained in Chapter 59A-11, F.A.C.

<sup>7</sup> The APGAR score is the result of a test given by the delivering physician, midwife or nurse to measure a baby's heart rate, muscle tone, and other signs to determine if extra medical attention is needed. A newborn is scored on a scale of 0 to 2, with 2 being the best score for each of the following: appearance (skin color), pulse (heart rate), grimace response (reflexes), activity (muscle tone), and respiration (breathing rate).

<sup>8</sup> Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Apr. 2019).

<sup>9</sup> Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 731, January 28, 2020 (on file with Health Market Reform Subcommittee staff).

## Hospital Licensure

### Current Situation

In 2019, the Legislature eliminated certificate of need review for general hospitals.<sup>10</sup> Section 395.003, F.S., requires AHCA to include certain information on a license issued to a hospital, including, the service categories and the number of hospital beds in each bed category. Current law in this section includes an outdated CON provision directing AHCA to identify hospital beds as general beds on the face of the hospital's license, when not covered by any specialty-bed-need methodology. Beds covered by a specialty-bed-need methodology include neonatal intensive care beds, comprehensive medical rehabilitation beds, adult psychiatric beds, child/adolescent psychiatric beds, and adult substance abuse beds. Currently, these specialty hospital beds might be incorrectly reported as general beds on the face of the hospital's license.

### Effect of the Bill

The bill removes this obsolete language to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee.

## Annual Assessments on Health Care Facilities

### Current Situation

Section 395.7015, F.S., imposes an annual assessment on ambulatory surgical centers and certain diagnostic imaging centers<sup>11</sup>, to be deposited into the Public Medical Assistance Trust Fund (PMATF). These assessments were ruled unconstitutional in 2002, and are no longer collected.<sup>12</sup>

### Effect of the Bill

The bill repeals s. 395.7015, F.S., to remove unenforceable statutory authority for AHCA to collect the annual assessments. The bill also amends s. 395.7016, F.S., to make a conforming change by removing a cross-reference to s. 395.7015, F.S.

## Nursing Home Inspections

### Current Situation

Uniform licensing requirements in s. 408.811, F.S., require all facilities licensed by AHCA to be inspected biennially unless otherwise specified in statute or rule.

Section 400.19, F.S., requires AHCA to conduct at least one unannounced inspection of licensed nursing homes every 15 months. Federal law also requires AHCA to inspect nursing homes every 15 months.<sup>13</sup>

Current law in s. 400.19, F.S., also requires AHCA to conduct additional inspections of nursing homes that are cited for multiple deficiencies within specified timeframes. Specifically, AHCA is required to inspect a nursing home every six months for two years if the facility has been cited for a class I

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<sup>10</sup> Ch. 2019-136, L.O.F.

<sup>11</sup> Diagnostic imaging centers that are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services, and in which services are rendered by a licensed physician or a licensed osteopathic physician.

<sup>12</sup> *Agency for Health Care Administration v. Hameroff*, 816 So. 2d 1145, 1149-1150 (Fla. 1<sup>st</sup> DCA 2002).

<sup>13</sup> 42 C.F.R. §. 488.308(a).

deficiency<sup>14</sup>, has been cited for two or more class II deficiencies<sup>15</sup> arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a six-month period that resulted in at least one class I or class II deficiency. Current law also requires nursing homes to pay a \$6,000 fine for falling under the additional inspection cycle.

### Effect of the Bill

The bill amends s. 400.19, F.S., to remove the 15-month inspection requirement. However, AHCA will still be required to inspect nursing homes every 15 months as required by federal law.

The bill revises the requirement for AHCA to additionally inspect nursing homes every six months for two years as detailed above. Instead, the bill requires AHCA to conduct one additional inspection under those circumstances.

## **Hospice Inspections**

### Current Situation

Section 400.605, F.S., requires AHCA to conduct annual inspections of hospices, with the exception that inspections may be conducted biennially for hospices having a three-year record of substantial compliance.

### Effect of the Bill

The bill amends s. 400.605, F.S., removing the requirement for AHCA to inspect hospices annually, or biennially for hospices having a three-year record of substantial compliance. Instead, the bill requires AHCA to inspect hospices biennially in accordance with the uniform licensing requirements in s. 408.811, F.S. In addition, the bill authorizes AHCA to conduct inspections less frequently than biennially. The bill requires AHCA to consider certain measures reflective of quality and safety in granting an extended inspection period to a hospice, including whether the facility has:

- A favorable regulatory history of deficiencies, sanctions, complaints, and other regulatory measures;
- Outcome measures that demonstrate quality performance;
- Successful participation in a recognized, quality program; and
- Accreditation status.

The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for the extended inspection period.

## **Adult Day Care Center Inspections**

### Current Situation

Adult day care centers are inspected biennially by AHCA in accordance with the uniform licensing requirements in s. 408.811, F.S. Adult day care center programs that are collocated in an ALF or a

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<sup>14</sup> S. 408.813(2)(a), F.S. Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.

<sup>15</sup> S. 408.813(2)(b), F.S. Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

nursing home are also required to be inspected biennially by AHCA pursuant to the adult day care center licensing statute in s. 429.905, F.S.

Section 429.929, F.S., authorizes AHCA to conduct, in lieu of a full inspection, an abbreviated biennial inspection of key quality of care standards if the adult day care center has a record of good performance.

#### Effect of the Bill

The bill amends s. 429.905, F.S., to remove the biennial inspection requirement for adult day care center programs collocated in an ALF or a nursing home. As a result, AHCA will be required to inspect adult day care center programs collocated in an ALF or a nursing home in accordance with the inspection requirements for ALFs and nursing homes. For nursing homes, the inspection frequency is once every 15 months. For adult day care centers collocated in an ALF, the inspections will be in accordance with the new ALF inspection requirements detailed in the ALF section above. This will have no measurable effect because both settings in which an adult day care center may be collocated will be inspected more frequently than biennially.

The bill removes the authority for AHCA to conduct abbreviated biennial inspections of adult days care centers. Instead, the bill requires AHCA to inspect adult day care centers biennially in accordance with the uniform licensing requirements in s. 408.811, F.S. In addition, the bill authorizes AHCA to conduct inspections less frequently than biennially. The bill requires AHCA to consider certain measures reflective of quality and safety in granting an extended inspection period to an adult day care center, including whether the facility has:

- A favorable regulatory history of deficiencies, sanctions, complaints, and other regulatory measures;
- Outcome measures that demonstrate quality performance;
- Successful participation in a recognized, quality program; and
- Accreditation status.

The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for the extended inspection period.

### **Inspections of Health Care Clinics, Home Medical Equipment Providers and Nurse Registries**

#### Current Situation

Health care clinics, home medical equipment providers, and nurse registries are all subject to initial licensure inspections and biennial inspections pursuant to the uniform licensing requirements of s. 408.811, F.S.

According to AHCA, the inspection history for these three provider types have been good compared to other provider types, which indicates to AHCA that they are low-risk providers as compared to other providers.<sup>16</sup>

The results of inspections conducted during fiscal years 2017-18 and 2018-19, for these three provider types found that:

- 87 percent of health care clinics were deficiency free;
- 79 percent of home medical equipment providers were deficiency free; and
- 59 percent of nurse registries were deficiency free.<sup>17</sup>

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<sup>16</sup> Id.

<sup>17</sup> Id.

## Effect of the Bill

The bill exempts health care clinics, home medical equipment providers, and nurse registries from licensure inspections. Instead, the bill authorizes AHCA to conduct verification of compliance inspections for health care clinics, home medical equipment providers, and nurse registries. The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers to verify regulatory compliance. According to ACHA, this will provide the agency the flexibility to conduct fewer inspection visits to providers with a good regulatory history, and allow them to spend more time and resources inspecting poorly performing providers.<sup>18</sup>

## **Home Health Agencies**

### Current Situation

A “home health agency” is an organization that provides home health services and staffing services.<sup>19</sup> According to AHCA, there is concern that the definition could be interpreted to mean a provider is exempt from licensure as a home health agency if they provide home health services but not staffing services.<sup>20</sup>

Home health services are health and medical services and supplies furnished by an organization<sup>21</sup> to an individual in the individual’s home or place of residence, including organizations that provide one or more of the following:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Dietetics and nutrition practice and nutrition counseling; or
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.<sup>22</sup>

According to AHCA, the current definition of organization is problematic because it only refers to entities and does not include an individual person, which creates a loophole for an individual to employ health care personnel for the provision of home health services without having to obtain a license.<sup>23</sup>

Current law, requires an applicant for initial home health agency licensure to provide proof of accreditation and a survey demonstrating compliance with survey standards prior to the addition of skilled care or services. However, current law does include such requirements for a change of ownership or licensure renewal.<sup>24</sup>

### Effect of the Bill

The bill amends the definition of home health agency by removing the reference to staffing services to clarify that a home health agency that provides only home health services, but not staffing services, is required to be licensed as a home health agency.

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<sup>18</sup> Supra FN 9.

<sup>19</sup> S. 400.462(12), F.S.

<sup>20</sup> Id.

<sup>21</sup> S. 400.462(22), F.S. Organization means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.

<sup>22</sup> S. 400.462(14), F.S.

<sup>23</sup> Supra FN 9.

<sup>24</sup> S. 400.471((2)(g)), F.S.

The bill also deletes the definition of organization to exclude programs that offer home visits for a single profession. According to AHCA, this change will clarify that current law only requires a home health license when an organization offers multiple professional disciplines in the home.<sup>25</sup> The bill amends various sections of home health agency statute to replace the term “organization” with “person or entity.”

The bill retains an exemption from home health agency licensure for a person or entity that provides skilled care by health care professionals licensed solely under part I of ch. 464, F.S. (nursing), part I, part III, or part V of ch. 408, F.S. (speech, operational or respiratory therapy), or ch. 486, F.S. (physical therapy). According to AHCA, this exemption indirectly exists within the current definition of “organization”, which is deleted by the bill.<sup>26</sup> AHCA states that by adding this exemption, a person or entity would be able to voluntarily apply for a certificate of exemption from home health agency licensure as documentation of exempt status.<sup>27</sup>

The bill requires applicants for, not only initial licensure, but also for a change of ownership or license renewal to provide proof to AHCA of accreditation and a survey demonstrating compliance with survey standards prior to the addition of skilled care or services.

### **Health Care Clinic Act**

The Health Care Clinic Act (Act), ss. 400.990 – 400.995, F.S., was enacted in 2003 to reduce fraud and abuse in the personal injury protection (PIP) insurance system.<sup>28</sup> Pursuant to the Act, AHCA licenses health care clinics, ensures that clinics meet basic business and billing related standards, and provides administrative oversight.

Pursuant to the uniform licensure requirements of part II of ch. 408, F.S., applicants for licensure as a health care clinic are required to demonstrate financial ability to operate by showing that the applicant’s assets, credits, and projected revenues will meet or exceed projected liabilities and expense<sup>29</sup> As an alternative to submitting proof of financial ability to operate, s. 400.991, F.S., allows a health care clinic to submit a surety bond to AHCA of at least \$500,000. According to AHCA, no clinic has ever submitted a surety bond instead of submitting proof of financial ability to operate.<sup>30</sup> The bill amends s. 400.991, F.S., to remove the alternative option for a health care clinic to prove their financial ability to operate.

### Healthcare Clinic Exemptions

#### *Federally Certified Providers*

##### Current Situation

Any entity that meets the definition of a health care clinic must be licensed as a health care clinic. Although all clinics must be licensed by AHCA, the Act creates many exceptions from the health care clinic licensure requirements.<sup>31</sup> A health care clinic may voluntarily apply for a certificate of exemption for a fee of \$100.<sup>32</sup> Certificates of exemption are valid for up to two years.<sup>33</sup> Among many other exemptions, certain federally certified entities are exempt from licensure under the Act, including:

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<sup>25</sup> Supra FN 9

<sup>26</sup> Id.

<sup>27</sup> Id.

<sup>28</sup> Chapter 2003-411, Laws of Fla. PIP insurance is no fault auto insurance that provides certain benefits for individuals injured as a result of a motor vehicle accident. All motor vehicles registered in this state must have PIP insurance.

<sup>29</sup> S. 408.8065, F.S., and s. 408.810, F.S.

<sup>30</sup> Supra FN 9.

<sup>31</sup> S. 400.9905(4), F.S.

<sup>32</sup> S. 400.9935(6), F.S.

<sup>33</sup> Id.

- Entities federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories;
- Entities that own, directly or indirectly, entities federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories;
- Entities that are owned, directly or indirectly, by an entity federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories; and
- Entities that are under common ownership, directly or indirectly, with an entity federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories.

Federal certification requirements are more stringent than the licensure standards of the Health Care Clinic Act. Current law does not include exemptions from health care clinic licensure for federally certified community mental health center-partial hospitalization programs<sup>34</sup>, portable x-ray providers<sup>35</sup>, or rural health care clinics<sup>36</sup>.

### Effect of the Bill

The bill creates exemptions for these providers similar to current exemptions for other federally certified providers. Approximately 200 providers will qualify for this exemption.<sup>37</sup>

### *Ownership*

#### Current Situation

In 2019, SB 2502 (Implementing the 2019-2020 GAA), provided two exemptions from health care clinic licensure in order to implement specific appropriations 208<sup>38</sup>, 225-236, and 368<sup>39</sup> of the GAA. The exemptions expire on July 1, 2020. Specifically, the bill provided an exemption for entities that are:

- Under the common ownership or control by a mutual insurance holding company with an entity licensed or certified under chapter 624, F.S., or chapter 641, F.S., that has \$1 billion or more in total annual sales in this state; or
- Owned by an entity who is a behavioral health service provider in at least 5 states other than Florida and that, together with its affiliates, have \$90 million or more in total annual revenues associated with the provision of behavioral health care services and where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and is responsible for the entity's compliance with state law for purposes of part X of chapter 400, F.S.

### Effect of the Bill

The bill creates permanent statutory exemptions for the exemptions above that are set to expire on July 1, 2020.

<sup>34</sup> 42 C.F.R. §§. 485.900-485.920.

<sup>35</sup> 42 C.F.R. §§. 486.100-486.110.

<sup>36</sup> 42 C.F.R. §§. 491.1-491.12.

<sup>37</sup> Supra FN 9.

<sup>38</sup> 2019, HB 5001, General Appropriations Act, Funds in specific appropriation 208 are for the inclusion of freestanding dialysis clinics in the Medicaid Program.

<sup>39</sup> 2019, HB 5001, General Appropriations Act, Funds in specific appropriation 368 are to fund the following projects: Citrus Health Network; Apalachee Center Forensic Treatment Services; Mental Health Care-Forensic Treatment Services; Apalachee Center-Civil Treatment Services; New Horizons of the Treasure Coast-Civil Treatment Services.



## Medicaid Providers

### Current Situation

Applied Behavioral Analysis (ABA) is an umbrella term referring to the principles and techniques used to assess, treat, and prevent challenging behaviors while promoting new, desired behaviors. ABA focuses on improving social skills, communication, reading, and academics as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence. ABA can be effective for children and adults with psychological disorders in a variety of settings, including schools, workplaces, homes, and clinics.<sup>40</sup>

In 2019, AHCA required all ABA provider groups to be licensed as health care clinics under ch. 400, F.S., as a condition of Medicaid enrollment, effective July 1, 2020. This change will also require ABA provider groups to employ a physician to be the medical or clinical director. Consequently, over 30,000 Medicaid providers will be required to obtain a health care clinic license or a certificate of exemption from licensure as a health care clinic by July 1, 2020.<sup>41</sup>

### Effect of the Bill

The bill creates an exemption from health care clinic licensure for all Medicaid providers. AHCA estimates that approximately 28,291 ABA providers would qualify for the exemption.<sup>42</sup>

The bill also allows a clinic that exclusively provides behavior analysis services to appoint as a clinic director, a health care practitioner who maintains an active and unencumbered certification as a Board Certified Behavior Analyst.

### Public Posting of a Schedule of Charges

#### Current Situation

Current law in s. 400.9935, F.S., requires health care clinics to publish a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for services by cash, check, credit card, or debit card. The schedule may group services by three price levels, listing services in each price level. The schedule may be a sign that must be at least 15 square feet in size or an electronic messaging board that is at least three square feet in size. A health care clinic that does not publish and post a schedule of charges may be assessed a fine of up to \$1,000 per day.

Further, the statute requires the schedule to be posted in a conspicuous place in the reception area of an urgent care center. The specific reference to an urgent care center complicates the interpretation as to whether the posting requirements apply only to urgent care centers or to all health care clinics. As a result, AHCA only has the authority to enforce the posting requirements on urgent care centers.

#### Effect of the Bill

The bill removes the ambiguity of the current law by specifically requiring an urgent care center to post a schedule of charges in the in their reception area. The bill is silent as to the means by which all other health care clinics will be required to publish a schedule of charges; however, AHCA has indicated that the Agency will require clinics to publish them on the clinic's website, in a document available at the

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<sup>40</sup> "Applied Behavioral Analysis", *Psychology Today*, available at <https://www.psychologytoday.com/us/therapy-types/applied-behavior-analysis> (last accessed January 31, 2020).

<sup>41</sup> Supra FN 9.

<sup>42</sup> Id.

clinic, in a scanned document that can be emailed upon request, or in posted signage of an undetermined size.<sup>43</sup>

## **AHCA Reports**

### Hospice Annual Report

#### Current Situation

Section 400.60501, F.S., provides reporting requirements for AHCA on certain hospice data. AHCA is required to make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices. Further, AHCA is required to develop an annual report that analyzes and evaluates the national hospice outcome measures and survey data.

#### Effect of the Bill

The bill removes the requirement for AHCA to develop an annual report, but retains the requirement for AHCA to make the national hospice outcome measures and survey data available to the public. AHCA already publishes the outcome measures and survey data on FloridaHealthFinder.gov.<sup>44</sup>

### Electronic Prescribing Annual Report

#### Current Situation

Electronic prescribing is the electronic review of a patient's medication history, the electronic generation of the patient's prescription, and the electronic transmission of the patient's prescription to a pharmacy.<sup>45</sup> Current law requires AHCA to work with electronic prescribing initiatives and relevant stakeholders to create a clearinghouse of information on electronic prescribing for health care practitioners, health care facilities, and pharmacies.<sup>46</sup> AHCA must monitor the implementation of electronic prescribing and provide an annual report on the progress of implementation to the Governor and the Legislature. The report is also required to include information on federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically submitted.<sup>47</sup> AHCA publishes the electronic prescribing data online<sup>48</sup>, and it is updated quarterly.

#### Effect of the Bill

The bill removes the requirement for AHCA to provide an annual report on the progress of implementation to the Governor and the Legislature. Instead, the bill requires AHCA to annually publish the report online.

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<sup>43</sup> Supra FN 9.

<sup>44</sup> AHCA, FloridaHealthFinder.gov, Hospice Quality Reporting Program, CAHPS (Patient and Family Experience Measures-Consumer Assessment of Healthcare Providers and Systems), and HIS (Quality of Patient Care Measures-Hospice Item Set), available at <https://www.floridahealthfinder.gov/Hospice/Hospice.aspx> (last accessed January 31, 2020).

<sup>45</sup> S. 408.0611(2)(a), F.S.

<sup>46</sup> Ch. 2007-156, Laws of Fla.

<sup>47</sup> S. 408.0611(4), F.S.

<sup>48</sup> AHCA, ePrescribing Dashboard, Quarterly Metrics Summary and Data Charts, available at <http://fhin.net/eprescribing/dashboard/index.shtml> (last accessed January 31, 2020).

## Emergency Department Utilization Annual Report

### Current Situation

Section 408.062, F.S., requires AHCA to conduct research, analyses, and studies relating to health care costs and access to and quality of health care services, which must include the use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing non-urgent care in emergency departments. Based on this monitoring and assessment, AHCA must submit an annual report to the Governor and the Legislature, and substantive Legislative committees. Most of, but not all, of the information required to be in the annual report is available anytime by using the emergency department query tool on FloridaHealthFinder.gov. Not included on the website is the use of emergency department services by patient acuity level and its impact on increasing hospital cost by providing non-urgent care in emergency departments.

### Effect of the Bill

The bill repeals annual report on emergency department utilization required to be sent to the Governor and the Legislature. Instead, the bill requires AHCA to annually publish online, information on the use of emergency department services by patient acuity level.

## Florida Center for Health Information and Transparency Annual Report

### Current Situation

Section 408.062, F.S., requires AHCA to publish on its website, and make available in a hard copy format upon request, data on patient charges, volumes, length of stay, and performance indicators from data collected from hospitals, for specific procedures, medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities. The data must be updated quarterly. AHCA is also required to submit an annual report on the status of the collection of data and publication of health care quality measures to the Governor and the Legislature, and substantive Legislative committees. All of this information is easily accessible on FloridaHealthFinder.gov<sup>49</sup>, and the data is updated bi-weekly.

### Effect of the Bill

The bill retains the requirement for AHCA to publish data currently contained in the annual report, but removes the requirement for the annual report to be submitted to the Governor, and the Legislature. According to AHCA, if the bill passes, all of the data that is currently required to be published will still be easily accessible for consumers and others.<sup>50</sup>

## State Health Expenditures Annual Report

### Current Situation

Section 408.063, F.S., requires AHCA to annually publish a comprehensive report of state health expenditures, which must identify the contribution of health care dollars made by all payers, and the dollars expended by type of health care service. According to AHCA, the data used to generate the Expenditure Report is not available until several years after the reporting period. AHCA publishes the current year report utilizing the available data from three years prior. The report includes information collected from the Department of Economic Opportunity, the U.S. Census Bureau, CMS, the Florida Office of Insurance Regulation (OIR), and the U.S. Bureau of Economic Analysis. All data is publicly

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<sup>49</sup> AHCA, Research Studies and Reports, Florida Center for Health Information and Transparency Annual Report, available at <https://www.floridahealthfinder.gov/researchers/studies-reports.aspx> (last accessed January 31, 2020).

<sup>50</sup> Supra FN 9

available on relevant government agency websites. The dashboard associated with this report received only 14 website hits over the course of a year.<sup>51</sup>

### Effect of the Bill

The bill removes the requirement for AHCA to publish the State Health Expenditures Annual Report. Should the bill pass, AHCA will no longer collect this information or publish it in any manner.

### Health Flex Plan Annual Report

#### Current Situation

The health flex plan began as a pilot program<sup>52</sup> to cover basic and preventative health care services to low-income families not eligible for public assistance programs and not covered by private insurance. Health flex plans are unique compared to the common health insurance plan. A health flex plan may limit or exclude benefits otherwise required by law, or they can cap the total amount of claims paid per year to an enrollee.<sup>53</sup> The pilot program began with three health flex plans in the three areas of the state with the highest number of uninsured individuals. Today, there is only one remaining health flex plan with less than 300 members.<sup>54</sup>

Section 408.909(9), F.S., requires AHCA and OIR to jointly submit an annual report to the Governor and the Legislature, which must include:

- An evaluation of the entities that seek approval as health flex plans;
- The number of enrollees and the scope of health care coverage offered;
- An assessment of the health flex plans and their potential applicability in other settings; and
- Information to evaluate low-income consumer driven benefit packages

According to AHCA, the online report has received no website hits in over a year.<sup>55</sup>

### Effect of the Bill

The bill repeals the health flex plan evaluation and annual reporting requirements. Should the bill pass, AHCA and OIR will still be required to collect certain data on health flex plans.

### Cover Florida Health Care Access Program Annual Report

#### Current Situation

In 2008, the Legislature created the Cover Florida Health Access Program to provide affordable health care options for uninsured residents. A Cover Florida plan must have two alternate benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage. Plans without catastrophic coverage must provide coverage options for certain services like preventive health services, behavioral health services, durable medical equipment, inpatient hospital stays, hospital emergency services, urgent care and more.<sup>56</sup>

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<sup>51</sup> Id.

<sup>52</sup> Ch. 2002-389, Laws of Fla.

<sup>53</sup> S. 409.909(3), F.S.

<sup>54</sup> Supra FN 9.

<sup>55</sup> Id.

<sup>56</sup> S. 408.9091(4)(a), F.S.

Section 408.9091, F.S., requires AHCA and OIR to:

- Evaluate the Program and its effect on the entities that seek approval, the number of enrollees, and on the scope of the health care coverage offered;
- Provide an assessment of the plans and their potential applicability in other settings;
- Use plans to gather more information to evaluate low-income, consumer-driven benefit packages; and
- Jointly submit an annual report to the Governor and the Legislature, which must include the gathered information above, and must include recommendations relating to the successful implementation and administration of the program.

Currently, there are no plans participating in the Cover Florida Health Care Access Program, and the last participating plan terminated its coverage policies in 2015.<sup>57</sup>

#### Effect of the Bill

The bill removes the requirement for AHCA and OIR to submit an annual report on the Cover Florida Health Care Access Program to the Governor and the Legislature. The bill retains current law requiring AHCA and OIR to evaluate and assess the program.

#### ALF Sanctions Annual Report

##### Current Situation

Section 429.19(9), F.S., requires AHCA to annually develop a list of all facilities that were sanctioned or fined, which must include the number and class of violations involved, the penalties imposed, and the current status of the cases. Upon developing the list, AHCA must annually disseminate it to the Department of Elder Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families must then disseminate the list to their contracted service providers who are responsible for referring individuals to an ALF for residency. The list may be provided electronically or through AHCA's website. The statutory requirement for AHCA to annually disseminate the list of ALF sanctions was adopted in 1993. Since that time, AHCA has committed significant resources towards moving information online that may be used by a consumer in selecting a health care provider, including the history of an ALF's citations and violations. The provider specific information on FloridaHealthFinder.gov is updated nightly to reflect licensure status, inspection details, and legal case activities.<sup>58</sup> However, aggregate data on the ALF industry is not provided on the website.

##### Effect of the Bill

The bill repeals s. 419.19(9), F.S. As a result, AHCA would no longer be required to annually compile or disseminate a list on facilities that were sanctioned or fined. Information on sanctions and fines is available online by specific provider.<sup>59</sup> Further, DCF would no longer be required to disseminate the list to their contracted service providers.

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<sup>57</sup> Supra FN 9.

<sup>58</sup> Id.

<sup>59</sup> AHCA, FloridaHealthFinder.gov, ALF compare, available at <https://www.floridahealthfinder.gov/CompareSC/SCSelectFilters.aspx> (last accessed January 31, 2020).

## **Background Screening**

### Current Situation

In 2012, the Legislature created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single “program” of screening individuals and allow for the results of criminal history checks of persons acting as covered care providers to be shared among the specified agencies.<sup>60</sup> Designated agencies include AHCA, the Department of Health, the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, Vocational Rehabilitation within the Department of Education, and the Department of Juvenile Justice.

Section 408.809(2), F.S., allows providers to provide proof of screening from agencies joining the Clearinghouse to meet screening requirements until such time as the specified agency is fully implemented in the Clearinghouse. Final implementation of the Clearinghouse by the designated state agencies was required by October 1, 2013.

The Clearinghouse was initially implemented by AHCA on January 1, 2013. It included language that allowed a person currently employed as of June 30, 2014, who was screened and qualified prior to employment, to apply for an exemption in the event that a disqualifying offense, that the employee committed prior to screening, is later added to the law. Because statute still includes the date of June 30, 2014, the exemption is unenforceable.

Section 408.809(5), F.S., provides a background screening schedule for a controlling interest, employee, or individual under contract with a licensee. The background screening schedule is expired.

Section 409.907, F.S., provides background screening requirements for Medicaid providers. According to AHCA, the background screening requirements are only intended to apply to staff having direct access to patients, but some Medicaid managed care plans have been screening all staff beyond those with access to clients.<sup>61</sup>

### Effect of the Bill

The bill allows an employee, who has previously qualified with background screening requirements, to apply for an exemption if the law is changed to add a disqualifying offense for which the employee committed prior to being screened.

The bill amends s. 408.809(2), F.S., to delete expired provisions relating implementation of the Clearinghouse. All specified agencies are now fully implemented in the Clearinghouse.

The bill also amends s. 408.809(5), F.S., to delete an expired background screening schedule.

The bill amends s. 409.907, F.S., clarify that background screening requirements for Medicaid providers apply to individuals who will have direct access to Medicaid recipients, recipient living areas, or the financial, medical, or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient.

## **Multiphasic Health Testing Centers**

### Current Situation

Multiphasic health testing centers are regulated by AHCA under part I of ch. 483, F.S. A multiphasic health testing center is a facility where specimens are taken from the human body for delivery to

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<sup>60</sup> Ch. 2014-84, Laws of Fla.

<sup>61</sup> Supra FN 9.

registered clinical laboratories for analysis and certain measurements and tests are taken, such as height and weight, blood pressure, limited audio and visual, and electrocardiograms.<sup>62</sup>

The federal Clinical Laboratory Improvement Amendments Act (CLIA) requires a clinical laboratory to receive CLIA certification if it examines materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being. The federal Centers for Medicare & Medicaid Services (CMS), within the United States Department of Health and Human Services, regulates all laboratory testing performed on humans in the United States through the CLIA.<sup>63</sup> The purpose of the CLIA program is to establish quality standards for all laboratory testing to ensure accuracy, reliability, and timeliness of test results regardless of where the test was performed.<sup>64</sup> The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Clinical Standards and Quality in CMS has the responsibility for implementing the CLIA Program, including laboratory registration, fee collection, onsite inspections, and enforcement.<sup>65</sup> In addition to CLIA inspections, AHCA is required to conduct biennial inspections of all licensed multiphasic health testing centers.

As of January 21, 2020, there were 187 multiphasic health testing centers licensed in Florida. Of these, 180 are CLIA certified, which means they are subject to federal inspections by CMS. The other 7 centers, although currently licensed, are not required to be licensed because they are not providing services that necessitate licensure as a multiphasic health testing center.<sup>66</sup>

Since 2011, AHCA has imposed only six fines against multiphasic health testing centers, and received only 10 complaints, with none substantiated.<sup>67</sup>

### Effect of the Bill

The bill repeals licensure of multiphasic health testing centers. Currently, 180 licensed centers are CLIA certified and will continue to be regulated and inspected by federal CMS.

## **Provisional Licensure**

### Current Situation

Section 408.808, F.S., provides the uniform licensing requirements for all health care facilities regulated by AHCA. There are three types of licenses issued by AHCA, including, standard, inactive, and provisional licenses. A standard license is valid for two years and is issued to an applicant at the time of initial licensure, licensure renewal, or a change of ownership.<sup>68</sup> An inactive license is issued to a health care provider subject to CON review when the provider is licensed, but does not have a provisional license, and will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<sup>69</sup>

A provisional license is issued to an applicant for licensure renewal when a proceeding is pending to deny or revoke their license.<sup>70</sup> A provisional license may also be issued to an applicant applying for a

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<sup>62</sup> S. 483.288(2), F.S.

<sup>63</sup> Centers for Medicare & Medicaid Services, *Clinical Laboratory Improvement Amendments (CLIA)*, available at [https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/10\\_Categorization\\_of\\_Tests.asp](https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/10_Categorization_of_Tests.asp) (last accessed January 31, 2020).

<sup>64</sup> Department of Health and Human Services, Office of the Inspector General, *Enrollment and Certification Processes in the Clinical Laboratory Improvement Amendments Program*, (Aug. 2001), available at <https://oig.hhs.gov/oei/reports/oei-05-00-00251.pdf> (last accessed January 31, 2020)

<sup>65</sup> Id.

<sup>66</sup> Supra FN 9.

<sup>67</sup> Id.

<sup>68</sup> S. 408.808(1), F.S.

<sup>69</sup> S. 408.808(3), F.S.

<sup>70</sup> S. 408.808(2), F.S.

change of ownership. Provisional licensure must be limited to a specific period of time, up to 12 months, as determined by AHCA. ALF statutes allow AHCA to issue a provisional license to an applicant for initial licensure for a specific period of time not to exceed 6 months. Current law does not allow the issuance of a provisional license for initial licensure for any facility regulated by AHCA.

### Effect of the Bill

The bill amends s. 408.808, F.S., to allow AHCA to issue a provisional license for initial licensure to all regulated providers. According to AHCA, there have been instances when a provider's license is revoked because they forgot to renew their license, so they have to go through the process of applying for initial licensure, which can often take a long time.<sup>71</sup> In such instances, residents or patients have to be moved and other accommodations must be made. Allowing AHCA to issue a provisional license in such instances will allow the provider to go through the licensure process while avoiding an interruption in client services.

## **Comprehensive Emergency Management Plans**

### Current Situation

Different provider types are subject to different comprehensive emergency management plan submission requirements in their authorizing statutes. ALFs are required to get plan approval by local emergency management officials prior to being licensed.<sup>72</sup> According to AHCA, some local jurisdictions refuse to review a plan until the provider is licensed, making it impossible for providers within those jurisdictions to become lawfully licensed.<sup>73</sup>

### Effect of the Bill

The bill amends s. 408.821, F.S., to require providers that are required by authorizing statutes and AHCA rule to have a comprehensive emergency management plan to:

- Submit the plan within 90 days after initial licensure and change of ownership, and notify AHCA within 30 days after submission of the plan;
- Submit the plan annually and within 30 days after any significant modification to a previously approved plan;
- Respond with necessary plan revisions within 30 days after notification that plan revisions are required; and
- Notify AHCA within 30 days after approval of its plan by the local emergency management agency, county health department, or DOH.

## **Medicaid Program Integrity Hospital Retrospective Review Program**

### Current Situation

Section 409.905(5), F.S., requires AHCA to pay for all covered services for the medical care of a Medicaid recipient who is admitted to a hospital as an inpatient by a licensed physician or dentist. However, AHCA may limit the payment for inpatient hospital services, for a Medicaid recipient 21 years of age or older, to 45 days or the number of days necessary to comply with the General Appropriations Act (GAA). This statute authorizes AHCA to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the GAA, including:

- Prior authorization for inpatient psychiatric days;

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<sup>71</sup> Supra FN 9.

<sup>72</sup> S. 429.41(1)(b), F.S.

<sup>73</sup> Supra FN 9.



- Prior authorization for non-emergency hospital inpatient admissions for individuals at least 21 years of age;
- Authorization of emergency and urgent-care admissions within 24 hours after admission;
- Enhanced utilization and concurrent review programs for highly utilized services;
- Reduction or elimination of covered days of service;
- Adjusting reimbursement ceilings for variable costs;
- Adjusting reimbursement ceilings for fixed and property costs; and
- Implementing target rates of increase.

Pursuant to s. 409.905(5)(a), F.S., AHCA must discontinue its hospital retrospective review program once it has implemented its prior authorization program for hospital inpatient services.

AHCA's hospital retrospective review program, within the AHCA's Bureau of Medicaid Program Integrity (MPI), performs routine pre-claim and post-claim reviews to determine the appropriateness of historical, existing, and future provider reimbursement. Since the inception of MPI, AHCA's claim review processes have recovered in excess of one billion dollars.<sup>74</sup>

MPI also conducts provider audits based on probable cause through the Alien Audit Program, which was created in 2010<sup>75</sup>. The Alien Audit Program is part of the hospital retrospective review program and was developed after an audit report from the Health and Human Services Office of Inspector General directed the state to return the federal share of erroneous payment for certain hospital claims related to Emergent Medicaid. Since its inception, the Alien Audit Program has closed 668 cases and collected \$57,056,455.79.

In February, 2019, the First District Court of Appeal ruled that s. 409.9905(5)(a), F.S., precludes post-payment audits, including the Alien Audit Program audits, to determine the appropriateness of reimbursement, including whether prior authorization was obtained under false pretenses.<sup>76</sup> As a result, AHCA lost \$13,449,595.12 related to 42 cases that have been or will be closed at zero overpayment due to the court ruling.<sup>77</sup>

Federal regulations require AHCA to have a post-payment review process for all Medicaid services.<sup>78</sup> State plans are also required, pursuant to Federal regulations, to have processes relating to identification, investigation, and referral of suspected fraud and abuse cases, which includes the requirement to have a post-payment review process.<sup>79</sup>

### Effect of the Bill

According to AHCA, the directive in s. 409.905(5)(a), F.S., to discontinue an inpatient retrospective review program was intended to refer to a specific program conducted in the Division of Medicaid when the Division shifted to a prior authorization review.<sup>80</sup> The bill removes obsolete language and adds language to clarify that AHCA may conduct reviews to determine fraud, abuse and overpayment in the Medicaid program. As a result, MPI would be able continue conducting retrospective reviews of hospital claims.

<sup>74</sup> Id.

<sup>75</sup> Ch. 2009-223 Laws of Fla.

<sup>76</sup> *Lee Mem'l Health Sys. Gulf Coast Med. Ctr. v. State of Fla., Agency for Health Care Admin.*, 272 So.3d 431 (Fla. 1st DCA 2019).

<sup>77</sup> Supra FN 9.

<sup>78</sup> 42 C.F.R. § 456.23.

<sup>79</sup> 42 C.F.R. § 455.12.

<sup>80</sup> Supra FN 9.

## Medicaid Program Integrity Legal Fees

### Current Situation

Current law authorizes AHCA to recover legal costs if they prevail in an overpayment case, but does not specifically reference costs for outside legal counsel. However, in 2019, the Division of Administrative Hearings (DOAH) ruled that s. 409.913(23)(a), F.S., does not authorize AHCA to recover full attorney's fees on MPI legal cases involving outside counsel.<sup>81</sup>

### Effect of the Bill

The bill amends s. 409.913(23)(a), F.S., to provide legal authority for AHCA to collect all legal fees incurred while defending a case if AHCA prevails, including the cost of outside counsel.

## Statewide Medicaid Managed Care Plan

### Current Situation

Section 409.967, F.S., requires AHCA to establish a 5-year contract with each managed care plan selected during the procurement process.

Section 409.973, F.S., requires AHCA to establish 5-year contracts with managed care plans in the prepaid dental health program during the procurement process.

### Effect of the Bill

The bill requires AHCA to re-procure contracts with managed care plans in the Statewide Medicaid Managed Care program and the prepaid dental health program every 6 years instead of every 5 years, beginning with the contract procurement process initiated during the 2023 calendar year. The bill requires AHCA to extend the term of existing plan contracts for the prepaid dental health program until December 31, 2024.

Except for the bill's amendments to s. 409.905, F.S., which take effect upon becoming law, the bill provides an effective date of July 1, 2020. Section 409.905, F.S., allows AHCA to continue conducting retrospective reviews of hospital claims.

## B. SECTION DIRECTORY:

**Section 1:** Amends s. 383.327, F.S., relating to birth and death records; reports.

**Section 2:** Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.

**Section 3:** Repeals s. 395.7015, F.S., relating to annual assessment on health care entities.

**Section 4:** Amends s. 395.7016, F.S., relating to annual appropriation.

**Section 5:** Amends s. 400.19, F.S., relating to right of entry and inspection.

**Section 6:** Amends s. 400.462, F.S., relating to definitions.

**Section 7:** Amends s. 400.464, F.S. relating to home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.

**Section 8:** Amends s. 400.471, F.S., relating to application for license; fee.

**Section 9:** Amends s. 400.492, F.S., relating to provision of services during an emergency.

**Section 10:** Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; penalties.

**Section 11:** Amends s. 400.509, F.S., relating to registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.

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<sup>81</sup> State of Florida, Division of Administrative Hearings, Case No. 18-5986F, June 12, 2019, the case had an overpayment of \$637,973.10 and a sanction of \$127,594.62 and AHCA was seeking fees and costs of \$330,186.14, but DOAH ruled that AHCA has the ability to collect the "costs" but not the "fees".

- Section 12:** Amends s. 400.605, F.S., relating to administration; forms; fees; rules; inspections; fines.
- Section 13:** Amends s. 400.60501, F.S., relating to outcome measures; adoption of federal quality measures; public reporting.
- Section 14:** Amends s. 400.9905, F.S., relating to definitions.
- Section 15:** Amends s. 400.991, F.S., relating to licensure requirements; background screenings; prohibitions.
- Section 16:** Amends s. 400.9935, F.S., relating to clinic responsibilities.
- Section 17:** Amends s. 408.033, F.S., relating to local and state health planning.
- Section 18:** Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
- Section 19:** Amends s. 408.0611, F.S., relating to electronic prescribing clearinghouse.
- Section 20:** Amends s. 408.062, F.S., relating to research, analyses, studies, and reports.
- Section 21:** Amends s. 408.063, F.S., relating to dissemination of health care information.
- Section 22:** Amends s. 408.802, F.S., relating to applicability.
- Section 23:** Amends s. 408.803, F.S., relating to definitions.
- Section 24:** Amends s. 408.806, F.S., relating to license application process.
- Section 25:** Amends s. 408.808, F.S., relating to license categories.
- Section 26:** Amends s. 408.809, F.S., relating to background screening; prohibited offenses.
- Section 27:** Amends s. 408.811, F.S., relating to right of inspection; copies; inspection reports; plan for correction of deficiencies.
- Section 28:** Amends s. 408.820, F.S., relating to exemptions.
- Section 29:** Amends s. 408.821, F.S., relating to emergency management planning; emergency operations; inactive license.
- Section 30:** Amends s. 408.831, F.S., relating to denial, suspension, or revocation of a license, registration, certificate, or application.
- Section 31:** Amends s. 408.832, F.S., relating to conflicts.
- Section 32:** Amends s. 408.909, F.S., relating to health flex plans.
- Section 33:** Amends s. 408.9091, F.S., relating to Cover Florida Health Care Access Program.
- Section 34:** Amends s. 409.905, F.S., relating to mandatory Medicaid services.
- Section 35:** It is the intent of the Legislature that s. 409.905(5)(a), F.S., as amended by this act, confirm and clarify existing law.
- Section 36:** Amend s. 409.907, F.S., relating to Medicaid provider agreements.
- Section 37:** Amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program.
- Section 38:** Amends s. 409.967, F.S., relating to managed care plan accountability.
- Section 39:** Amends s. 409.973, F.S., relating to provision of dental services.
- Section 40:** Amends s. 429.11, F.S., relating to initial application for license; provisional license.
- Section 41:** Amends s. 429.19, F.S., relating to violations; imposition of administrative fines; grounds.
- Section 42:** Amends s. 429.35, F.S., relating to maintenance of records; reports.
- Section 43:** Amends s. 429.905, F.S., relating to exemptions; monitoring of adult day care center programs collocated with assisted living facilities or licensed nursing home facilities.
- Section 44:** Amends s. 429.929, F.S., relating to rules establishing standards.
- Section 45:** Repeals part I of chapter 483, F.S., relating to multiphasic health testing centers.
- Section 46:** Provides an effective date of July 1, 2020, except as otherwise expressly provided in this act.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

(See fiscal comments)

#### 2. Expenditures:

(See fiscal comments)

## B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

### 1. Revenues:

None.

### 2. Expenditures:

None.

## C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill repeals licensure for multiphasic health testing center. Currently there are 187 licensed multiphasic health testing centers. As a result, multiphasic health testing centers will no longer be required to pay the biennial license renewal fee of \$952.64.

The bill exempts from health care clinic licensure, community mental health partial-hospitalization programs, and portable x-ray providers, and rural health care clinics. These providers will no longer be required to pay the \$2,000 biennial license renewal fee. AHCA estimates that approximately 200 providers would qualify for the exemption.<sup>82</sup>

The bill also exempts Medicaid providers, including behavior analysis providers, from health care clinic licensure. These providers are not currently required to be licensed, but licensure will be required effective July 1, 2020.<sup>83</sup> AHCA expects 28,291 providers to qualify for the exemption.<sup>84</sup> Providers who qualify for the exemption would not have to pay the \$2,000 initial licensure fee.

## D. FISCAL COMMENTS:

AHCA estimates a loss in annual revenue of \$489,071.84, and a commensurate workload reduction, resulting from the repeal of multiphasic health testing center licensure (\$89,071.84) and the new exemptions from health care clinic licensure for community mental health partial-hospitalization programs, portable x-ray providers, and rural health care clinics (\$400,000).

Exempting low-risk Medicaid providers from health care clinic licensure will result in a cost avoidance to AHCA. AHCA previously asked for 13 full-time equivalent (FTE) positions in a legislative budget request to process the approximately 28,000 anticipated applications that will be submitted by July 1, 2020.<sup>85</sup> The House proposed budget for FY 2020-21 re-classes 8 FTEs from administrative staff to registered nurse consultants, and allocates 14 OPS positions to address workload issues, which may include the impacts of this bill.<sup>86</sup>

AHCA lost approximately \$13.5 million in revenue related to 42 cases that have been or will be closed at zero overpayment due to the court ruling on retrospective hospital audits.<sup>87</sup> The MPI retrospective alien audit case was an isolated example; however, according to AHCA, the bill could protect the Agency from not being able to recoup significant amounts of revenue in the future.<sup>88</sup>

The bill provides authority for AHCA to collect all legal fees incurred while defending a Medicaid Program integrity case if AHCA prevails, including the cost of outside counsel. AHCA's tracking system for Medicaid recovery amounts does not distinguish legal fees, so they are unable to determine the

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<sup>82</sup> Supra FN 9.

<sup>83</sup> Florida Medicaid, Provider Enrollment Policy, at pg. 86, available at [https://ahca.myflorida.com/medicaid/review/Rules\\_in\\_Process/Proposed/59G-1.060\\_Enrollment\\_ProposedRule.pdf](https://ahca.myflorida.com/medicaid/review/Rules_in_Process/Proposed/59G-1.060_Enrollment_ProposedRule.pdf) (last accessed January 31, 2020).

<sup>84</sup> Supra FN 9.

<sup>85</sup> Id.

<sup>86</sup> HB 5001, specific appropriations 229 and 230.

<sup>87</sup> Id.

<sup>88</sup> Id.

future impact of the proposed change; however, AHCA has incurred over \$300,000 in legal fees for a single case.

The net fiscal impact of other licensure changes is indeterminate. However, the fiscal impact is expected to be minimal because any loss in revenue will likely be offset by gains in savings and workload reductions. Specifically, the loss of revenue from licensure repeals and exemptions coupled with the potential saving in funds recouped from Medicaid overpayments and attorney fees.

### **III. COMMENTS**

#### **A. CONSTITUTIONAL ISSUES:**

##### **1. Applicability of Municipality/County Mandates Provision:**

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

##### **2. Other:**

None.

#### **B. RULE-MAKING AUTHORITY:**

The bill provides sufficient rule-making to AHCA to implement the provisions in the bill.

#### **C. DRAFTING ISSUES OR OTHER COMMENTS:**

None.

### **IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

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

- Restructures fines for nursing homes that requires additional inspections due to poor performance;
- Redefines "home health agency" to eliminate a requirement to provide staffing services;
- Replaces "organization" with "entity or person" throughout the home health agency act;
- Retains definition of chief financial officer in the Health Care Clinic Act;
- Defines the "low-risk provider" for purposes inspection waivers or delays under the bill;
- Removes outdated language and dates from background screening statutes;
- Provides legislative intent that bill language related to retrospective reviews of Medicaid hospital billing confirm and clarify existing law; and
- Expands background screening requirements for Medicaid providers; requires screening for any person with direct access to recipient financial, medical or service records.

The analysis is drafted to the committee substitute as passed by the health market reform subcommittee.

1                   A bill to be entitled  
2           An act relating to the Agency for Health Care  
3           Administration; amending s. 383.327, F.S.; requiring  
4           birth centers to report certain deaths and stillbirths  
5           to the Agency for Health Care Administration; removing  
6           a requirement that a certain report be submitted  
7           annually to the agency; authorizing the agency to  
8           prescribe by rule the frequency at which such report  
9           is submitted; amending s. 395.003, F.S.; removing a  
10          requirement that specified information be listed on  
11          licenses for certain facilities; repealing s.  
12          395.7015, F.S., relating to an annual assessment on  
13          health care entities; amending s. 395.7016, F.S.;  
14          conforming a provision to changes made by the act;  
15          amending s. 400.19, F.S.; revising provisions  
16          requiring the agency to conduct licensure inspections  
17          of nursing homes; requiring the agency to conduct  
18          additional licensure surveys under certain  
19          circumstances; revising a provision requiring the  
20          agency to assess a specified fine for such surveys;  
21          amending s. 400.462, F.S.; revising definitions;  
22          amending ss. 400.464, 400.471, 400.492, 400.506, and  
23          400.509, F.S.; revising provisions relating to  
24          licensure requirements for home health agencies to  
25          conform to changes made by the act; exempting certain

26 persons and entities from such licensure requirements;  
27 amending s. 400.605, F.S.; removing a requirement that  
28 the agency conduct specified inspections of certain  
29 licensees; amending s. 400.60501, F.S.; removing an  
30 obsolete date and a requirement that the agency  
31 develop a specified annual report; amending s.  
32 400.9905, F.S.; revising the definition of the term  
33 "clinic"; amending s. 400.991, F.S.; conforming  
34 provisions to changes made by the act; removing the  
35 option for health care clinics to file a surety bond  
36 under certain circumstances; amending s. 400.9935,  
37 F.S.; requiring certain clinics to publish and post a  
38 schedule of charges; amending s. 408.033, F.S.;  
39 conforming a provision to changes made by the act;  
40 amending s. 408.061, F.S.; revising provisions  
41 requiring health care facilities to submit specified  
42 data to the agency; amending s. 408.0611, F.S.;  
43 requiring the agency to annually publish a report on  
44 the progress of implementation of electronic  
45 prescribing on its Internet website; amending s.  
46 408.062, F.S.; requiring the agency to annually  
47 publish certain information on its Internet website;  
48 removing a requirement that the agency submit certain  
49 annual reports to the Governor and Legislature;  
50 amending s. 408.063, F.S.; removing a requirement that

51 the agency annually publish certain reports; amending  
52 ss. 408.802, 408.820, 408.831, and 408.832, F.S.;  
53 conforming provisions to changes made by the act;  
54 amending s. 408.803, F.S.; conforming a provision to  
55 changes made by the act; providing a definition of the  
56 term "low-risk provider"; amending s. 408.806, F.S.;  
57 exempting certain low-risk providers from a specified  
58 inspection; amending s. 408.808, F.S.; authorizing the  
59 issuance of a provisional license to certain  
60 applicants; amending s. 408.809, F.S.; revising  
61 provisions relating to background screening  
62 requirements for certain licensure applicants;  
63 removing an obsolete date and provisions relating to  
64 certain rescreening requirements; amending s. 408.811,  
65 F.S.; authorizing the agency to exempt certain low-  
66 risk providers from inspections and conduct  
67 unannounced licensure inspections of such providers  
68 under certain circumstances; authorizing the agency to  
69 adopt rules to waive routine inspections and grant  
70 extended time periods between relicensure inspections  
71 under certain conditions; amending s. 408.821, F.S.;  
72 revising provisions requiring licensees to have a  
73 specified plan; providing requirements for the  
74 submission of such plan; amending s. 408.909, F.S.;  
75 removing a requirement that the agency and Office of



76 Insurance Regulation evaluate a specified program;  
77 amending s. 408.9091, F.S.; removing a requirement  
78 that the agency and office jointly submit a specified  
79 annual report to the Governor and Legislature;  
80 amending s. 409.905, F.S.; providing construction for  
81 a provision that requires the agency to discontinue  
82 its hospital retrospective review program under  
83 certain circumstances; providing legislative intent;  
84 amending s. 409.907, F.S.; requiring that a specified  
85 background screening be conducted through the agency  
86 on certain persons and entities; amending s. 409.913,  
87 F.S.; revising a requirement that the agency and the  
88 Medicaid Fraud Control Unit of the Department of Legal  
89 Affairs submit a specified report to the Legislature;  
90 authorizing the agency to recover specified costs  
91 associated with an audit, investigation, or  
92 enforcement action relating to provider fraud under  
93 the Medicaid program; amending ss. 409.967 and  
94 409.973, F.S.; revising the length of managed care  
95 plan and Medicaid prepaid dental health program  
96 contracts, respectively, procured by the agency  
97 beginning during a specified timeframe; requiring the  
98 agency to extend the term of certain existing  
99 contracts until a specified date; amending s. 429.11,  
100 F.S.; removing an authorization for the issuance of a

101 provisional license to certain facilities; amending s.  
 102 429.19, F.S.; removing requirements that the agency  
 103 develop and disseminate a specified list and the  
 104 Department of Children and Families disseminate such  
 105 list to certain providers; amending ss. 429.35,  
 106 429.905, and 429.929, F.S.; revising provisions  
 107 requiring a biennial inspection cycle for specified  
 108 facilities and centers, respectively; repealing part I  
 109 of chapter 483, F.S., relating to The Florida  
 110 Multiphasic Health Testing Center Law; providing  
 111 effective dates.

112

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

114

115 Section 1. Subsections (2) and (4) of section 383.327,  
 116 Florida Statutes, are amended to read:

117 383.327 Birth and death records; reports.—

118 (2) Each maternal death, newborn death, and stillbirth  
 119 shall be reported immediately to the medical examiner and the  
 120 agency.

121 (4) A report shall be submitted ~~annually~~ to the agency.  
 122 The contents of the report and the frequency at which it is  
 123 submitted shall be prescribed by rule of the agency.

124 Section 2. Subsection (4) of section 395.003, Florida  
 125 Statutes, is amended to read:

126           395.003 Licensure; denial, suspension, and revocation.—  
 127           (4) The agency shall issue a license that ~~which~~ specifies  
 128 the service categories and the number of hospital beds in each  
 129 bed category for which a license is received. Such information  
 130 shall be listed on the face of the license. ~~All beds which are~~  
 131 ~~not covered by any specialty-bed-need methodology shall be~~  
 132 ~~specified as general beds.~~ A licensed facility shall not operate  
 133 a number of hospital beds greater than the number indicated by  
 134 the agency on the face of the license without approval from the  
 135 agency under conditions established by rule.

136           Section 3. Section 395.7015, Florida Statutes, is  
 137 repealed.

138           Section 4. Section 395.7016, Florida Statutes, is amended  
 139 to read:

140           395.7016 Annual appropriation.—The Legislature shall  
 141 appropriate each fiscal year from either the General Revenue  
 142 Fund or the Agency for Health Care Administration Tobacco  
 143 Settlement Trust Fund an amount sufficient to replace the funds  
 144 lost due to ~~reduction by chapter 2000-256, Laws of Florida, of~~  
 145 ~~the assessment on other health care entities under s. 395.7015,~~  
 146 ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the  
 147 assessment on hospitals under s. 395.701~~7~~ and to maintain  
 148 federal approval of the reduced amount of funds deposited into  
 149 the Public Medical Assistance Trust Fund under s. 395.701~~7~~ as  
 150 state match for the state's Medicaid program.

151 Section 5. Subsection (3) of section 400.19, Florida  
152 Statutes, is amended to read:  
153 400.19 Right of entry and inspection.—  
154 (3) The agency shall conduct periodic, ~~every 15 months~~  
155 ~~conduct at least one~~ unannounced licensure inspections  
156 ~~inspection~~ to determine compliance by the licensee with  
157 statutes, and with rules adopted ~~promulgated~~ under the  
158 ~~provisions of~~ those statutes, governing minimum standards of  
159 construction, quality and adequacy of care, and rights of  
160 residents. ~~The survey shall be conducted every 6 months for the~~  
161 ~~next 2-year period~~ If the facility has been cited for a class I  
162 deficiency ~~or,~~ has been cited for two or more class II  
163 deficiencies arising from separate surveys or investigations  
164 within a 60-day period, the agency shall conduct an additional  
165 licensure survey ~~or has had three or more substantiated~~  
166 ~~complaints within a 6-month period, each resulting in at least~~  
167 ~~one class I or class II deficiency.~~ In addition to any other  
168 fees or fines in this part, the agency shall assess a fine for  
169 each facility that is subject to the additional licensure survey  
170 ~~6-month survey cycle.~~ The fine for the additional licensure  
171 survey 2-year period shall be \$3,000 ~~\$6,000, one-half to be paid~~  
172 ~~at the completion of each survey.~~ The agency may adjust such  
173 ~~this~~ fine by the change in the Consumer Price Index, based on  
174 the 12 months immediately preceding the increase, to cover the  
175 cost of the additional surveys. The agency shall verify through

176 subsequent inspection that any deficiency identified during  
 177 inspection is corrected. However, the agency may verify the  
 178 correction of a class III or class IV deficiency unrelated to  
 179 resident rights or resident care without reinspecting the  
 180 facility if adequate written documentation has been received  
 181 from the facility, which provides assurance that the deficiency  
 182 has been corrected. The giving or causing to be given of advance  
 183 notice of such unannounced inspections by an employee of the  
 184 agency to any unauthorized person shall constitute cause for  
 185 suspension of not fewer than 5 working days according to ~~the~~  
 186 ~~provisions of~~ chapter 110.

187 Section 6. Subsections (23) through (30) of section  
 188 400.462, Florida Statutes, are renumbered as subsections (22)  
 189 through (29), respectively, and subsections (12), (14), (17),  
 190 and (21) and present subsection (22) of that section are amended  
 191 to read:

192 400.462 Definitions.—As used in this part, the term:

193 (12) "Home health agency" means a person or entity ~~an~~  
 194 ~~organization~~ that provides one or more home health services ~~and~~  
 195 ~~staffing services~~.

196 (14) "Home health services" means health and medical  
 197 services and medical supplies furnished ~~by an organization~~ to an  
 198 individual in the individual's home or place of residence. The  
 199 term includes ~~organizations that provide one or more of the~~  
 200 following:

- 201 (a) Nursing care.
- 202 (b) Physical, occupational, respiratory, or speech  
203 therapy.
- 204 (c) Home health aide services.
- 205 (d) Dietetics and nutrition practice and nutrition  
206 counseling.
- 207 (e) Medical supplies, restricted to drugs and biologicals  
208 prescribed by a physician.
- 209 (17) "Home infusion therapy provider" means a person or  
210 entity ~~an organization~~ that employs, contracts with, or refers a  
211 licensed professional who has received advanced training and  
212 experience in intravenous infusion therapy and who administers  
213 infusion therapy to a patient in the patient's home or place of  
214 residence.
- 215 (21) "Nurse registry" means a ~~any~~ person or entity that  
216 procures, offers, promises, or attempts to secure health-care-  
217 related contracts for registered nurses, licensed practical  
218 nurses, certified nursing assistants, home health aides,  
219 companions, or homemakers, who are compensated by fees as  
220 independent contractors, including, but not limited to,  
221 contracts for the provision of services to patients and  
222 contracts to provide private duty or staffing services to health  
223 care facilities licensed under chapter 395, this chapter, or  
224 chapter 429 or other business entities.

225 ~~(22) "Organization" means a corporation, government or~~  
 226 ~~governmental subdivision or agency, partnership or association,~~  
 227 ~~or any other legal or commercial entity, any of which involve~~  
 228 ~~more than one health care professional discipline; a health care~~  
 229 ~~professional and a home health aide or certified nursing~~  
 230 ~~assistant; more than one home health aide; more than one~~  
 231 ~~certified nursing assistant; or a home health aide and a~~  
 232 ~~certified nursing assistant. The term does not include an entity~~  
 233 ~~that provides services using only volunteers or only individuals~~  
 234 ~~related by blood or marriage to the patient or client.~~

235 Section 7. Subsections (1), (4), and (5) of section  
 236 400.464, Florida Statutes, are amended to read:

237 400.464 Home health agencies to be licensed; expiration of  
 238 license; exemptions; unlawful acts; penalties.—

239 (1) The requirements of part II of chapter 408 apply to  
 240 the provision of services that require licensure pursuant to  
 241 this part and part II of chapter 408 and persons or entities  
 242 licensed or registered by or applying for such licensure or  
 243 registration from the Agency for Health Care Administration  
 244 pursuant to this part. A license or registration issued by the  
 245 agency is required in order to operate a home health agency in  
 246 this state. A license or registration issued on or after July 1,  
 247 2018, must specify the home health services the licensee or  
 248 registrant ~~organization~~ is authorized to perform and indicate  
 249 whether such specified services are considered skilled care. The

250 provision or advertising of services that require licensure or  
251 registration pursuant to this part without such services being  
252 specified on the face of the license or registration issued on  
253 or after July 1, 2018, constitutes unlicensed activity as  
254 prohibited under s. 408.812.

255 (4) (a) A licensee or registrant ~~An organization~~ that  
256 offers or advertises to the public any service for which  
257 licensure or registration is required under this part must  
258 include in the advertisement the license number or registration  
259 number issued to the licensee or registrant ~~organization~~ by the  
260 agency. The agency shall assess a fine of not less than \$100 to  
261 any licensee or registrant that ~~who~~ fails to include the license  
262 or registration number when submitting the advertisement for  
263 publication, broadcast, or printing. The fine for a second or  
264 subsequent offense is \$500. The holder of a license or  
265 registration issued under this part may not advertise or  
266 indicate to the public that it holds a home health agency or  
267 nurse registry license or registration other than the one it has  
268 been issued.

269 (b) The operation or maintenance of an unlicensed home  
270 health agency or the performance of any home health services in  
271 violation of this part is declared a nuisance, inimical to the  
272 public health, welfare, and safety. The agency or any state  
273 attorney may, in addition to other remedies provided in this  
274 part, bring an action for an injunction to restrain such



275 violation, or to enjoin the future operation or maintenance of  
276 the home health agency or the provision of home health services  
277 in violation of this part or part II of chapter 408, until  
278 compliance with this part or the rules adopted under this part  
279 has been demonstrated to the satisfaction of the agency.

280 (c) A person or entity that ~~who~~ violates paragraph (a) is  
281 subject to an injunctive proceeding under s. 408.816. A  
282 violation of paragraph (a) or s. 408.812 is a deceptive and  
283 unfair trade practice and constitutes a violation of the Florida  
284 Deceptive and Unfair Trade Practices Act under part II of  
285 chapter 501.

286 (d) A person or entity that ~~who~~ violates ~~the provisions of~~  
287 paragraph (a) commits a misdemeanor of the second degree,  
288 punishable as provided in s. 775.082 or s. 775.083. Any person  
289 or entity that ~~who~~ commits a second or subsequent violation  
290 commits a misdemeanor of the first degree, punishable as  
291 provided in s. 775.082 or s. 775.083. Each day of continuing  
292 violation constitutes a separate offense.

293 (e) ~~A~~ Any person or entity that ~~who~~ owns, operates, or  
294 maintains an unlicensed home health agency and ~~who~~, after  
295 receiving notification from the agency, fails to cease operation  
296 and apply for a license under this part commits a misdemeanor of  
297 the second degree, punishable as provided in s. 775.082 or s.  
298 775.083. Each day of continued operation is a separate offense.

299 (f) A ~~Any~~ home health agency that fails to cease operation  
 300 after agency notification may be fined in accordance with s.  
 301 408.812.

302 (5) The following are exempt from ~~the~~ licensure as a home  
 303 health agency under ~~requirements of~~ this part:

304 (a) A home health agency operated by the Federal  
 305 Government.

306 (b) Home health services provided by a state agency,  
 307 either directly or through a contractor with:

308 1. The Department of Elderly Affairs.

309 2. The Department of Health, a community health center, or  
 310 a rural health network that furnishes home visits for the  
 311 purpose of providing environmental assessments, case management,  
 312 health education, personal care services, family planning, or  
 313 followup treatment, or for the purpose of monitoring and  
 314 tracking disease.

315 3. Services provided to persons with developmental  
 316 disabilities, as defined in s. 393.063.

317 4. Companion and sitter organizations that were registered  
 318 under s. 400.509(1) on January 1, 1999, and were authorized to  
 319 provide personal services under a developmental services  
 320 provider certificate on January 1, 1999, may continue to provide  
 321 such services to past, present, and future clients of the  
 322 organization who need such services, notwithstanding ~~the~~  
 323 ~~provisions of~~ this act.

324 5. The Department of Children and Families.

325 (c) A health care professional, whether or not  
326 incorporated, who is licensed under chapter 457; chapter 458;  
327 chapter 459; part I of chapter 464; chapter 467; part I, part  
328 III, part V, or part X of chapter 468; chapter 480; chapter 486;  
329 chapter 490; or chapter 491; and who is acting alone within the  
330 scope of his or her professional license to provide care to  
331 patients in their homes.

332 (d) A home health aide or certified nursing assistant who  
333 is acting in his or her individual capacity, within the  
334 definitions and standards of his or her occupation, and who  
335 provides hands-on care to patients in their homes.

336 (e) An individual who acts alone, in his or her individual  
337 capacity, and who is not employed by or affiliated with a  
338 licensed home health agency or registered with a licensed nurse  
339 registry. This exemption does not entitle an individual to  
340 perform home health services without the required professional  
341 license.

342 (f) The delivery of instructional services in home  
343 dialysis and home dialysis supplies and equipment.

344 (g) The delivery of nursing home services for which the  
345 nursing home is licensed under part II of this chapter, to serve  
346 its residents in its facility.

347 (h) The delivery of assisted living facility services for  
348 which the assisted living facility is licensed under part I of  
349 chapter 429, to serve its residents in its facility.

350 (i) The delivery of hospice services for which the hospice  
351 is licensed under part IV of this chapter, to serve hospice  
352 patients admitted to its service.

353 (j) A hospital that provides services for which it is  
354 licensed under chapter 395.

355 (k) The delivery of community residential services for  
356 which the community residential home is licensed under chapter  
357 419, to serve the residents in its facility.

358 (l) A not-for-profit, community-based agency that provides  
359 early intervention services to infants and toddlers.

360 (m) Certified rehabilitation agencies and comprehensive  
361 outpatient rehabilitation facilities that are certified under  
362 Title 18 of the Social Security Act.

363 (n) The delivery of adult family-care home services for  
364 which the adult family-care home is licensed under part II of  
365 chapter 429, to serve the residents in its facility.

366 (o) A person or entity that provides skilled care by  
367 health care professionals licensed solely under part I of  
368 chapter 464; part I, part III, or part V of chapter 468; or  
369 chapter 486.

370       (p) A person or entity that provides services using only  
371 volunteers or individuals related by blood or marriage to the  
372 patient or client.

373       Section 8. Paragraph (g) of subsection (2) of section  
374 400.471, Florida Statutes, is amended to read:

375       400.471 Application for license; fee.—

376       (2) In addition to the requirements of part II of chapter  
377 408, the initial applicant, the applicant for a change of  
378 ownership, and the applicant for the addition of skilled care  
379 services must file with the application satisfactory proof that  
380 the home health agency is in compliance with this part and  
381 applicable rules, including:

382       (g) In the case of an application for initial licensure,  
383 an application for a change of ownership, or an application for  
384 the addition of skilled care services, documentation of  
385 accreditation, or an application for accreditation, from an  
386 accrediting organization that is recognized by the agency as  
387 having standards comparable to those required by this part and  
388 part II of chapter 408. A home health agency that does not  
389 provide skilled care is exempt from this paragraph.

390 Notwithstanding s. 408.806, the ~~an initial~~ applicant must  
391 provide proof of accreditation that is not conditional or  
392 provisional and a survey demonstrating compliance with the  
393 requirements of this part, part II of chapter 408, and  
394 applicable rules from an accrediting organization that is

395 recognized by the agency as having standards comparable to those  
396 required by this part and part II of chapter 408 within 120 days  
397 after the date of the agency's receipt of the application for  
398 licensure. Such accreditation must be continuously maintained by  
399 the home health agency to maintain licensure. The agency shall  
400 accept, in lieu of its own periodic licensure survey, the  
401 submission of the survey of an accrediting organization that is  
402 recognized by the agency if the accreditation of the licensed  
403 home health agency is not provisional and if the licensed home  
404 health agency authorizes release of, and the agency receives the  
405 report of, the accrediting organization.

406 Section 9. Section 400.492, Florida Statutes, is amended  
407 to read:

408 400.492 Provision of services during an emergency.—Each  
409 home health agency shall prepare and maintain a comprehensive  
410 emergency management plan that is consistent with the standards  
411 adopted by national or state accreditation organizations and  
412 consistent with the local special needs plan. The plan shall be  
413 updated annually and shall provide for continuing home health  
414 services during an emergency that interrupts patient care or  
415 services in the patient's home. The plan shall include the means  
416 by which the home health agency will continue to provide staff  
417 to perform the same type and quantity of services to their  
418 patients who evacuate to special needs shelters that were being  
419 provided to those patients prior to evacuation. The plan shall

420 describe how the home health agency establishes and maintains an  
421 effective response to emergencies and disasters, including:  
422 notifying staff when emergency response measures are initiated;  
423 providing for communication between staff members, county health  
424 departments, and local emergency management agencies, including  
425 a backup system; identifying resources necessary to continue  
426 essential care or services or referrals to other health care  
427 providers ~~organizations~~ subject to written agreement; and  
428 prioritizing and contacting patients who need continued care or  
429 services.

430 (1) Each patient record for patients who are listed in the  
431 registry established pursuant to s. 252.355 shall include a  
432 description of how care or services will be continued in the  
433 event of an emergency or disaster. The home health agency shall  
434 discuss the emergency provisions with the patient and the  
435 patient's caregivers, including where and how the patient is to  
436 evacuate, procedures for notifying the home health agency in the  
437 event that the patient evacuates to a location other than the  
438 shelter identified in the patient record, and a list of  
439 medications and equipment which must either accompany the  
440 patient or will be needed by the patient in the event of an  
441 evacuation.

442 (2) Each home health agency shall maintain a current  
443 prioritized list of patients who need continued services during  
444 an emergency. The list shall indicate how services shall be

445 continued in the event of an emergency or disaster for each  
446 patient and if the patient is to be transported to a special  
447 needs shelter, and shall indicate if the patient is receiving  
448 skilled nursing services and the patient's medication and  
449 equipment needs. The list shall be furnished to county health  
450 departments and to local emergency management agencies, upon  
451 request.

452 (3) Home health agencies shall not be required to continue  
453 to provide care to patients in emergency situations that are  
454 beyond their control and that make it impossible to provide  
455 services, such as when roads are impassable or when patients do  
456 not go to the location specified in their patient records. Home  
457 health agencies may establish links to local emergency  
458 operations centers to determine a mechanism by which to approach  
459 specific areas within a disaster area in order for the agency to  
460 reach its clients. Home health agencies shall demonstrate a good  
461 faith effort to comply with the requirements of this subsection  
462 by documenting attempts of staff to follow procedures outlined  
463 in the home health agency's comprehensive emergency management  
464 plan, and by the patient's record, which support a finding that  
465 the provision of continuing care has been attempted for those  
466 patients who have been identified as needing care by the home  
467 health agency and registered under s. 252.355, in the event of  
468 an emergency or disaster under subsection (1).



469 (4) Notwithstanding the provisions of s. 400.464(2) or any  
470 other provision of law to the contrary, a home health agency may  
471 provide services in a special needs shelter located in any  
472 county.

473 Section 10. Subsection (4) and paragraph (a) of subsection  
474 (5) of section 400.506, Florida Statutes, are amended to read:

475 400.506 Licensure of nurse registries; requirements;  
476 penalties.—

477 (4) A licensee ~~person~~ that provides, offers, or advertises  
478 to the public any service for which licensure is required under  
479 this section must include in such advertisement the license  
480 number issued to it by the Agency for Health Care  
481 Administration. The agency shall assess a fine of not less than  
482 \$100 against a ~~any~~ licensee that ~~who~~ fails to include the  
483 license number when submitting the advertisement for  
484 publication, broadcast, or printing. The fine for a second or  
485 subsequent offense is \$500.

486 (5) (a) In addition to the requirements of s. 408.812, a  
487 ~~any~~ person or entity that ~~who~~ owns, operates, or maintains an  
488 unlicensed nurse registry and ~~who~~, after receiving notification  
489 from the agency, fails to cease operation and apply for a  
490 license under this part commits a misdemeanor of the second  
491 degree, punishable as provided in s. 775.082 or s. 775.083. Each  
492 day of continued operation is a separate offense.

493 Section 11. Subsections (1), (2), (4), and (5) of section  
494 400.509, Florida Statutes, are amended to read:

495 400.509 Registration of particular service providers  
496 exempt from licensure; certificate of registration; regulation  
497 of registrants.—

498 (1) A person or entity ~~Any organization~~ that provides  
499 companion services or homemaker services and does not provide a  
500 home health service to a person is exempt from licensure under  
501 this part. However, a person or entity ~~any organization~~ that  
502 provides companion services or homemaker services must register  
503 with the agency. A person or entity ~~An organization~~ under  
504 contract with the Agency for Persons with Disabilities that  
505 ~~which~~ provides companion services only for persons with a  
506 developmental disability, as defined in s. 393.063, is exempt  
507 from registration.

508 (2) The requirements of part II of chapter 408 apply to  
509 the provision of services that require registration or licensure  
510 pursuant to this section and part II of chapter 408 and entities  
511 registered by or applying for such registration from the Agency  
512 for Health Care Administration pursuant to this section. Each  
513 applicant for registration and each registrant must comply with  
514 all provisions of part II of chapter 408. Registration or a  
515 license issued by the agency is required for the operation of a  
516 person or entity ~~an organization~~ that provides companion  
517 services or homemaker services.

518 (4) Each registrant must obtain the employment or contract  
519 history of persons who are employed by or under contract with  
520 the person or entity ~~organization~~ and who will have contact at  
521 any time with patients or clients in their homes by:

522 (a) Requiring such persons to submit an employment or  
523 contractual history to the registrant; and

524 (b) Verifying the employment or contractual history,  
525 unless through diligent efforts such verification is not  
526 possible. The agency shall prescribe by rule the minimum  
527 requirements for establishing that diligent efforts have been  
528 made.

529

530 There is no monetary liability on the part of, and no cause of  
531 action for damages arises against, a former employer of a  
532 prospective employee of or prospective independent contractor  
533 with a registrant who reasonably and in good faith communicates  
534 his or her honest opinions about the former employee's or  
535 contractor's job performance. This subsection does not affect  
536 the official immunity of an officer or employee of a public  
537 corporation.

538 (5) A person or entity that offers or advertises to the  
539 public a service for which registration is required must include  
540 in its advertisement the registration number issued by the  
541 Agency for Health Care Administration.

542 Section 12. Subsection (3) of section 400.605, Florida  
543 Statutes, is amended to read:

544 400.605 Administration; forms; fees; rules; inspections;  
545 fines.—

546 (3) In accordance with s. 408.811, the agency shall  
547 conduct ~~annual inspections of all licensees, except that~~  
548 ~~licensure inspections may be conducted biennially for hospices~~  
549 ~~having a 3-year record of substantial compliance. The agency~~  
550 ~~shall conduct~~ such inspections and investigations as are  
551 necessary in order to determine the state of compliance with ~~the~~  
552 ~~provisions of~~ this part, part II of chapter 408, and applicable  
553 rules.

554 Section 13. Section 400.60501, Florida Statutes, is  
555 amended to read:

556 400.60501 Outcome measures; adoption of federal quality  
557 measures; public reporting; ~~annual report.~~—

558 (1) ~~No later than December 31, 2019,~~ The agency shall  
559 adopt the national hospice outcome measures and survey data in  
560 42 C.F.R. part 418 to determine the quality and effectiveness of  
561 hospice care for hospices licensed in the state.

562 (2) The agency shall ~~+~~

563 ~~(a)~~ make available to the public the national hospice  
564 outcome measures and survey data in a format that is  
565 comprehensible by a layperson and that allows a consumer to  
566 compare such measures of one or more hospices.

567 ~~(b) Develop an annual report that analyzes and evaluates~~  
568 ~~the information collected under this act and any other data~~  
569 ~~collection or reporting provisions of law.~~

570 Section 14. Paragraphs (a), (b), (c), and (d) of  
571 subsection (4) of section 400.9905, Florida Statutes, are  
572 amended, and paragraphs (o), (p), and (q) are added to that  
573 subsection, to read:

574 400.9905 Definitions.—

575 (4) "Clinic" means an entity where health care services  
576 are provided to individuals and which tenders charges for  
577 reimbursement for such services, including a mobile clinic and a  
578 portable equipment provider. As used in this part, the term does  
579 not include and the licensure requirements of this part do not  
580 apply to:

581 (a) Entities licensed or registered by the state under  
582 chapter 395; entities licensed or registered by the state and  
583 providing only health care services within the scope of services  
584 authorized under their respective licenses under ss. 383.30-  
585 383.332, chapter 390, chapter 394, chapter 397, this chapter  
586 except part X, chapter 429, chapter 463, chapter 465, chapter  
587 466, chapter 478, chapter 484, or chapter 651; end-stage renal  
588 disease providers authorized under 42 C.F.R. part 494 ~~405,~~  
589 ~~subpart U~~; providers certified and providing only health care  
590 services within the scope of services authorized under their  
591 respective certifications under 42 C.F.R. part 485, subpart B,

592 ~~or~~ subpart H, or subpart J; providers certified and providing  
593 only health care services within the scope of services  
594 authorized under their respective certifications under 42 C.F.R.  
595 part 486, subpart C; providers certified and providing only  
596 health care services within the scope of services authorized  
597 under their respective certifications under 42 C.F.R. part 491,  
598 subpart A; providers certified by the Centers for Medicare and  
599 Medicaid services under the federal Clinical Laboratory  
600 Improvement Amendments and the federal rules adopted thereunder;  
601 or any entity that provides neonatal or pediatric hospital-based  
602 health care services or other health care services by licensed  
603 practitioners solely within a hospital licensed under chapter  
604 395.

605 (b) Entities that own, directly or indirectly, entities  
606 licensed or registered by the state pursuant to chapter 395;  
607 entities that own, directly or indirectly, entities licensed or  
608 registered by the state and providing only health care services  
609 within the scope of services authorized pursuant to their  
610 respective licenses under ss. 383.30-383.332, chapter 390,  
611 chapter 394, chapter 397, this chapter except part X, chapter  
612 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter  
613 484, or chapter 651; end-stage renal disease providers  
614 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers  
615 certified and providing only health care services within the  
616 scope of services authorized under their respective

617 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart  
618 H, or subpart J; providers certified and providing only health  
619 care services within the scope of services authorized under  
620 their respective certifications under 42 C.F.R. part 486,  
621 subpart C; providers certified and providing only health care  
622 services within the scope of services authorized under their  
623 respective certifications under 42 C.F.R. part 491, subpart A;  
624 providers certified by the Centers for Medicare and Medicaid  
625 services under the federal Clinical Laboratory Improvement  
626 Amendments and the federal rules adopted thereunder; or any  
627 entity that provides neonatal or pediatric hospital-based health  
628 care services by licensed practitioners solely within a hospital  
629 licensed under chapter 395.

630 (c) Entities that are owned, directly or indirectly, by an  
631 entity licensed or registered by the state pursuant to chapter  
632 395; entities that are owned, directly or indirectly, by an  
633 entity licensed or registered by the state and providing only  
634 health care services within the scope of services authorized  
635 pursuant to their respective licenses under ss. 383.30-383.332,  
636 chapter 390, chapter 394, chapter 397, this chapter except part  
637 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter  
638 478, chapter 484, or chapter 651; end-stage renal disease  
639 providers authorized under 42 C.F.R. part 494 ~~405, subpart U;~~  
640 providers certified and providing only health care services  
641 within the scope of services authorized under their respective

642 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart  
643 H, or subpart J; providers certified and providing only health  
644 care services within the scope of services authorized under  
645 their respective certifications under 42 C.F.R. part 486,  
646 subpart C; providers certified and providing only health care  
647 services within the scope of services authorized under their  
648 respective certifications under 42 C.F.R. part 491, subpart A;  
649 providers certified by the Centers for Medicare and Medicaid  
650 services under the federal Clinical Laboratory Improvement  
651 Amendments and the federal rules adopted thereunder; or any  
652 entity that provides neonatal or pediatric hospital-based health  
653 care services by licensed practitioners solely within a hospital  
654 under chapter 395.

655 (d) Entities that are under common ownership, directly or  
656 indirectly, with an entity licensed or registered by the state  
657 pursuant to chapter 395; entities that are under common  
658 ownership, directly or indirectly, with an entity licensed or  
659 registered by the state and providing only health care services  
660 within the scope of services authorized pursuant to their  
661 respective licenses under ss. 383.30-383.332, chapter 390,  
662 chapter 394, chapter 397, this chapter except part X, chapter  
663 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter  
664 484, or chapter 651; end-stage renal disease providers  
665 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers  
666 certified and providing only health care services within the



667 scope of services authorized under their respective  
668 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart  
669 H, or subpart J; providers certified and providing only health  
670 care services within the scope of services authorized under  
671 their respective certifications under 42 C.F.R. part 486,  
672 subpart C; providers certified and providing only health care  
673 services within the scope of services authorized under their  
674 respective certifications under 42 C.F.R. part 491, subpart A;  
675 providers certified by the Centers for Medicare and Medicaid  
676 services under the federal Clinical Laboratory Improvement  
677 Amendments and the federal rules adopted thereunder; or any  
678 entity that provides neonatal or pediatric hospital-based health  
679 care services by licensed practitioners solely within a hospital  
680 licensed under chapter 395.

681 (o) Entities that are, directly or indirectly, under the  
682 common ownership of or that are subject to common control by a  
683 mutual insurance holding company, as defined in s. 628.703, with  
684 an entity licensed or certified under chapter 627 or chapter 641  
685 which has \$1 billion or more in total annual sales in this  
686 state.

687 (p) Entities that are owned by an entity that is a  
688 behavioral health care service provider in at least five other  
689 states; that, together with its affiliates, have \$90 million or  
690 more in total annual revenues associated with the provision of  
691 behavioral health care services; and wherein one or more of the

692 persons responsible for the operations of the entity is a health  
 693 care practitioner who is licensed in this state, who is  
 694 responsible for supervising the business activities of the  
 695 entity, and who is responsible for the entity's compliance with  
 696 state law for purposes of this part.

697 (g) Medicaid providers.

698  
 699 Notwithstanding this subsection, an entity shall be deemed a  
 700 clinic and must be licensed under this part in order to receive  
 701 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.  
 702 627.730-627.7405, unless exempted under s. 627.736(5)(h).

703 Section 15. Paragraph (c) of subsection (3) of section  
 704 400.991, Florida Statutes, is amended to read:

705 400.991 License requirements; background screenings;  
 706 prohibitions.-

707 (3) In addition to the requirements of part II of chapter  
 708 408, the applicant must file with the application satisfactory  
 709 proof that the clinic is in compliance with this part and  
 710 applicable rules, including:

711 (c) Proof of financial ability to operate as required  
 712 under ss. 408.8065(1) and s. 408.810(8). ~~As an alternative to~~  
 713 ~~submitting proof of financial ability to operate as required~~  
 714 ~~under s. 408.810(8), the applicant may file a surety bond of at~~  
 715 ~~least \$500,000 which guarantees that the clinic will act in full~~  
 716 ~~conformity with all legal requirements for operating a clinic,~~

717 ~~payable to the agency. The agency may adopt rules to specify~~  
718 ~~related requirements for such surety bond.~~

719 Section 16. Paragraph (i) of subsection (1) of section  
720 400.9935, Florida Statutes, is amended to read:

721 400.9935 Clinic responsibilities.—

722 (1) Each clinic shall appoint a medical director or clinic  
723 director who shall agree in writing to accept legal  
724 responsibility for the following activities on behalf of the  
725 clinic. The medical director or the clinic director shall:

726 (i) Ensure that the clinic publishes a schedule of charges  
727 for the medical services offered to patients. The schedule must  
728 include the prices charged to an uninsured person paying for  
729 such services by cash, check, credit card, or debit card. The  
730 schedule may group services by price levels, listing services in  
731 each price level. The schedule must be posted in a conspicuous  
732 place in the reception area of any clinic that is considered an  
733 the urgent care center as defined in s. 395.002(29)(b) and must  
734 include, but is not limited to, the 50 services most frequently  
735 provided by the clinic. ~~The schedule may group services by three~~  
736 ~~price levels, listing services in each price level.~~ The posting  
737 may be a sign that must be at least 15 square feet in size or  
738 through an electronic messaging board that is at least 3 square  
739 feet in size. The failure of a clinic, including a clinic that  
740 is considered an urgent care center, to publish and post a  
741 schedule of charges as required by this section shall result in

742 a fine of not more than \$1,000, per day, until the schedule is  
 743 published and posted.

744 Section 17. Paragraph (a) of subsection (2) of section  
 745 408.033, Florida Statutes, is amended to read:

746 408.033 Local and state health planning.—

747 (2) FUNDING.—

748 (a) The Legislature intends that the cost of local health  
 749 councils be borne by assessments on selected health care  
 750 facilities subject to facility licensure by the Agency for  
 751 Health Care Administration, including abortion clinics, assisted  
 752 living facilities, ambulatory surgical centers, birth centers,  
 753 home health agencies, hospices, hospitals, intermediate care  
 754 facilities for the developmentally disabled, nursing homes, and  
 755 health care clinics, ~~and multiphasic testing centers~~ and by  
 756 assessments on organizations subject to certification by the  
 757 agency pursuant to chapter 641, part III, including health  
 758 maintenance organizations and prepaid health clinics. Fees  
 759 assessed may be collected prospectively at the time of licensure  
 760 renewal and prorated for the licensure period.

761 Section 18. Paragraph (a) of subsection (1) of section  
 762 408.061, Florida Statutes, is amended to read:

763 408.061 Data collection; uniform systems of financial  
 764 reporting; information relating to physician charges;  
 765 confidential information; immunity.—

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

776 (a) Data submitted by health care facilities, including  
777 the facilities as defined in chapter 395, shall include, but are  
778 not limited to, + case-mix data, patient admission and discharge  
779 data, hospital emergency department data which shall include the  
780 number of patients treated in the emergency department of a  
781 licensed hospital reported by patient acuity level, data on  
782 hospital-acquired infections as specified by rule, data on  
783 complications as specified by rule, data on readmissions as  
784 specified by rule, including patient- ~~with patient~~ and provider-  
785 specific identifiers ~~included~~, actual charge data by diagnostic  
786 groups or other bundled groupings as specified by rule,  
787 financial data, accounting data, operating expenses, expenses  
788 incurred for rendering services to patients who cannot or do not  
789 pay, interest charges, depreciation expenses based on the  
790 expected useful life of the property and equipment involved, and

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

805 Section 19. Subsection (4) of section 408.0611, Florida  
806 Statutes, is amended to read:

807 408.0611 Electronic prescribing clearinghouse.—

808 (4) Pursuant to s. 408.061, the agency shall monitor the  
809 implementation of electronic prescribing by health care  
810 practitioners, health care facilities, and pharmacies. ~~By~~  
811 ~~January 31 of each year,~~ The agency shall annually publish a  
812 report on the progress of implementation of electronic  
813 prescribing on its Internet website ~~to the Governor and the~~  
814 ~~Legislature.~~ Information reported pursuant to this subsection  
815 shall include federal and private sector electronic prescribing

816 initiatives and, to the extent that data is readily available  
817 from organizations that operate electronic prescribing networks,  
818 the number of health care practitioners using electronic  
819 prescribing and the number of prescriptions electronically  
820 transmitted.

821 Section 20. Paragraphs (i) and (j) of subsection (1) of  
822 section 408.062, Florida Statutes, are amended to read:

823 408.062 Research, analyses, studies, and reports.—

824 (1) The agency shall conduct research, analyses, and  
825 studies relating to health care costs and access to and quality  
826 of health care services as access and quality are affected by  
827 changes in health care costs. Such research, analyses, and  
828 studies shall include, but not be limited to:

829 (i) The use of emergency department services by patient  
830 acuity level ~~and the implication of increasing hospital cost by~~  
831 ~~providing nonurgent care in emergency departments.~~ The agency  
832 shall annually publish information ~~submit an annual report~~ based  
833 on this monitoring and assessment on its Internet website ~~to the~~  
834 ~~Governor, the Speaker of the House of Representatives, the~~  
835 ~~President of the Senate, and the substantive legislative~~  
836 ~~committees, due January 1.~~

837 (j) The making available on its Internet website, and in a  
838 hard-copy format upon request, of patient charge, volumes,  
839 length of stay, and performance indicators collected from health  
840 care facilities pursuant to s. 408.061(1)(a) for specific

841 | medical conditions, surgeries, and procedures provided in  
842 | inpatient and outpatient facilities as determined by the agency.  
843 | In making the determination of specific medical conditions,  
844 | surgeries, and procedures to include, the agency shall consider  
845 | such factors as volume, severity of the illness, urgency of  
846 | admission, individual and societal costs, and whether the  
847 | condition is acute or chronic. Performance outcome indicators  
848 | shall be risk adjusted or severity adjusted, as applicable,  
849 | using nationally recognized risk adjustment methodologies or  
850 | software consistent with the standards of the Agency for  
851 | Healthcare Research and Quality and as selected by the agency.  
852 | The website shall also provide an interactive search that allows  
853 | consumers to view and compare the information for specific  
854 | facilities, a map that allows consumers to select a county or  
855 | region, definitions of all of the data, descriptions of each  
856 | procedure, and an explanation about why the data may differ from  
857 | facility to facility. Such public data shall be updated  
858 | quarterly. The agency shall annually publish information  
859 | regarding ~~submit an annual status report on~~ the collection of  
860 | data and publication of health care quality measures on its  
861 | Internet website ~~to the Governor, the Speaker of the House of~~  
862 | ~~Representatives, the President of the Senate, and the~~  
863 | ~~substantive legislative committees, due January 1.~~

864 |         Section 21. Subsection (5) of section 408.063, Florida  
865 | Statutes, is amended to read:



866 408.063 Dissemination of health care information.—  
 867 ~~(5) The agency shall publish annually a comprehensive~~  
 868 ~~report of state health expenditures. The report shall identify:~~  
 869 ~~(a) The contribution of health care dollars made by all~~  
 870 ~~payors.~~  
 871 ~~(b) The dollars expended by type of health care service in~~  
 872 ~~Florida.~~  
 873 Section 22. Section 408.802, Florida Statutes, is amended  
 874 to read:  
 875 408.802 Applicability. ~~The provisions of~~ This part applies  
 876 apply to the provision of services that require licensure as  
 877 defined in this part and to the following entities licensed,  
 878 registered, or certified by the agency, as described in chapters  
 879 112, 383, 390, 394, 395, 400, 429, 440, ~~483~~, and 765:  
 880 (1) Laboratories authorized to perform testing under the  
 881 Drug-Free Workplace Act, as provided under ss. 112.0455 and  
 882 440.102.  
 883 (2) Birth centers, as provided under chapter 383.  
 884 (3) Abortion clinics, as provided under chapter 390.  
 885 (4) Crisis stabilization units, as provided under parts I  
 886 and IV of chapter 394.  
 887 (5) Short-term residential treatment facilities, as  
 888 provided under parts I and IV of chapter 394.  
 889 (6) Residential treatment facilities, as provided under  
 890 part IV of chapter 394.

- 891           (7) Residential treatment centers for children and  
 892 adolescents, as provided under part IV of chapter 394.
- 893           (8) Hospitals, as provided under part I of chapter 395.
- 894           (9) Ambulatory surgical centers, as provided under part I  
 895 of chapter 395.
- 896           (10) Nursing homes, as provided under part II of chapter  
 897 400.
- 898           (11) Assisted living facilities, as provided under part I  
 899 of chapter 429.
- 900           (12) Home health agencies, as provided under part III of  
 901 chapter 400.
- 902           (13) Nurse registries, as provided under part III of  
 903 chapter 400.
- 904           (14) Companion services or homemaker services providers,  
 905 as provided under part III of chapter 400.
- 906           (15) Adult day care centers, as provided under part III of  
 907 chapter 429.
- 908           (16) Hospices, as provided under part IV of chapter 400.
- 909           (17) Adult family-care homes, as provided under part II of  
 910 chapter 429.
- 911           (18) Homes for special services, as provided under part V  
 912 of chapter 400.
- 913           (19) Transitional living facilities, as provided under  
 914 part XI of chapter 400.

915 (20) Prescribed pediatric extended care centers, as  
 916 provided under part VI of chapter 400.

917 (21) Home medical equipment providers, as provided under  
 918 part VII of chapter 400.

919 (22) Intermediate care facilities for persons with  
 920 developmental disabilities, as provided under part VIII of  
 921 chapter 400.

922 (23) Health care services pools, as provided under part IX  
 923 of chapter 400.

924 (24) Health care clinics, as provided under part X of  
 925 chapter 400.

926 ~~(25) Multiphasic health testing centers, as provided under~~  
 927 ~~part I of chapter 483.~~

928 (25)~~(26)~~ Organ, tissue, and eye procurement organizations,  
 929 as provided under part V of chapter 765.

930 Section 23. Subsections (10) through (14) of section  
 931 408.803, Florida Statutes, are renumbered as subsections (11)  
 932 through (15), respectively, subsection (3) is amended, and a new  
 933 subsection (10) is added to that section, to read:

934 408.803 Definitions.—As used in this part, the term:

935 (3) "Authorizing statute" means the statute authorizing  
 936 the licensed operation of a provider listed in s. 408.802 and  
 937 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~  
 938 and 765.

939           (10) "Low-risk provider" means a nonresidential provider,  
940 including a nurse registry, a home medical equipment provider,  
941 or a health care clinic.

942           Section 24. Paragraph (b) of subsection (7) of section  
943 408.806, Florida Statutes, is amended to read:

944           408.806 License application process.—

945           (7)

946           (b) An initial inspection is not required for companion  
947 services or homemaker services providers~~7~~ as provided under part  
948 III of chapter 400, ~~or~~ for health care services pools~~7~~ as  
949 provided under part IX of chapter 400, or for low-risk providers  
950 as provided in s. 408.811(1)(c).

951           Section 25. Subsection (2) of section 408.808, Florida  
952 Statutes, is amended to read:

953           408.808 License categories.—

954           (2) PROVISIONAL LICENSE.—An applicant against whom a  
955 proceeding denying or revoking a license is pending at the time  
956 of license renewal may be issued a provisional license effective  
957 until final action not subject to further appeal. A provisional  
958 license may also be issued to an applicant making initial  
959 application for licensure or making application ~~applying~~ for a  
960 change of ownership. A provisional license must be limited in  
961 duration to a specific period of time, up to 12 months, as  
962 determined by the agency.

963 Section 26. Subsections (6) through (9) of section  
964 408.809, Florida Statutes, are renumbered as subsections (5)  
965 through (8), respectively, and subsections (2) and (4) and  
966 present subsection (5) of that section are amended to read:  
967 408.809 Background screening; prohibited offenses.—  
968 (2) Every 5 years following his or her licensure,  
969 employment, or entry into a contract in a capacity that under  
970 subsection (1) would require level 2 background screening under  
971 chapter 435, each such person must submit to level 2 background  
972 rescreening as a condition of retaining such license or  
973 continuing in such employment or contractual status. For any  
974 such rescreening, the agency shall request the Department of Law  
975 Enforcement to forward the person's fingerprints to the Federal  
976 Bureau of Investigation for a national criminal history record  
977 check unless the person's fingerprints are enrolled in the  
978 Federal Bureau of Investigation's national retained print arrest  
979 notification program. If the fingerprints of such a person are  
980 not retained by the Department of Law Enforcement under s.  
981 943.05(2)(g) and (h), the person must submit fingerprints  
982 electronically to the Department of Law Enforcement for state  
983 processing, and the Department of Law Enforcement shall forward  
984 the fingerprints to the Federal Bureau of Investigation for a  
985 national criminal history record check. The fingerprints shall  
986 be retained by the Department of Law Enforcement under s.  
987 943.05(2)(g) and (h) and enrolled in the national retained print

988 | arrest notification program when the Department of Law  
989 | Enforcement begins participation in the program. The cost of the  
990 | state and national criminal history records checks required by  
991 | level 2 screening may be borne by the licensee or the person  
992 | fingerprinted. ~~Until a specified agency is fully implemented in~~  
993 | ~~the clearinghouse created under s. 435.12,~~ The agency may accept  
994 | as satisfying the requirements of this section proof of  
995 | compliance with level 2 screening standards submitted within the  
996 | previous 5 years to meet any provider or professional licensure  
997 | requirements of ~~the agency, the Department of Health, the~~  
998 | ~~Department of Elderly Affairs, the Agency for Persons with~~  
999 | ~~Disabilities, the Department of Children and Families, or the~~  
1000 | Department of Financial Services for an applicant for a  
1001 | certificate of authority or provisional certificate of authority  
1002 | to operate a continuing care retirement community under chapter  
1003 | 651, provided that:

1004 |       (a) The screening standards and disqualifying offenses for  
1005 | the prior screening are equivalent to those specified in s.  
1006 | 435.04 and this section;

1007 |       (b) The person subject to screening has not had a break in  
1008 | service from a position that requires level 2 screening for more  
1009 | than 90 days; and

1010 |       (c) Such proof is accompanied, under penalty of perjury,  
1011 | by an attestation of compliance with chapter 435 and this  
1012 | section using forms provided by the agency.

1013 (4) In addition to the offenses listed in s. 435.04, all  
1014 persons required to undergo background screening pursuant to  
1015 this part or authorizing statutes must not have an arrest  
1016 awaiting final disposition for, must not have been found guilty  
1017 of, regardless of adjudication, or entered a plea of nolo  
1018 contendere or guilty to, and must not have been adjudicated  
1019 delinquent and the record not have been sealed or expunged for  
1020 any of the following offenses or any similar offense of another  
1021 jurisdiction:

1022 (a) Any authorizing statutes, if the offense was a felony.

1023 (b) This chapter, if the offense was a felony.

1024 (c) Section 409.920, relating to Medicaid provider fraud.

1025 (d) Section 409.9201, relating to Medicaid fraud.

1026 (e) Section 741.28, relating to domestic violence.

1027 (f) Section 777.04, relating to attempts, solicitation,  
1028 and conspiracy to commit an offense listed in this subsection.

1029 (g) Section 817.034, relating to fraudulent acts through  
1030 mail, wire, radio, electromagnetic, photoelectronic, or  
1031 photooptical systems.

1032 (h) Section 817.234, relating to false and fraudulent  
1033 insurance claims.

1034 (i) Section 817.481, relating to obtaining goods by using  
1035 a false or expired credit card or other credit device, if the  
1036 offense was a felony.

- 1037 (j) Section 817.50, relating to fraudulently obtaining  
 1038 goods or services from a health care provider.
- 1039 (k) Section 817.505, relating to patient brokering.
- 1040 (l) Section 817.568, relating to criminal use of personal  
 1041 identification information.
- 1042 (m) Section 817.60, relating to obtaining a credit card  
 1043 through fraudulent means.
- 1044 (n) Section 817.61, relating to fraudulent use of credit  
 1045 cards, if the offense was a felony.
- 1046 (o) Section 831.01, relating to forgery.
- 1047 (p) Section 831.02, relating to uttering forged  
 1048 instruments.
- 1049 (q) Section 831.07, relating to forging bank bills,  
 1050 checks, drafts, or promissory notes.
- 1051 (r) Section 831.09, relating to uttering forged bank  
 1052 bills, checks, drafts, or promissory notes.
- 1053 (s) Section 831.30, relating to fraud in obtaining  
 1054 medicinal drugs.
- 1055 (t) Section 831.31, relating to the sale, manufacture,  
 1056 delivery, or possession with the intent to sell, manufacture, or  
 1057 deliver any counterfeit controlled substance, if the offense was  
 1058 a felony.
- 1059 (u) Section 895.03, relating to racketeering and  
 1060 collection of unlawful debts.



1061 (v) Section 896.101, relating to the Florida Money  
1062 Laundering Act.

1063  
1064 If, upon rescreening, a person who is currently employed or  
1065 contracted with a licensee ~~as of June 30, 2014,~~ and was screened  
1066 and qualified under s. ss. 435.03 and 435.04, has a  
1067 disqualifying offense that was not a disqualifying offense at  
1068 the time of the last screening, but is a current disqualifying  
1069 offense and was committed before the last screening, he or she  
1070 may apply for an exemption from the appropriate licensing agency  
1071 and, if agreed to by the employer, may continue to perform his  
1072 or her duties until the licensing agency renders a decision on  
1073 the application for exemption if the person is eligible to apply  
1074 for an exemption and the exemption request is received by the  
1075 agency no later than 30 days after receipt of the rescreening  
1076 results by the person.

1077 ~~(5) A person who serves as a controlling interest of, is~~  
1078 ~~employed by, or contracts with a licensee on July 31, 2010, who~~  
1079 ~~has been screened and qualified according to standards specified~~  
1080 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~  
1081 ~~in compliance with the following schedule. If, upon rescreening,~~  
1082 ~~such person has a disqualifying offense that was not a~~  
1083 ~~disqualifying offense at the time of the last screening, but is~~  
1084 ~~a current disqualifying offense and was committed before the~~  
1085 ~~last screening, he or she may apply for an exemption from the~~

1086 ~~appropriate licensing agency and, if agreed to by the employer,~~  
1087 ~~may continue to perform his or her duties until the licensing~~  
1088 ~~agency renders a decision on the application for exemption if~~  
1089 ~~the person is eligible to apply for an exemption and the~~  
1090 ~~exemption request is received by the agency within 30 days after~~  
1091 ~~receipt of the rescreening results by the person. The~~  
1092 ~~rescreening schedule shall be:~~

1093 ~~(a) Individuals for whom the last screening was conducted~~  
1094 ~~on or before December 31, 2004, must be rescreened by July 31,~~  
1095 ~~2013.~~

1096 ~~(b) Individuals for whom the last screening conducted was~~  
1097 ~~between January 1, 2005, and December 31, 2008, must be~~  
1098 ~~rescreened by July 31, 2014.~~

1099 ~~(c) Individuals for whom the last screening conducted was~~  
1100 ~~between January 1, 2009, through July 31, 2011, must be~~  
1101 ~~rescreened by July 31, 2015.~~

1102 Section 27. Subsection (1) of section 408.811, Florida  
1103 Statutes, is amended to read:

1104 408.811 Right of inspection; copies; inspection reports;  
1105 plan for correction of deficiencies.—

1106 (1) An authorized officer or employee of the agency may  
1107 make or cause to be made any inspection or investigation deemed  
1108 necessary by the agency to determine the state of compliance  
1109 with this part, authorizing statutes, and applicable rules. The  
1110 right of inspection extends to any business that the agency has

1111 reason to believe is being operated as a provider without a  
1112 license, but inspection of any business suspected of being  
1113 operated without the appropriate license may not be made without  
1114 the permission of the owner or person in charge unless a warrant  
1115 is first obtained from a circuit court. Any application for a  
1116 license issued under this part, authorizing statutes, or  
1117 applicable rules constitutes permission for an appropriate  
1118 inspection to verify the information submitted on or in  
1119 connection with the application.

1120 (a) All inspections shall be unannounced, except as  
1121 specified in s. 408.806.

1122 (b) Inspections for relicensure shall be conducted  
1123 biennially unless otherwise specified by this section,  
1124 authorizing statutes, or applicable rules.

1125 (c) The agency may exempt a low-risk provider from a  
1126 licensure inspection if the provider or a controlling interest  
1127 has an excellent regulatory history with regard to deficiencies,  
1128 sanctions, complaints, or other regulatory actions as defined in  
1129 agency rule. The agency must conduct unannounced licensure  
1130 inspections on at least 10 percent of the exempt low-risk  
1131 providers to verify regulatory compliance.

1132 (d) The agency may adopt rules to waive any inspection,  
1133 including a relicensure inspection, or grant an extended time  
1134 period between relicensure inspections based upon:

- 1135        1. An excellent regulatory history with regard to  
 1136 deficiencies, sanctions, complaints, or other regulatory  
 1137 measures.
- 1138        2. Outcome measures that demonstrate quality performance.
- 1139        3. Successful participation in a recognized, quality  
 1140 program.
- 1141        4. Accreditation status.
- 1142        5. Other measures reflective of quality and safety.
- 1143        6. The length of time between inspections.

1144

1145        The agency shall continue to conduct unannounced licensure  
 1146 inspections on at least 10 percent of providers that qualify for  
 1147 an exemption or extended period between relicensure inspections.  
 1148        The agency may conduct an inspection of any provider at any time  
 1149 to verify regulatory compliance.

1150        Section 28. Subsection (24) of section 408.820, Florida  
 1151 Statutes, is amended to read:

1152        408.820 Exemptions.—Except as prescribed in authorizing  
 1153 statutes, the following exemptions shall apply to specified  
 1154 requirements of this part:

1155        ~~(24) Multiphasic health testing centers, as provided under~~  
 1156 ~~part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

1157        Section 29. Subsections (1) and (2) of section 408.821,  
 1158 Florida Statutes, are amended to read:

1159 408.821 Emergency management planning; emergency  
1160 operations; inactive license.—

1161 (1) A licensee required by authorizing statutes and agency  
1162 rule to have a comprehensive ~~an~~ emergency management ~~operations~~  
1163 plan must designate a safety liaison to serve as the primary  
1164 contact for emergency operations. Such licensee shall submit its  
1165 comprehensive emergency management plan to the local emergency  
1166 management agency, county health department, or Department of  
1167 Health as follows:

1168 (a) Submit the plan within 30 days after initial licensure  
1169 and change of ownership, and notify the agency within 30 days  
1170 after submission of the plan.

1171 (b) Submit the plan annually and within 30 days after any  
1172 significant modification, as defined by agency rule, to a  
1173 previously approved plan.

1174 (c) Submit necessary plan revisions within 30 days after  
1175 notification that plan revisions are required.

1176 (d) Notify the agency within 30 days after approval of its  
1177 plan by the local emergency management agency, county health  
1178 department, or Department of Health.

1179 (2) An entity subject to this part may temporarily exceed  
1180 its licensed capacity to act as a receiving provider in  
1181 accordance with an approved comprehensive emergency management  
1182 ~~operations~~ plan for up to 15 days. While in an overcapacity  
1183 status, each provider must furnish or arrange for appropriate

1184 care and services to all clients. In addition, the agency may  
 1185 approve requests for overcapacity in excess of 15 days, which  
 1186 approvals may be based upon satisfactory justification and need  
 1187 as provided by the receiving and sending providers.

1188 Section 30. Subsection (3) of section 408.831, Florida  
 1189 Statutes, is amended to read:

1190 408.831 Denial, suspension, or revocation of a license,  
 1191 registration, certificate, or application.-

1192 (3) This section provides standards of enforcement  
 1193 applicable to all entities licensed or regulated by the Agency  
 1194 for Health Care Administration. This section controls over any  
 1195 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,  
 1196 400, 408, 429, 468, ~~483~~, and 765 or rules adopted pursuant to  
 1197 those chapters.

1198 Section 31. Section 408.832, Florida Statutes, is amended  
 1199 to read:

1200 408.832 Conflicts.-In case of conflict between ~~the~~  
 1201 ~~provisions of~~ this part and the authorizing statutes governing  
 1202 the licensure of health care providers by the Agency for Health  
 1203 Care Administration found in s. 112.0455 and chapters 383, 390,  
 1204 394, 395, 400, 429, 440, ~~483~~, and 765, ~~the provisions of~~ this  
 1205 part shall prevail.

1206 Section 32. Subsection (9) of section 408.909, Florida  
 1207 Statutes, is amended to read:

1208 408.909 Health flex plans.-

1209 ~~(9) PROGRAM EVALUATION.—The agency and the office shall~~  
 1210 ~~evaluate the pilot program and its effect on the entities that~~  
 1211 ~~seek approval as health flex plans, on the number of enrollees,~~  
 1212 ~~and on the scope of the health care coverage offered under a~~  
 1213 ~~health flex plan; shall provide an assessment of the health flex~~  
 1214 ~~plans and their potential applicability in other settings; shall~~  
 1215 ~~use health flex plans to gather more information to evaluate~~  
 1216 ~~low-income consumer driven benefit packages; and shall, by~~  
 1217 ~~January 15, 2016, and annually thereafter, jointly submit a~~  
 1218 ~~report to the Governor, the President of the Senate, and the~~  
 1219 ~~Speaker of the House of Representatives.~~

1220 Section 33. Paragraph (d) of subsection (10) of section  
 1221 408.9091, Florida Statutes, is amended to read:

1222 408.9091 Cover Florida Health Care Access Program.—

1223 (10) PROGRAM EVALUATION.—The agency and the office shall:

1224 ~~(d) Jointly submit by March 1, annually, a report to the~~  
 1225 ~~Governor, the President of the Senate, and the Speaker of the~~  
 1226 ~~House of Representatives which provides the information~~  
 1227 ~~specified in paragraphs (a)–(c) and recommendations relating to~~  
 1228 ~~the successful implementation and administration of the program.~~

1229 Section 34. Effective upon becoming a law, paragraph (a)  
 1230 of subsection (5) of section 409.905, Florida Statutes, is  
 1231 amended to read:

1232 409.905 Mandatory Medicaid services.—The agency may make  
 1233 payments for the following services, which are required of the

1234 state by Title XIX of the Social Security Act, furnished by  
1235 Medicaid providers to recipients who are determined to be  
1236 eligible on the dates on which the services were provided. Any  
1237 service under this section shall be provided only when medically  
1238 necessary and in accordance with state and federal law.  
1239 Mandatory services rendered by providers in mobile units to  
1240 Medicaid recipients may be restricted by the agency. Nothing in  
1241 this section shall be construed to prevent or limit the agency  
1242 from adjusting fees, reimbursement rates, lengths of stay,  
1243 number of visits, number of services, or any other adjustments  
1244 necessary to comply with the availability of moneys and any  
1245 limitations or directions provided for in the General  
1246 Appropriations Act or chapter 216.

1247 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for  
1248 all covered services provided for the medical care and treatment  
1249 of a recipient who is admitted as an inpatient by a licensed  
1250 physician or dentist to a hospital licensed under part I of  
1251 chapter 395. However, the agency shall limit the payment for  
1252 inpatient hospital services for a Medicaid recipient 21 years of  
1253 age or older to 45 days or the number of days necessary to  
1254 comply with the General Appropriations Act.

1255 (a)1. The agency may implement reimbursement and  
1256 utilization management reforms in order to comply with any  
1257 limitations or directions in the General Appropriations Act,  
1258 which may include, but are not limited to: prior authorization



1259 for inpatient psychiatric days; prior authorization for  
1260 nonemergency hospital inpatient admissions for individuals 21  
1261 years of age and older; authorization of emergency and urgent-  
1262 care admissions within 24 hours after admission; enhanced  
1263 utilization and concurrent review programs for highly utilized  
1264 services; reduction or elimination of covered days of service;  
1265 adjusting reimbursement ceilings for variable costs; adjusting  
1266 reimbursement ceilings for fixed and property costs; and  
1267 implementing target rates of increase.

1268 2. The agency may limit prior authorization for hospital  
1269 inpatient services to selected diagnosis-related groups, based  
1270 on an analysis of the cost and potential for unnecessary  
1271 hospitalizations represented by certain diagnoses. Admissions  
1272 for normal delivery and newborns are exempt from requirements  
1273 for prior authorization.

1274 3. In implementing the provisions of this section related  
1275 to prior authorization, the agency shall ensure that the process  
1276 for authorization is accessible 24 hours per day, 7 days per  
1277 week and authorization is automatically granted when not denied  
1278 within 4 hours after the request. Authorization procedures must  
1279 include steps for review of denials.

1280 4. Upon implementing the prior authorization program for  
1281 hospital inpatient services, the agency shall discontinue its  
1282 hospital retrospective review program. However, this  
1283 subparagraph may not be construed to prevent the agency from

1284 conducting retrospective reviews under s. 409.913, including  
1285 reviews in which overpayment is suspected due to improper  
1286 claiming, mistake, or any other reason that does not rise to the  
1287 level of fraud or abuse.

1288 Section 35. It is the intent of the Legislature that s.  
1289 409.905(5)(a), Florida Statutes, as amended by this act, confirm  
1290 and clarify existing law.

1291 Section 36. Subsection (8) of section 409.907, Florida  
1292 Statutes, is amended to read:

1293 409.907 Medicaid provider agreements.—The agency may make  
1294 payments for medical assistance and related services rendered to  
1295 Medicaid recipients only to an individual or entity who has a  
1296 provider agreement in effect with the agency, who is performing  
1297 services or supplying goods in accordance with federal, state,  
1298 and local law, and who agrees that no person shall, on the  
1299 grounds of handicap, race, color, or national origin, or for any  
1300 other reason, be subjected to discrimination under any program  
1301 or activity for which the provider receives payment from the  
1302 agency.

1303 (8) (a) A level 2 background screening pursuant to chapter  
1304 435 must be conducted through the agency on each of the  
1305 following:

1306 1. The ~~Each~~ provider, or each principal of the provider if  
1307 the provider is a corporation, partnership, association, or  
1308 other entity, ~~seeking to participate in the Medicaid program~~

1309 ~~must submit a complete set of his or her fingerprints to the~~  
1310 ~~agency for the purpose of conducting a criminal history record~~  
1311 ~~check.~~

1312       2. Principals of the provider, who include any officer,  
1313 director, billing agent, managing employee, or affiliated  
1314 person, or any partner or shareholder who has an ownership  
1315 interest equal to 5 percent or more in the provider. However,  
1316 for a hospital licensed under chapter 395 or a nursing home  
1317 licensed under chapter 400, principals of the provider are those  
1318 who meet the definition of a controlling interest under s.  
1319 408.803. A director of a not-for-profit corporation or  
1320 organization is not a principal for purposes of a background  
1321 investigation required by this section if the director: serves  
1322 solely in a voluntary capacity for the corporation or  
1323 organization, does not regularly take part in the day-to-day  
1324 operational decisions of the corporation or organization,  
1325 receives no remuneration from the not-for-profit corporation or  
1326 organization for his or her service on the board of directors,  
1327 has no financial interest in the not-for-profit corporation or  
1328 organization, and has no family members with a financial  
1329 interest in the not-for-profit corporation or organization; and  
1330 if the director submits an affidavit, under penalty of perjury,  
1331 to this effect to the agency and the not-for-profit corporation  
1332 or organization submits an affidavit, under penalty of perjury,

1333 to this effect to the agency as part of the corporation's or  
1334 organization's Medicaid provider agreement application.

1335 3. Any person who participates or seeks to participate in  
1336 the Medicaid program by way of rendering services to Medicaid  
1337 recipients or having direct access to Medicaid recipients,  
1338 recipient living areas, or the financial, medical, or service  
1339 records of a Medicaid recipient or who supervises the delivery  
1340 of goods or services to a Medicaid recipient. This subparagraph  
1341 does not impose additional screening requirements on any  
1342 providers licensed under part II of chapter 408.

1343 (b) Notwithstanding paragraph (a) the above, the agency  
1344 may require a background check for any person reasonably  
1345 suspected by the agency to have been convicted of a crime.

1346 (c)-(a) Paragraph (a) This subsection does not apply to:

1347 1. A unit of local government, except that requirements of  
1348 this subsection apply to nongovernmental providers and entities  
1349 contracting with the local government to provide Medicaid  
1350 services. The actual cost of the state and national criminal  
1351 history record checks must be borne by the nongovernmental  
1352 provider or entity; or

1353 2. Any business that derives more than 50 percent of its  
1354 revenue from the sale of goods to the final consumer, and the  
1355 business or its controlling parent is required to file a form  
1356 10-K or other similar statement with the Securities and Exchange  
1357 Commission or has a net worth of \$50 million or more.

1358            (d) ~~(b)~~ Background screening shall be conducted in  
1359 accordance with chapter 435 and s. 408.809. The cost of the  
1360 state and national criminal record check shall be borne by the  
1361 provider.

1362            Section 37. Section 409.913, Florida Statutes, is amended  
1363 to read:

1364            409.913 Oversight of the integrity of the Medicaid  
1365 program.—The agency shall operate a program to oversee the  
1366 activities of Florida Medicaid recipients, and providers and  
1367 their representatives, to ensure that fraudulent and abusive  
1368 behavior and neglect of recipients occur to the minimum extent  
1369 possible, and to recover overpayments and impose sanctions as  
1370 appropriate. Each January 15 ~~1~~, the agency and the Medicaid  
1371 Fraud Control Unit of the Department of Legal Affairs shall  
1372 submit a ~~joint~~ report to the Legislature documenting the  
1373 effectiveness of the state's efforts to control Medicaid fraud  
1374 and abuse and to recover Medicaid overpayments during the  
1375 previous fiscal year. The report must describe the number of  
1376 cases opened and investigated each year; the sources of the  
1377 cases opened; the disposition of the cases closed each year; the  
1378 amount of overpayments alleged in preliminary and final audit  
1379 letters; the number and amount of fines or penalties imposed;  
1380 any reductions in overpayment amounts negotiated in settlement  
1381 agreements or by other means; the amount of final agency  
1382 determinations of overpayments; the amount deducted from federal

1383 claiming as a result of overpayments; the amount of overpayments  
1384 recovered each year; the amount of cost of investigation  
1385 recovered each year; the average length of time to collect from  
1386 the time the case was opened until the overpayment is paid in  
1387 full; the amount determined as uncollectible and the portion of  
1388 the uncollectible amount subsequently reclaimed from the Federal  
1389 Government; the number of providers, by type, that are  
1390 terminated from participation in the Medicaid program as a  
1391 result of fraud and abuse; and all costs associated with  
1392 discovering and prosecuting cases of Medicaid overpayments and  
1393 making recoveries in such cases. The report must also document  
1394 actions taken to prevent overpayments and the number of  
1395 providers prevented from enrolling in or reenrolling in the  
1396 Medicaid program as a result of documented Medicaid fraud and  
1397 abuse and must include policy recommendations necessary to  
1398 prevent or recover overpayments and changes necessary to prevent  
1399 and detect Medicaid fraud. All policy recommendations in the  
1400 report must include a detailed fiscal analysis, including, but  
1401 not limited to, implementation costs, estimated savings to the  
1402 Medicaid program, and the return on investment. The agency must  
1403 submit the policy recommendations and fiscal analyses in the  
1404 report to the appropriate estimating conference, pursuant to s.  
1405 216.137, by February 15 of each year. The agency and the  
1406 Medicaid Fraud Control Unit of the Department of Legal Affairs  
1407 each must include detailed unit-specific performance standards,

1408 benchmarks, and metrics in the report, including projected cost  
1409 savings to the state Medicaid program during the following  
1410 fiscal year.

1411 (1) For the purposes of this section, the term:

1412 (a) "Abuse" means:

1413 1. Provider practices that are inconsistent with generally  
1414 accepted business or medical practices and that result in an  
1415 unnecessary cost to the Medicaid program or in reimbursement for  
1416 goods or services that are not medically necessary or that fail  
1417 to meet professionally recognized standards for health care.

1418 2. Recipient practices that result in unnecessary cost to  
1419 the Medicaid program.

1420 (b) "Complaint" means an allegation that fraud, abuse, or  
1421 an overpayment has occurred.

1422 (c) "Fraud" means an intentional deception or  
1423 misrepresentation made by a person with the knowledge that the  
1424 deception results in unauthorized benefit to herself or himself  
1425 or another person. The term includes any act that constitutes  
1426 fraud under applicable federal or state law.

1427 (d) "Medical necessity" or "medically necessary" means any  
1428 goods or services necessary to palliate the effects of a  
1429 terminal condition, or to prevent, diagnose, correct, cure,  
1430 alleviate, or preclude deterioration of a condition that  
1431 threatens life, causes pain or suffering, or results in illness  
1432 or infirmity, which goods or services are provided in accordance

1433 with generally accepted standards of medical practice. For  
1434 purposes of determining Medicaid reimbursement, the agency is  
1435 the final arbiter of medical necessity. Determinations of  
1436 medical necessity must be made by a licensed physician employed  
1437 by or under contract with the agency and must be based upon  
1438 information available at the time the goods or services are  
1439 provided.

1440 (e) "Overpayment" includes any amount that is not  
1441 authorized to be paid by the Medicaid program whether paid as a  
1442 result of inaccurate or improper cost reporting, improper  
1443 claiming, unacceptable practices, fraud, abuse, or mistake.

1444 (f) "Person" means any natural person, corporation,  
1445 partnership, association, clinic, group, or other entity,  
1446 whether or not such person is enrolled in the Medicaid program  
1447 or is a provider of health care.

1448 (2) The agency shall conduct, or cause to be conducted by  
1449 contract or otherwise, reviews, investigations, analyses,  
1450 audits, or any combination thereof, to determine possible fraud,  
1451 abuse, overpayment, or recipient neglect in the Medicaid program  
1452 and shall report the findings of any overpayments in audit  
1453 reports as appropriate. At least 5 percent of all audits shall  
1454 be conducted on a random basis. As part of its ongoing fraud  
1455 detection activities, the agency shall identify and monitor, by  
1456 contract or otherwise, patterns of overutilization of Medicaid  
1457 services based on state averages. The agency shall track



1458 Medicaid provider prescription and billing patterns and evaluate  
1459 them against Medicaid medical necessity criteria and coverage  
1460 and limitation guidelines adopted by rule. Medical necessity  
1461 determination requires that service be consistent with symptoms  
1462 or confirmed diagnosis of illness or injury under treatment and  
1463 not in excess of the patient's needs. The agency shall conduct  
1464 reviews of provider exceptions to peer group norms and shall,  
1465 using statistical methodologies, provider profiling, and  
1466 analysis of billing patterns, detect and investigate abnormal or  
1467 unusual increases in billing or payment of claims for Medicaid  
1468 services and medically unnecessary provision of services.

1469 (3) The agency may conduct, or may contract for,  
1470 prepayment review of provider claims to ensure cost-effective  
1471 purchasing; to ensure that billing by a provider to the agency  
1472 is in accordance with applicable provisions of all Medicaid  
1473 rules, regulations, handbooks, and policies and in accordance  
1474 with federal, state, and local law; and to ensure that  
1475 appropriate care is rendered to Medicaid recipients. Such  
1476 prepayment reviews may be conducted as determined appropriate by  
1477 the agency, without any suspicion or allegation of fraud, abuse,  
1478 or neglect, and may last for up to 1 year. Unless the agency has  
1479 reliable evidence of fraud, misrepresentation, abuse, or  
1480 neglect, claims shall be adjudicated for denial or payment  
1481 within 90 days after receipt of complete documentation by the  
1482 agency for review. If there is reliable evidence of fraud,

1483 misrepresentation, abuse, or neglect, claims shall be  
1484 adjudicated for denial of payment within 180 days after receipt  
1485 of complete documentation by the agency for review.

1486 (4) Any suspected criminal violation identified by the  
1487 agency must be referred to the Medicaid Fraud Control Unit of  
1488 the Office of the Attorney General for investigation. The agency  
1489 and the Attorney General shall enter into a memorandum of  
1490 understanding, which must include, but need not be limited to, a  
1491 protocol for regularly sharing information and coordinating  
1492 casework. The protocol must establish a procedure for the  
1493 referral by the agency of cases involving suspected Medicaid  
1494 fraud to the Medicaid Fraud Control Unit for investigation, and  
1495 the return to the agency of those cases where investigation  
1496 determines that administrative action by the agency is  
1497 appropriate. Offices of the Medicaid program integrity program  
1498 and the Medicaid Fraud Control Unit of the Department of Legal  
1499 Affairs, shall, to the extent possible, be collocated. The  
1500 agency and the Department of Legal Affairs shall periodically  
1501 conduct joint training and other joint activities designed to  
1502 increase communication and coordination in recovering  
1503 overpayments.

1504 (5) A Medicaid provider is subject to having goods and  
1505 services that are paid for by the Medicaid program reviewed by  
1506 an appropriate peer-review organization designated by the  
1507 agency. The written findings of the applicable peer-review

1508 organization are admissible in any court or administrative  
 1509 proceeding as evidence of medical necessity or the lack thereof.

1510 (6) Any notice required to be given to a provider under  
 1511 this section is presumed to be sufficient notice if sent to the  
 1512 address last shown on the provider enrollment file. It is the  
 1513 responsibility of the provider to furnish and keep the agency  
 1514 informed of the provider's current address. United States Postal  
 1515 Service proof of mailing or certified or registered mailing of  
 1516 such notice to the provider at the address shown on the provider  
 1517 enrollment file constitutes sufficient proof of notice. Any  
 1518 notice required to be given to the agency by this section must  
 1519 be sent to the agency at an address designated by rule.

1520 (7) When presenting a claim for payment under the Medicaid  
 1521 program, a provider has an affirmative duty to supervise the  
 1522 provision of, and be responsible for, goods and services claimed  
 1523 to have been provided, to supervise and be responsible for  
 1524 preparation and submission of the claim, and to present a claim  
 1525 that is true and accurate and that is for goods and services  
 1526 that:

1527 (a) Have actually been furnished to the recipient by the  
 1528 provider prior to submitting the claim.

1529 (b) Are Medicaid-covered goods or services that are  
 1530 medically necessary.

1531 (c) Are of a quality comparable to those furnished to the  
 1532 general public by the provider's peers.

1533 (d) Have not been billed in whole or in part to a  
 1534 recipient or a recipient's responsible party, except for such  
 1535 copayments, coinsurance, or deductibles as are authorized by the  
 1536 agency.

1537 (e) Are provided in accord with applicable provisions of  
 1538 all Medicaid rules, regulations, handbooks, and policies and in  
 1539 accordance with federal, state, and local law.

1540 (f) Are documented by records made at the time the goods  
 1541 or services were provided, demonstrating the medical necessity  
 1542 for the goods or services rendered. Medicaid goods or services  
 1543 are excessive or not medically necessary unless both the medical  
 1544 basis and the specific need for them are fully and properly  
 1545 documented in the recipient's medical record.

1546  
 1547 The agency shall deny payment or require repayment for goods or  
 1548 services that are not presented as required in this subsection.

1549 (8) The agency shall not reimburse any person or entity  
 1550 for any prescription for medications, medical supplies, or  
 1551 medical services if the prescription was written by a physician  
 1552 or other prescribing practitioner who is not enrolled in the  
 1553 Medicaid program. This section does not apply:

1554 (a) In instances involving bona fide emergency medical  
 1555 conditions as determined by the agency;

1556 (b) To a provider of medical services to a patient in a  
 1557 hospital emergency department, hospital inpatient or outpatient  
 1558 setting, or nursing home;

1559 (c) To bona fide pro bono services by preapproved non-  
 1560 Medicaid providers as determined by the agency;

1561 (d) To prescribing physicians who are board-certified  
 1562 specialists treating Medicaid recipients referred for treatment  
 1563 by a treating physician who is enrolled in the Medicaid program;

1564 (e) To prescriptions written for dually eligible Medicare  
 1565 beneficiaries by an authorized Medicare provider who is not  
 1566 enrolled in the Medicaid program;

1567 (f) To other physicians who are not enrolled in the  
 1568 Medicaid program but who provide a medically necessary service  
 1569 or prescription not otherwise reasonably available from a  
 1570 Medicaid-enrolled physician; or

1571 (9) A Medicaid provider shall retain medical,  
 1572 professional, financial, and business records pertaining to  
 1573 services and goods furnished to a Medicaid recipient and billed  
 1574 to Medicaid for a period of 5 years after the date of furnishing  
 1575 such services or goods. The agency may investigate, review, or  
 1576 analyze such records, which must be made available during normal  
 1577 business hours. However, 24-hour notice must be provided if  
 1578 patient treatment would be disrupted. The provider must keep the  
 1579 agency informed of the location of the provider's Medicaid-  
 1580 related records. The authority of the agency to obtain Medicaid-

1581 related records from a provider is neither curtailed nor limited  
1582 during a period of litigation between the agency and the  
1583 provider.

1584 (10) Payments for the services of billing agents or  
1585 persons participating in the preparation of a Medicaid claim  
1586 shall not be based on amounts for which they bill nor based on  
1587 the amount a provider receives from the Medicaid program.

1588 (11) The agency shall deny payment or require repayment  
1589 for inappropriate, medically unnecessary, or excessive goods or  
1590 services from the person furnishing them, the person under whose  
1591 supervision they were furnished, or the person causing them to  
1592 be furnished.

1593 (12) The complaint and all information obtained pursuant  
1594 to an investigation of a Medicaid provider, or the authorized  
1595 representative or agent of a provider, relating to an allegation  
1596 of fraud, abuse, or neglect are confidential and exempt from the  
1597 provisions of s. 119.07(1):

1598 (a) Until the agency takes final agency action with  
1599 respect to the provider and requires repayment of any  
1600 overpayment, or imposes an administrative sanction;

1601 (b) Until the Attorney General refers the case for  
1602 criminal prosecution;

1603 (c) Until 10 days after the complaint is determined  
1604 without merit; or

1605 (d) At all times if the complaint or information is  
1606 otherwise protected by law.

1607 (13) The agency shall terminate participation of a  
1608 Medicaid provider in the Medicaid program and may seek civil  
1609 remedies or impose other administrative sanctions against a  
1610 Medicaid provider, if the provider or any principal, officer,  
1611 director, agent, managing employee, or affiliated person of the  
1612 provider, or any partner or shareholder having an ownership  
1613 interest in the provider equal to 5 percent or greater, has been  
1614 convicted of a criminal offense under federal law or the law of  
1615 any state relating to the practice of the provider's profession,  
1616 or a criminal offense listed under s. 408.809(4), s.  
1617 409.907(10), or s. 435.04(2). If the agency determines that the  
1618 provider did not participate or acquiesce in the offense,  
1619 termination will not be imposed. If the agency effects a  
1620 termination under this subsection, the agency shall take final  
1621 agency action.

1622 (14) If the provider has been suspended or terminated from  
1623 participation in the Medicaid program or the Medicare program by  
1624 the Federal Government or any state, the agency must immediately  
1625 suspend or terminate, as appropriate, the provider's  
1626 participation in this state's Medicaid program for a period no  
1627 less than that imposed by the Federal Government or any other  
1628 state, and may not enroll such provider in this state's Medicaid  
1629 program while such foreign suspension or termination remains in

1630 effect. The agency shall also immediately suspend or terminate,  
1631 as appropriate, a provider's participation in this state's  
1632 Medicaid program if the provider participated or acquiesced in  
1633 any action for which any principal, officer, director, agent,  
1634 managing employee, or affiliated person of the provider, or any  
1635 partner or shareholder having an ownership interest in the  
1636 provider equal to 5 percent or greater, was suspended or  
1637 terminated from participating in the Medicaid program or the  
1638 Medicare program by the Federal Government or any state. This  
1639 sanction is in addition to all other remedies provided by law.

1640 (15) The agency shall seek a remedy provided by law,  
1641 including, but not limited to, any remedy provided in  
1642 subsections (13) and (16) and s. 812.035, if:

1643 (a) The provider's license has not been renewed, or has  
1644 been revoked, suspended, or terminated, for cause, by the  
1645 licensing agency of any state;

1646 (b) The provider has failed to make available or has  
1647 refused access to Medicaid-related records to an auditor,  
1648 investigator, or other authorized employee or agent of the  
1649 agency, the Attorney General, a state attorney, or the Federal  
1650 Government;

1651 (c) The provider has not furnished or has failed to make  
1652 available such Medicaid-related records as the agency has found  
1653 necessary to determine whether Medicaid payments are or were due  
1654 and the amounts thereof;



1655 (d) The provider has failed to maintain medical records  
1656 made at the time of service, or prior to service if prior  
1657 authorization is required, demonstrating the necessity and  
1658 appropriateness of the goods or services rendered;

1659 (e) The provider is not in compliance with provisions of  
1660 Medicaid provider publications that have been adopted by  
1661 reference as rules in the Florida Administrative Code; with  
1662 provisions of state or federal laws, rules, or regulations; with  
1663 provisions of the provider agreement between the agency and the  
1664 provider; or with certifications found on claim forms or on  
1665 transmittal forms for electronically submitted claims that are  
1666 submitted by the provider or authorized representative, as such  
1667 provisions apply to the Medicaid program;

1668 (f) The provider or person who ordered, authorized, or  
1669 prescribed the care, services, or supplies has furnished, or  
1670 ordered or authorized the furnishing of, goods or services to a  
1671 recipient which are inappropriate, unnecessary, excessive, or  
1672 harmful to the recipient or are of inferior quality;

1673 (g) The provider has demonstrated a pattern of failure to  
1674 provide goods or services that are medically necessary;

1675 (h) The provider or an authorized representative of the  
1676 provider, or a person who ordered, authorized, or prescribed the  
1677 goods or services, has submitted or caused to be submitted false  
1678 or a pattern of erroneous Medicaid claims;

1679 (i) The provider or an authorized representative of the  
1680 provider, or a person who has ordered, authorized, or prescribed  
1681 the goods or services, has submitted or caused to be submitted a  
1682 Medicaid provider enrollment application, a request for prior  
1683 authorization for Medicaid services, a drug exception request,  
1684 or a Medicaid cost report that contains materially false or  
1685 incorrect information;

1686 (j) The provider or an authorized representative of the  
1687 provider has collected from or billed a recipient or a  
1688 recipient's responsible party improperly for amounts that should  
1689 not have been so collected or billed by reason of the provider's  
1690 billing the Medicaid program for the same service;

1691 (k) The provider or an authorized representative of the  
1692 provider has included in a cost report costs that are not  
1693 allowable under a Florida Title XIX reimbursement plan after the  
1694 provider or authorized representative had been advised in an  
1695 audit exit conference or audit report that the costs were not  
1696 allowable;

1697 (l) The provider is charged by information or indictment  
1698 with fraudulent billing practices or an offense referenced in  
1699 subsection (13). The sanction applied for this reason is limited  
1700 to suspension of the provider's participation in the Medicaid  
1701 program for the duration of the indictment unless the provider  
1702 is found guilty pursuant to the information or indictment;

1703 (m) The provider or a person who ordered, authorized, or  
 1704 prescribed the goods or services is found liable for negligent  
 1705 practice resulting in death or injury to the provider's patient;

1706 (n) The provider fails to demonstrate that it had  
 1707 available during a specific audit or review period sufficient  
 1708 quantities of goods, or sufficient time in the case of services,  
 1709 to support the provider's billings to the Medicaid program;

1710 (o) The provider has failed to comply with the notice and  
 1711 reporting requirements of s. 409.907;

1712 (p) The agency has received reliable information of  
 1713 patient abuse or neglect or of any act prohibited by s. 409.920;  
 1714 or

1715 (q) The provider has failed to comply with an agreed-upon  
 1716 repayment schedule.

1717  
 1718 A provider is subject to sanctions for violations of this  
 1719 subsection as the result of actions or inactions of the  
 1720 provider, or actions or inactions of any principal, officer,  
 1721 director, agent, managing employee, or affiliated person of the  
 1722 provider, or any partner or shareholder having an ownership  
 1723 interest in the provider equal to 5 percent or greater, in which  
 1724 the provider participated or acquiesced.

1725 (16) The agency shall impose any of the following  
 1726 sanctions or disincentives on a provider or a person for any of  
 1727 the acts described in subsection (15):

1728 (a) Suspension for a specific period of time of not more  
 1729 than 1 year. Suspension precludes participation in the Medicaid  
 1730 program, which includes any action that results in a claim for  
 1731 payment to the Medicaid program for furnishing, supervising a  
 1732 person who is furnishing, or causing a person to furnish goods  
 1733 or services.

1734 (b) Termination for a specific period of time ranging from  
 1735 more than 1 year to 20 years. Termination precludes  
 1736 participation in the Medicaid program, which includes any action  
 1737 that results in a claim for payment to the Medicaid program for  
 1738 furnishing, supervising a person who is furnishing, or causing a  
 1739 person to furnish goods or services.

1740 (c) Imposition of a fine of up to \$5,000 for each  
 1741 violation. Each day that an ongoing violation continues, such as  
 1742 refusing to furnish Medicaid-related records or refusing access  
 1743 to records, is considered a separate violation. Each instance of  
 1744 improper billing of a Medicaid recipient; each instance of  
 1745 including an unallowable cost on a hospital or nursing home  
 1746 Medicaid cost report after the provider or authorized  
 1747 representative has been advised in an audit exit conference or  
 1748 previous audit report of the cost unallowability; each instance  
 1749 of furnishing a Medicaid recipient goods or professional  
 1750 services that are inappropriate or of inferior quality as  
 1751 determined by competent peer judgment; each instance of  
 1752 knowingly submitting a materially false or erroneous Medicaid

1753 provider enrollment application, request for prior authorization  
1754 for Medicaid services, drug exception request, or cost report;  
1755 each instance of inappropriate prescribing of drugs for a  
1756 Medicaid recipient as determined by competent peer judgment; and  
1757 each false or erroneous Medicaid claim leading to an overpayment  
1758 to a provider is considered a separate violation.

1759 (d) Immediate suspension, if the agency has received  
1760 information of patient abuse or neglect or of any act prohibited  
1761 by s. 409.920. Upon suspension, the agency must issue an  
1762 immediate final order under s. 120.569(2)(n).

1763 (e) A fine, not to exceed \$10,000, for a violation of  
1764 paragraph (15)(i).

1765 (f) Imposition of liens against provider assets,  
1766 including, but not limited to, financial assets and real  
1767 property, not to exceed the amount of fines or recoveries  
1768 sought, upon entry of an order determining that such moneys are  
1769 due or recoverable.

1770 (g) Prepayment reviews of claims for a specified period of  
1771 time.

1772 (h) Comprehensive followup reviews of providers every 6  
1773 months to ensure that they are billing Medicaid correctly.

1774 (i) Corrective-action plans that remain in effect for up  
1775 to 3 years and that are monitored by the agency every 6 months  
1776 while in effect.

1777 (j) Other remedies as permitted by law to effect the  
 1778 recovery of a fine or overpayment.

1779  
 1780 If a provider voluntarily relinquishes its Medicaid provider  
 1781 number or an associated license, or allows the associated  
 1782 licensure to expire after receiving written notice that the  
 1783 agency is conducting, or has conducted, an audit, survey,  
 1784 inspection, or investigation and that a sanction of suspension  
 1785 or termination will or would be imposed for noncompliance  
 1786 discovered as a result of the audit, survey, inspection, or  
 1787 investigation, the agency shall impose the sanction of  
 1788 termination for cause against the provider. The agency's  
 1789 termination with cause is subject to hearing rights as may be  
 1790 provided under chapter 120. The Secretary of Health Care  
 1791 Administration may make a determination that imposition of a  
 1792 sanction or disincentive is not in the best interest of the  
 1793 Medicaid program, in which case a sanction or disincentive may  
 1794 not be imposed.

1795 (17) In determining the appropriate administrative  
 1796 sanction to be applied, or the duration of any suspension or  
 1797 termination, the agency shall consider:

1798 (a) The seriousness and extent of the violation or  
 1799 violations.

1800 (b) Any prior history of violations by the provider  
 1801 relating to the delivery of health care programs which resulted

1802 | in either a criminal conviction or in administrative sanction or  
1803 | penalty.

1804 |       (c) Evidence of continued violation within the provider's  
1805 | management control of Medicaid statutes, rules, regulations, or  
1806 | policies after written notification to the provider of improper  
1807 | practice or instance of violation.

1808 |       (d) The effect, if any, on the quality of medical care  
1809 | provided to Medicaid recipients as a result of the acts of the  
1810 | provider.

1811 |       (e) Any action by a licensing agency respecting the  
1812 | provider in any state in which the provider operates or has  
1813 | operated.

1814 |       (f) The apparent impact on access by recipients to  
1815 | Medicaid services if the provider is suspended or terminated, in  
1816 | the best judgment of the agency.

1817 |  
1818 | The agency shall document the basis for all sanctioning actions  
1819 | and recommendations.

1820 |       (18) The agency may take action to sanction, suspend, or  
1821 | terminate a particular provider working for a group provider,  
1822 | and may suspend or terminate Medicaid participation at a  
1823 | specific location, rather than or in addition to taking action  
1824 | against an entire group.

1825 |       (19) The agency shall establish a process for conducting  
1826 | followup reviews of a sampling of providers who have a history

1827 of overpayment under the Medicaid program. This process must  
1828 consider the magnitude of previous fraud or abuse and the  
1829 potential effect of continued fraud or abuse on Medicaid costs.

1830 (20) In making a determination of overpayment to a  
1831 provider, the agency must use accepted and valid auditing,  
1832 accounting, analytical, statistical, or peer-review methods, or  
1833 combinations thereof. Appropriate statistical methods may  
1834 include, but are not limited to, sampling and extension to the  
1835 population, parametric and nonparametric statistics, tests of  
1836 hypotheses, and other generally accepted statistical methods.  
1837 Appropriate analytical methods may include, but are not limited  
1838 to, reviews to determine variances between the quantities of  
1839 products that a provider had on hand and available to be  
1840 purveyed to Medicaid recipients during the review period and the  
1841 quantities of the same products paid for by the Medicaid program  
1842 for the same period, taking into appropriate consideration sales  
1843 of the same products to non-Medicaid customers during the same  
1844 period. In meeting its burden of proof in any administrative or  
1845 court proceeding, the agency may introduce the results of such  
1846 statistical methods as evidence of overpayment.

1847 (21) When making a determination that an overpayment has  
1848 occurred, the agency shall prepare and issue an audit report to  
1849 the provider showing the calculation of overpayments. The  
1850 agency's determination must be based solely upon information  
1851 available to it before issuance of the audit report and, in the



1852 case of documentation obtained to substantiate claims for  
1853 Medicaid reimbursement, based solely upon contemporaneous  
1854 records. The agency may consider addenda or modifications to a  
1855 note that was made contemporaneously with the patient care  
1856 episode if the addenda or modifications are germane to the note.

1857 (22) The audit report, supported by agency work papers,  
1858 showing an overpayment to a provider constitutes evidence of the  
1859 overpayment. A provider may not present or elicit testimony on  
1860 direct examination or cross-examination in any court or  
1861 administrative proceeding, regarding the purchase or acquisition  
1862 by any means of drugs, goods, or supplies; sales or divestment  
1863 by any means of drugs, goods, or supplies; or inventory of  
1864 drugs, goods, or supplies, unless such acquisition, sales,  
1865 divestment, or inventory is documented by written invoices,  
1866 written inventory records, or other competent written  
1867 documentary evidence maintained in the normal course of the  
1868 provider's business. A provider may not present records to  
1869 contest an overpayment or sanction unless such records are  
1870 contemporaneous and, if requested during the audit process, were  
1871 furnished to the agency or its agent upon request. This  
1872 limitation does not apply to Medicaid cost report audits. This  
1873 limitation does not preclude consideration by the agency of  
1874 addenda or modifications to a note if the addenda or  
1875 modifications are made before notification of the audit, the  
1876 addenda or modifications are germane to the note, and the note

1877 | was made contemporaneously with a patient care episode.  
1878 | Notwithstanding the applicable rules of discovery, all  
1879 | documentation to be offered as evidence at an administrative  
1880 | hearing on a Medicaid overpayment or an administrative sanction  
1881 | must be exchanged by all parties at least 14 days before the  
1882 | administrative hearing or be excluded from consideration.

1883 |       (23) (a) In an audit, ~~or~~ investigation, or enforcement  
1884 | action for ~~of~~ a violation committed by a provider which is  
1885 | conducted or taken pursuant to this section, the agency or  
1886 | contractor is entitled to recover any and all investigative and  
1887 | legal costs incurred as a result of such audit, investigation,  
1888 | or enforcement action. Such costs may include, but are not  
1889 | limited to, salaries and benefits of personnel, costs related to  
1890 | the time spent by an attorney and other personnel working on the  
1891 | case, and any other expenses incurred by the agency or  
1892 | contractor that are associated with the case, including any, ~~and~~  
1893 | expert witness costs and attorney fees incurred on behalf of the  
1894 | agency or contractor if the agency's findings were not contested  
1895 | by the provider or, if contested, the agency ultimately  
1896 | prevailed.

1897 |       (24) If the agency imposes an administrative sanction  
1898 | pursuant to subsection (13), subsection (14), or subsection  
1899 | (15), except paragraphs (15) (e) and (o), upon any provider or  
1900 | any principal, officer, director, agent, managing employee, or  
1901 | affiliated person of the provider who is regulated by another

1902 state entity, the agency shall notify that other entity of the  
1903 imposition of the sanction within 5 business days. Such  
1904 notification must include the provider's or person's name and  
1905 license number and the specific reasons for sanction.

1906 (25) (a) The agency shall withhold Medicaid payments, in  
1907 whole or in part, to a provider upon receipt of reliable  
1908 evidence that the circumstances giving rise to the need for a  
1909 withholding of payments involve fraud, willful  
1910 misrepresentation, or abuse under the Medicaid program, or a  
1911 crime committed while rendering goods or services to Medicaid  
1912 recipients. If it is determined that fraud, willful  
1913 misrepresentation, abuse, or a crime did not occur, the payments  
1914 withheld must be paid to the provider within 14 days after such  
1915 determination. Amounts not paid within 14 days accrue interest  
1916 at the rate of 10 percent per year, beginning after the 14th  
1917 day.

1918 (b) The agency shall deny payment, or require repayment,  
1919 if the goods or services were furnished, supervised, or caused  
1920 to be furnished by a person who has been suspended or terminated  
1921 from the Medicaid program or Medicare program by the Federal  
1922 Government or any state.

1923 (c) Overpayments owed to the agency bear interest at the  
1924 rate of 10 percent per year from the date of final determination  
1925 of the overpayment by the agency, and payment arrangements must

1926 be made within 30 days after the date of the final order, which  
1927 is not subject to further appeal.

1928 (d) The agency, upon entry of a final agency order, a  
1929 judgment or order of a court of competent jurisdiction, or a  
1930 stipulation or settlement, may collect the moneys owed by all  
1931 means allowable by law, including, but not limited to, notifying  
1932 any fiscal intermediary of Medicare benefits that the state has  
1933 a superior right of payment. Upon receipt of such written  
1934 notification, the Medicare fiscal intermediary shall remit to  
1935 the state the sum claimed.

1936 (e) The agency may institute amnesty programs to allow  
1937 Medicaid providers the opportunity to voluntarily repay  
1938 overpayments. The agency may adopt rules to administer such  
1939 programs.

1940 (26) The agency may impose administrative sanctions  
1941 against a Medicaid recipient, or the agency may seek any other  
1942 remedy provided by law, including, but not limited to, the  
1943 remedies provided in s. 812.035, if the agency finds that a  
1944 recipient has engaged in solicitation in violation of s. 409.920  
1945 or that the recipient has otherwise abused the Medicaid program.

1946 (27) When the Agency for Health Care Administration has  
1947 made a probable cause determination and alleged that an  
1948 overpayment to a Medicaid provider has occurred, the agency,  
1949 after notice to the provider, shall:

1950 (a) Withhold, and continue to withhold during the pendency  
 1951 of an administrative hearing pursuant to chapter 120, any  
 1952 medical assistance reimbursement payments until such time as the  
 1953 overpayment is recovered, unless within 30 days after receiving  
 1954 notice thereof the provider:

- 1955 1. Makes repayment in full; or
- 1956 2. Establishes a repayment plan that is satisfactory to  
 1957 the Agency for Health Care Administration.

1958 (b) Withhold, and continue to withhold during the pendency  
 1959 of an administrative hearing pursuant to chapter 120, medical  
 1960 assistance reimbursement payments if the terms of a repayment  
 1961 plan are not adhered to by the provider.

1962 (28) Venue for all Medicaid program integrity cases lies  
 1963 in Leon County, at the discretion of the agency.

1964 (29) Notwithstanding other provisions of law, the agency  
 1965 and the Medicaid Fraud Control Unit of the Department of Legal  
 1966 Affairs may review a provider's Medicaid-related and non-  
 1967 Medicaid-related records in order to determine the total output  
 1968 of a provider's practice to reconcile quantities of goods or  
 1969 services billed to Medicaid with quantities of goods or services  
 1970 used in the provider's total practice.

1971 (30) The agency shall terminate a provider's participation  
 1972 in the Medicaid program if the provider fails to reimburse an  
 1973 overpayment or pay an agency-imposed fine that has been  
 1974 determined by final order, not subject to further appeal, within

1975 | 30 days after the date of the final order, unless the provider  
 1976 | and the agency have entered into a repayment agreement.

1977 |         (31) If a provider requests an administrative hearing  
 1978 | pursuant to chapter 120, such hearing must be conducted within  
 1979 | 90 days following assignment of an administrative law judge,  
 1980 | absent exceptionally good cause shown as determined by the  
 1981 | administrative law judge or hearing officer. Upon issuance of a  
 1982 | final order, the outstanding balance of the amount determined to  
 1983 | constitute the overpayment and fines is due. If a provider fails  
 1984 | to make payments in full, fails to enter into a satisfactory  
 1985 | repayment plan, or fails to comply with the terms of a repayment  
 1986 | plan or settlement agreement, the agency shall withhold  
 1987 | reimbursement payments for Medicaid services until the amount  
 1988 | due is paid in full.

1989 |         (32) Duly authorized agents and employees of the agency  
 1990 | shall have the power to inspect, during normal business hours,  
 1991 | the records of any pharmacy, wholesale establishment, or  
 1992 | manufacturer, or any other place in which drugs and medical  
 1993 | supplies are manufactured, packed, packaged, made, stored, sold,  
 1994 | or kept for sale, for the purpose of verifying the amount of  
 1995 | drugs and medical supplies ordered, delivered, or purchased by a  
 1996 | provider. The agency shall provide at least 2 business days'  
 1997 | prior notice of any such inspection. The notice must identify  
 1998 | the provider whose records will be inspected, and the inspection

1999 | shall include only records specifically related to that  
 2000 | provider.

2001 |       (33) In accordance with federal law, Medicaid recipients  
 2002 | convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be  
 2003 | limited, restricted, or suspended from Medicaid eligibility for  
 2004 | a period not to exceed 1 year, as determined by the agency head  
 2005 | or designee.

2006 |       (34) To deter fraud and abuse in the Medicaid program, the  
 2007 | agency may limit the number of Schedule II and Schedule III  
 2008 | refill prescription claims submitted from a pharmacy provider.  
 2009 | The agency shall limit the allowable amount of reimbursement of  
 2010 | prescription refill claims for Schedule II and Schedule III  
 2011 | pharmaceuticals if the agency or the Medicaid Fraud Control Unit  
 2012 | determines that the specific prescription refill was not  
 2013 | requested by the Medicaid recipient or authorized representative  
 2014 | for whom the refill claim is submitted or was not prescribed by  
 2015 | the recipient's medical provider or physician. Any such refill  
 2016 | request must be consistent with the original prescription.

2017 |       (35) The Office of Program Policy Analysis and Government  
 2018 | Accountability shall provide a report to the President of the  
 2019 | Senate and the Speaker of the House of Representatives on a  
 2020 | biennial basis, beginning January 31, 2006, on the agency's  
 2021 | efforts to prevent, detect, and deter, as well as recover funds  
 2022 | lost to, fraud and abuse in the Medicaid program.

2023 (36) The agency may provide to a sample of Medicaid  
2024 recipients or their representatives through the distribution of  
2025 explanations of benefits information about services reimbursed  
2026 by the Medicaid program for goods and services to such  
2027 recipients, including information on how to report inappropriate  
2028 or incorrect billing to the agency or other law enforcement  
2029 entities for review or investigation, information on how to  
2030 report criminal Medicaid fraud to the Medicaid Fraud Control  
2031 Unit's toll-free hotline number, and information about the  
2032 rewards available under s. 409.9203. The explanation of benefits  
2033 may not be mailed for Medicaid independent laboratory services  
2034 as described in s. 409.905(7) or for Medicaid certified match  
2035 services as described in ss. 409.9071 and 1011.70.

2036 (37) The agency shall post on its website a current list  
2037 of each Medicaid provider, including any principal, officer,  
2038 director, agent, managing employee, or affiliated person of the  
2039 provider, or any partner or shareholder having an ownership  
2040 interest in the provider equal to 5 percent or greater, who has  
2041 been terminated for cause from the Medicaid program or  
2042 sanctioned under this section. The list must be searchable by a  
2043 variety of search parameters and provide for the creation of  
2044 formatted lists that may be printed or imported into other  
2045 applications, including spreadsheets. The agency shall update  
2046 the list at least monthly.



2047 (38) In order to improve the detection of health care  
2048 fraud, use technology to prevent and detect fraud, and maximize  
2049 the electronic exchange of health care fraud information, the  
2050 agency shall:

2051 (a) Compile, maintain, and publish on its website a  
2052 detailed list of all state and federal databases that contain  
2053 health care fraud information and update the list at least  
2054 biannually;

2055 (b) Develop a strategic plan to connect all databases that  
2056 contain health care fraud information to facilitate the  
2057 electronic exchange of health information between the agency,  
2058 the Department of Health, the Department of Law Enforcement, and  
2059 the Attorney General's Office. The plan must include recommended  
2060 standard data formats, fraud identification strategies, and  
2061 specifications for the technical interface between state and  
2062 federal health care fraud databases;

2063 (c) Monitor innovations in health information technology,  
2064 specifically as it pertains to Medicaid fraud prevention and  
2065 detection; and

2066 (d) Periodically publish policy briefs that highlight  
2067 available new technology to prevent or detect health care fraud  
2068 and projects implemented by other states, the private sector, or  
2069 the Federal Government which use technology to prevent or detect  
2070 health care fraud.

2071 Section 38. Subsection (1) of section 409.967, Florida  
 2072 Statutes, is amended to read:

2073 409.967 Managed care plan accountability.—

2074 (1) Beginning with the contract procurement process  
 2075 initiated during the 2023 calendar year, the agency shall  
 2076 establish a 6-year ~~5-year~~ contract with each managed care plan  
 2077 selected through the procurement process described in s.  
 2078 409.966. A plan contract may not be renewed; however, the agency  
 2079 may extend the term of a plan contract to cover any delays  
 2080 during the transition to a new plan. The agency shall extend  
 2081 until December 31, 2024, the term of existing plan contracts  
 2082 awarded pursuant to the invitation to negotiate published in  
 2083 July 2017.

2084 Section 39. Paragraph (b) of subsection (5) of section  
 2085 409.973, Florida Statutes, is amended to read:

2086 409.973 Benefits.—

2087 (5) PROVISION OF DENTAL SERVICES.—

2088 (b) In the event the Legislature takes no action before  
 2089 July 1, 2017, with respect to the report findings required under  
 2090 subparagraph (a)2., the agency shall implement a statewide  
 2091 Medicaid prepaid dental health program for children and adults  
 2092 with a choice of at least two licensed dental managed care  
 2093 providers who must have substantial experience in providing  
 2094 dental care to Medicaid enrollees and children eligible for  
 2095 medical assistance under Title XXI of the Social Security Act

2096 and who meet all agency standards and requirements. To qualify  
 2097 as a provider under the prepaid dental health program, the  
 2098 entity must be licensed as a prepaid limited health service  
 2099 organization under part I of chapter 636 or as a health  
 2100 maintenance organization under part I of chapter 641. The  
 2101 contracts for program providers shall be awarded through a  
 2102 competitive procurement process. Beginning with the contract  
 2103 procurement process initiated during the 2023 calendar year, the  
 2104 contracts must be for 6 5 years and may not be renewed; however,  
 2105 the agency may extend the term of a plan contract to cover  
 2106 delays during a transition to a new plan provider. The agency  
 2107 shall include in the contracts a medical loss ratio provision  
 2108 consistent with s. 409.967(4). The agency is authorized to seek  
 2109 any necessary state plan amendment or federal waiver to commence  
 2110 enrollment in the Medicaid prepaid dental health program no  
 2111 later than March 1, 2019. The agency shall extend until December  
 2112 31, 2024, the term of existing plan contracts awarded pursuant  
 2113 to the invitation to negotiate published in October 2017.

2114 Section 40. Subsection (6) of section 429.11, Florida  
 2115 Statutes, is amended to read:

2116 429.11 Initial application for license; provisional  
 2117 license.—

2118 ~~(6) In addition to the license categories available in s.~~  
 2119 ~~408.808, a provisional license may be issued to an applicant~~  
 2120 ~~making initial application for licensure or making application~~

2121 ~~for a change of ownership. A provisional license shall be~~  
2122 ~~limited in duration to a specific period of time not to exceed 6~~  
2123 ~~months, as determined by the agency.~~

2124 Section 41. Subsection (9) of section 429.19, Florida  
2125 Statutes, is amended to read:

2126 429.19 Violations; imposition of administrative fines;  
2127 grounds.—

2128 ~~(9) The agency shall develop and disseminate an annual~~  
2129 ~~list of all facilities sanctioned or fined for violations of~~  
2130 ~~state standards, the number and class of violations involved,~~  
2131 ~~the penalties imposed, and the current status of cases. The list~~  
2132 ~~shall be disseminated, at no charge, to the Department of~~  
2133 ~~Elderly Affairs, the Department of Health, the Department of~~  
2134 ~~Children and Families, the Agency for Persons with Disabilities,~~  
2135 ~~the area agencies on aging, the Florida Statewide Advocacy~~  
2136 ~~Council, the State Long-Term Care Ombudsman Program, and state~~  
2137 ~~and local ombudsman councils. The Department of Children and~~  
2138 ~~Families shall disseminate the list to service providers under~~  
2139 ~~contract to the department who are responsible for referring~~  
2140 ~~persons to a facility for residency. The agency may charge a fee~~  
2141 ~~commensurate with the cost of printing and postage to other~~  
2142 ~~interested parties requesting a copy of this list. This~~  
2143 ~~information may be provided electronically or through the~~  
2144 ~~agency's Internet site.~~

2145 Section 42. Subsection (2) of section 429.35, Florida  
 2146 Statutes, is amended to read:

2147 429.35 Maintenance of records; reports.—

2148 (2) Within 60 days after the date of an ~~the biennial~~  
 2149 inspection conducted ~~visit required~~ under s. 408.811 or within  
 2150 30 days after the date of an ~~any~~ interim visit, the agency shall  
 2151 forward the results of the inspection to the local ombudsman  
 2152 council in the district where the facility is located; to at  
 2153 least one public library or, in the absence of a public library,  
 2154 the county seat in the county in which the inspected assisted  
 2155 living facility is located; and, when appropriate, to the  
 2156 district Adult Services and Mental Health Program Offices.

2157 Section 43. Subsection (2) of section 429.905, Florida  
 2158 Statutes, is amended to read:

2159 429.905 Exemptions; monitoring of adult day care center  
 2160 programs colocated with assisted living facilities or licensed  
 2161 nursing home facilities.—

2162 (2) A licensed assisted living facility, a licensed  
 2163 hospital, or a licensed nursing home facility may provide  
 2164 services during the day which include, but are not limited to,  
 2165 social, health, therapeutic, recreational, nutritional, and  
 2166 respite services, to adults who are not residents. Such a  
 2167 facility need not be licensed as an adult day care center;  
 2168 however, the agency must monitor the facility during the regular  
 2169 inspection ~~and at least biennially~~ to ensure adequate space and

2170 sufficient staff. If an assisted living facility, a hospital, or  
2171 a nursing home holds itself out to the public as an adult day  
2172 care center, it must be licensed as such and meet all standards  
2173 prescribed by statute and rule. For the purpose of this  
2174 subsection, the term "day" means any portion of a 24-hour day.

2175 Section 44. Subsection (2) of section 429.929, Florida  
2176 Statutes, is amended to read:

2177 429.929 Rules establishing standards.—

2178 ~~(2) Pursuant to this part, s. 408.811, and applicable~~  
2179 ~~rules, the agency may conduct an abbreviated biennial inspection~~  
2180 ~~of key quality of care standards, in lieu of a full inspection,~~  
2181 ~~of a center that has a record of good performance. However, the~~  
2182 ~~agency must conduct a full inspection of a center that has had~~  
2183 ~~one or more confirmed complaints within the licensure period~~  
2184 ~~immediately preceding the inspection or which has a serious~~  
2185 ~~problem identified during the abbreviated inspection. The agency~~  
2186 ~~shall develop the key quality of care standards, taking into~~  
2187 ~~consideration the comments and recommendations of provider~~  
2188 ~~groups. These standards shall be included in rules adopted by~~  
2189 ~~the agency.~~

2190 Section 45. Part I of chapter 483, Florida Statutes, is  
2191 repealed.

2192 Section 46. Except as otherwise expressly provided in this  
2193 act and except for this section, which shall take effect upon  
2194 this act becoming a law, this act shall take effect July 1,

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2020

2195 | 2020.

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COMMITTEE/SUBCOMMITTEE ACTION

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

1 Committee/Subcommittee hearing bill: Health & Human Services  
 2 Committee

3 Representative Perez offered the following:

4

5 **Amendment (with title amendment)**

6 Remove everything after the enacting clause and insert:

7 Section 1. Subsections (2) and (4) of section 383.327,  
 8 Florida Statutes, are amended to read:

9 383.327 Birth and death records; reports.-

10 (2) Each maternal death, newborn death, and stillbirth  
 11 shall be reported immediately to the medical examiner and the  
 12 agency.

13 (4) A report shall be submitted ~~annually~~ to the agency.  
 14 The contents of the report and the frequency at which it is  
 15 submitted shall be prescribed by rule of the agency.



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16 Section 2. Subsection (4) of section 395.003, Florida  
17 Statutes, is amended to read:

18 395.003 Licensure; denial, suspension, and revocation.—

19 (4) The agency shall issue a license that ~~which~~ specifies  
20 the service categories and the number of hospital beds in each  
21 bed category for which a license is received. Such information  
22 shall be listed on the face of the license. ~~All beds which are~~  
23 ~~not covered by any specialty-bed-need methodology shall be~~  
24 ~~specified as general beds.~~ A licensed facility shall not operate  
25 a number of hospital beds greater than the number indicated by  
26 the agency on the face of the license without approval from the  
27 agency under conditions established by rule.

28 Section 3. Subsection (18) of section 395.1055, Florida  
29 Statutes, is amended to read:

30 395.1055 Rules and enforcement.—

31 (18) In establishing rules for adult cardiovascular  
32 services, the agency shall include provisions that allow for:

33 (a) The establishment of two hospital program licensure  
34 levels, a Level I program that authorizes the performance of  
35 adult percutaneous cardiac intervention without onsite cardiac  
36 surgery and a Level II program that authorizes the performance  
37 of percutaneous cardiac intervention with onsite cardiac  
38 surgery.

39 (b)1. For a hospital seeking a Level I program,  
40 demonstration that, for the most recent 12-month period as

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41 reported to the agency, the hospital has provided a minimum of  
42 300 adult inpatient and outpatient diagnostic cardiac  
43 catheterizations or, for the most recent 12-month period, has  
44 discharged or transferred at least 300 patients with the  
45 principal diagnosis of ischemic heart disease and that it has a  
46 formalized, written transfer agreement with a hospital that has  
47 a Level II program, including written transport protocols to  
48 ensure safe and efficient transfer of a patient within 60  
49 minutes.

50 2.a. A hospital located more than 100 road miles from the  
51 closest Level II adult cardiovascular services program is not  
52 required to meet the diagnostic cardiac catheterization volume  
53 and ischemic heart disease diagnosis volume requirements in  
54 subparagraph 1. if the hospital demonstrates that it has, for  
55 the most recent 12-month period as reported to the agency,  
56 provided a minimum of 100 adult inpatient and outpatient  
57 diagnostic cardiac catheterizations or that, for the most recent  
58 12-month period, it has discharged or transferred at least 300  
59 patients with the principal diagnosis of ischemic heart disease.

60 b. A hospital located more than 100 road miles from the  
61 closest Level II adult cardiovascular services program does not  
62 need to meet the 60-minute transfer time protocol requirement in  
63 subparagraph 1. if the hospital demonstrates that it has a  
64 formalized, written transfer agreement with a hospital that has  
65 a Level II program. The agreement must include written transport

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66 protocols to ensure the safe and efficient transfer of a  
67 patient, taking into consideration the patient's clinical and  
68 physical characteristics, road and weather conditions, and  
69 viability of ground and air ambulance service to transfer the  
70 patient.

71 3. At a minimum, the rules for adult cardiovascular  
72 services must require nursing and technical staff to have  
73 demonstrated experience in handling acutely ill patients  
74 requiring intervention, based on the staff member's previous  
75 experience in dedicated cardiac interventional laboratories or  
76 surgical centers. If a staff member's previous experience is in  
77 a dedicated cardiac interventional laboratory at a hospital that  
78 does not have an approved adult open heart surgery program, the  
79 staff member's previous experience qualifies only if, at the  
80 time the staff member acquired his or her experience, the  
81 dedicated cardiac interventional laboratory:

82 a. Had an annual volume of 500 or more percutaneous  
83 cardiac intervention procedures.

84 b. Achieved a demonstrated success rate of 95 percent or  
85 greater for percutaneous cardiac intervention procedures.

86 c. Experienced a complication rate of less than 5 percent  
87 for percutaneous cardiac intervention procedures.

88 d. Performed diverse cardiac procedures, including, but  
89 not limited to, balloon angioplasty and stenting, rotational

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90 atherectomy, cutting balloon atheroma remodeling, and procedures  
91 relating to left ventricular support capability.

92 (c) For a hospital seeking a Level II program,  
93 demonstration that, for the most recent 12-month period as  
94 reported to the agency, the hospital has performed a minimum of  
95 1,100 adult inpatient and outpatient cardiac catheterizations,  
96 of which at least 400 must be therapeutic catheterizations, or,  
97 for the most recent 12-month period, has discharged at least 800  
98 patients with the principal diagnosis of ischemic heart disease.

99 (d) Compliance with the most recent guidelines of the  
100 American College of Cardiology and the American Heart  
101 Association guidelines for staffing, physician training and  
102 experience, operating procedures, equipment, physical plant, and  
103 patient selection criteria, to ensure patient quality and  
104 safety.

105 (e) The establishment of appropriate hours of operation  
106 and protocols to ensure availability and timely referral in the  
107 event of emergencies.

108 (f) The demonstration of a plan to provide services to  
109 Medicaid and charity care patients.

110 (g) Hospitals licensed for adult diagnostic cardiac  
111 catheterization, Level I or Level II adult cardiovascular  
112 services must participate in the American College of Cardiology  
113 - National Cardiovascular Data Registry or the American Heart  
114 Association Get with the Guidelines - Coronary Artery Disease

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115 Data Registry and document an ongoing quality improvement plan  
116 to ensure these licensed programs meet or exceed national  
117 quality and outcome benchmarks reported by the registry in which  
118 they participate. Hospitals licensed for Level II adult  
119 cardiovascular services must also participate in the clinical  
120 outcome reporting systems operated by the Society for Thoracic  
121 Surgeons.

122 Section 4. Paragraph (b) of subsection (2) of section  
123 395.602, Florida Statutes, is amended to read:

124 395.602 Rural hospitals.—

125 (2) DEFINITIONS.—As used in this part, the term:

126 (b) "Rural hospital" means an acute care hospital licensed  
127 under this chapter, having 100 or fewer licensed beds and an  
128 emergency room, which is:

129 1. The sole provider within a county with a population  
130 density of up to 100 persons per square mile;

131 2. An acute care hospital, in a county with a population  
132 density of up to 100 persons per square mile, which is at least  
133 30 minutes of travel time, on normally traveled roads under  
134 normal traffic conditions, from any other acute care hospital  
135 within the same county;

136 3. A hospital supported by a tax district or subdistrict  
137 whose boundaries encompass a population of up to 100 persons per  
138 square mile;

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139 4. A hospital classified as a sole community hospital  
140 under 42 C.F.R. s. 412.92, regardless of the number of licensed  
141 beds;

142 5. A hospital with a service area that has a population of  
143 up to 100 persons per square mile. As used in this subparagraph,  
144 the term "service area" means the fewest number of zip codes  
145 that account for 75 percent of the hospital's discharges for the  
146 most recent 5-year period, based on information available from  
147 the hospital inpatient discharge database in the Florida Center  
148 for Health Information and Transparency at the agency; or

149 6. A hospital designated as a critical access hospital, as  
150 defined in s. 408.07.

151  
152 Population densities used in this paragraph must be based upon  
153 the most recently completed United States census. A hospital  
154 that received funds under s. 409.9116 for a quarter beginning no  
155 later than July 1, 2002, is deemed to have been and shall  
156 continue to be a rural hospital from that date through June 30,  
157 2021, if the hospital continues to have up to 100 licensed beds  
158 and an emergency room. An acute care hospital that has not  
159 previously been designated as a rural hospital and that meets  
160 the criteria of this paragraph shall be granted such designation  
161 upon application, including supporting documentation, to the  
162 agency. A hospital that was licensed as a rural hospital during  
163 the 2010-2011 or 2011-2012 fiscal year shall continue to be a

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164 rural hospital from the date of designation through June 30,  
165 ~~2025~~2021, if the hospital continues to have up to 100 licensed  
166 beds and an emergency room.

167 Section 5. Section 395.7015, Florida Statutes, is  
168 repealed.

169 Section 6. Section 395.7016, Florida Statutes, is amended  
170 to read:

171 395.7016 Annual appropriation.—The Legislature shall  
172 appropriate each fiscal year from either the General Revenue  
173 Fund or the Agency for Health Care Administration Tobacco  
174 Settlement Trust Fund an amount sufficient to replace the funds  
175 lost due to ~~reduction by chapter 2000-256, Laws of Florida, of~~  
176 ~~the assessment on other health care entities under s. 395.7015,~~  
177 ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the  
178 assessment on hospitals under s. 395.701~~7~~, and to maintain  
179 federal approval of the reduced amount of funds deposited into  
180 the Public Medical Assistance Trust Fund under s. 395.701~~7~~ as  
181 state match for the state's Medicaid program.

182 Section 7. Subsection (3) of section 400.19, Florida  
183 Statutes, is amended to read:

184 400.19 Right of entry and inspection.—

185 (3) The agency shall conduct periodic, ~~every 15 months~~  
186 ~~conduct at least one~~ unannounced licensure inspections  
187 ~~inspection~~ to determine compliance by the licensee with  
188 statutes, and with rules adopted ~~promulgated~~ under the

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189 ~~provisions of those statutes, governing minimum standards of~~  
190 ~~construction, quality and adequacy of care, and rights of~~  
191 ~~residents. The survey shall be conducted every 6 months for the~~  
192 ~~next 2-year period~~ If the facility has been cited for a class I  
193 deficiency ~~or,~~ has been cited for two or more class II  
194 deficiencies arising from separate surveys or investigations  
195 within a 60-day period, or has had three or more substantiated  
196 complaints within a 6-month period, each resulting in at least  
197 one class I or class II deficiency, the agency shall conduct  
198 biannual licensure surveys until the facility has two  
199 consecutive licensure surveys without a citation for a Class I  
200 or a Class II deficiency. In addition to any other fees or fines  
201 in this part, the agency shall assess a fine of ~~for each~~  
202 ~~facility that is subject to the 6-month survey cycle. The fine~~  
203 ~~for the 2-year period shall be \$6,000~~ for the biannual licensure  
204 surveys, one-half to be paid at the completion of each survey.  
205 The agency may adjust such ~~this~~ fine by the change in the  
206 Consumer Price Index, based on the 12 months immediately  
207 preceding the increase, to cover the cost of the additional  
208 surveys. The agency shall verify through subsequent inspection  
209 that any deficiency identified during inspection is corrected.  
210 However, the agency may verify the correction of a class III or  
211 class IV deficiency unrelated to resident rights or resident  
212 care without reinspecting the facility if adequate written  
213 documentation has been received from the facility, which

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214 provides assurance that the deficiency has been corrected. The  
215 giving or causing to be given of advance notice of such  
216 unannounced inspections by an employee of the agency to any  
217 unauthorized person shall constitute cause for suspension of not  
218 fewer than 5 working days according to ~~the provisions of~~ chapter  
219 110.

220 Section 8. Subsections (23) through (30) of section  
221 400.462, Florida Statutes, are renumbered as subsections (22)  
222 through (29), respectively, and subsections (12), (14), (17),  
223 and (21) and present subsection (22) of that section are amended  
224 to read:

225 400.462 Definitions.—As used in this part, the term:

226 (12) "Home health agency" means a person ~~an organization~~  
227 that provides one or more home health services ~~and staffing~~  
228 services.

229 (14) "Home health services" means health and medical  
230 services and medical supplies furnished ~~by an organization~~ to an  
231 individual in the individual's home or place of residence. The  
232 term includes ~~organizations that provide one or more of the~~  
233 following:

234 (a) Nursing care.

235 (b) Physical, occupational, respiratory, or speech  
236 therapy.

237 (c) Home health aide services.

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238 (d) Dietetics and nutrition practice and nutrition  
239 counseling.

240 (e) Medical supplies, restricted to drugs and biologicals  
241 prescribed by a physician.

242 (17) "Home infusion therapy provider" means a person ~~an~~  
243 ~~organization~~ that employs, contracts with, or refers a licensed  
244 professional who has received advanced training and experience  
245 in intravenous infusion therapy and who administers infusion  
246 therapy to a patient in the patient's home or place of  
247 residence.

248 (21) "Nurse registry" means any person that procures,  
249 offers, promises, or attempts to secure health-care-related  
250 contracts for registered nurses, licensed practical nurses,  
251 certified nursing assistants, home health aides, companions, or  
252 homemakers, who are compensated by fees as independent  
253 contractors, including, but not limited to, contracts for the  
254 provision of services to patients and contracts to provide  
255 private duty or staffing services to health care facilities  
256 licensed under chapter 395, this chapter, or chapter 429 or  
257 other business entities.

258 ~~(22) "Organization" means a corporation, government or~~  
259 ~~governmental subdivision or agency, partnership or association,~~  
260 ~~or any other legal or commercial entity, any of which involve~~  
261 ~~more than one health care professional discipline; a health care~~  
262 ~~professional and a home health aide or certified nursing~~

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263 ~~assistant; more than one home health aide; more than one~~  
264 ~~certified nursing assistant; or a home health aide and a~~  
265 ~~certified nursing assistant. The term does not include an entity~~  
266 ~~that provides services using only volunteers or only individuals~~  
267 ~~related by blood or marriage to the patient or client.~~

268 Section 9. Subsections (1), (4), and (5) of section  
269 400.464, Florida Statutes, are amended to read:

270 400.464 Home health agencies to be licensed; expiration of  
271 license; exemptions; unlawful acts; penalties.—

272 (1) The requirements of part II of chapter 408 apply to  
273 the provision of services that require licensure pursuant to  
274 this part and part II of chapter 408 and persons or entities  
275 licensed or registered by or applying for such licensure or  
276 registration from the Agency for Health Care Administration  
277 pursuant to this part. A license or registration issued by the  
278 agency is required in order to operate a home health agency in  
279 this state. A license or registration issued on or after July 1,  
280 2018, must specify the home health services the licensee or  
281 registrant organization is authorized to perform and indicate  
282 whether such specified services are considered skilled care. The  
283 provision or advertising of services that require licensure or  
284 registration pursuant to this part without such services being  
285 specified on the face of the license or registration issued on  
286 or after July 1, 2018, constitutes unlicensed activity as  
287 prohibited under s. 408.812.

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288 (4) (a) A licensee or registrant ~~An organization~~ that  
289 offers or advertises to the public any service for which  
290 licensure or registration is required under this part must  
291 include in the advertisement the license number or registration  
292 number issued to the licensee or registrant ~~organization~~ by the  
293 agency. The agency shall assess a fine of not less than \$100 to  
294 any licensee or registrant that ~~who~~ fails to include the license  
295 or registration number when submitting the advertisement for  
296 publication, broadcast, or printing. The fine for a second or  
297 subsequent offense is \$500. The holder of a license or  
298 registration issued under this part may not advertise or  
299 indicate to the public that it holds a home health agency or  
300 nurse registry license or registration other than the one it has  
301 been issued.

302 (b) The operation or maintenance of an unlicensed home  
303 health agency or the performance of any home health services in  
304 violation of this part is declared a nuisance, inimical to the  
305 public health, welfare, and safety. The agency or any state  
306 attorney may, in addition to other remedies provided in this  
307 part, bring an action for an injunction to restrain such  
308 violation, or to enjoin the future operation or maintenance of  
309 the home health agency or the provision of home health services  
310 in violation of this part or part II of chapter 408, until  
311 compliance with this part or the rules adopted under this part  
312 has been demonstrated to the satisfaction of the agency.

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313 (c) A person who violates paragraph (a) is subject to an  
314 injunctive proceeding under s. 408.816. A violation of paragraph  
315 (a) or s. 408.812 is a deceptive and unfair trade practice and  
316 constitutes a violation of the Florida Deceptive and Unfair  
317 Trade Practices Act under part II of chapter 501.

318 (d) A person who violates the provisions of paragraph (a)  
319 commits a misdemeanor of the second degree, punishable as  
320 provided in s. 775.082 or s. 775.083. Any person who commits a  
321 second or subsequent violation commits a misdemeanor of the  
322 first degree, punishable as provided in s. 775.082 or s.  
323 775.083. Each day of continuing violation constitutes a separate  
324 offense.

325 (e) Any person who owns, operates, or maintains an  
326 unlicensed home health agency and who, after receiving  
327 notification from the agency, fails to cease operation and apply  
328 for a license under this part commits a misdemeanor of the  
329 second degree, punishable as provided in s. 775.082 or s.  
330 775.083. Each day of continued operation is a separate offense.

331 (f) A ~~Any~~ home health agency that fails to cease operation  
332 after agency notification may be fined in accordance with s.  
333 408.812.

334 (5) The following are exempt from ~~the~~ licensure as a home  
335 health agency under requirements of this part:

336 (a) A home health agency operated by the Federal  
337 Government.

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- 338 (b) Home health services provided by a state agency,  
339 either directly or through a contractor with:
- 340 1. The Department of Elderly Affairs.
  - 341 2. The Department of Health, a community health center, or  
342 a rural health network that furnishes home visits for the  
343 purpose of providing environmental assessments, case management,  
344 health education, personal care services, family planning, or  
345 followup treatment, or for the purpose of monitoring and  
346 tracking disease.
  - 347 3. Services provided to persons with developmental  
348 disabilities, as defined in s. 393.063.
  - 349 4. Companion and sitter organizations that were registered  
350 under s. 400.509(1) on January 1, 1999, and were authorized to  
351 provide personal services under a developmental services  
352 provider certificate on January 1, 1999, may continue to provide  
353 such services to past, present, and future clients of the  
354 organization who need such services, notwithstanding ~~the~~  
355 ~~provisions of~~ this act.
  - 356 5. The Department of Children and Families.
- 357 (c) A health care professional, whether or not  
358 incorporated, who is licensed under chapter 457; chapter 458;  
359 chapter 459; part I of chapter 464; chapter 467; part I, part  
360 III, part V, or part X of chapter 468; chapter 480; chapter 486;  
361 chapter 490; or chapter 491; and who is acting alone within the

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362 scope of his or her professional license to provide care to  
363 patients in their homes.

364 (d) A home health aide or certified nursing assistant who  
365 is acting in his or her individual capacity, within the  
366 definitions and standards of his or her occupation, and who  
367 provides hands-on care to patients in their homes.

368 (e) An individual who acts alone, in his or her individual  
369 capacity, and who is not employed by or affiliated with a  
370 licensed home health agency or registered with a licensed nurse  
371 registry. This exemption does not entitle an individual to  
372 perform home health services without the required professional  
373 license.

374 (f) The delivery of instructional services in home  
375 dialysis and home dialysis supplies and equipment.

376 (g) The delivery of nursing home services for which the  
377 nursing home is licensed under part II of this chapter, to serve  
378 its residents in its facility.

379 (h) The delivery of assisted living facility services for  
380 which the assisted living facility is licensed under part I of  
381 chapter 429, to serve its residents in its facility.

382 (i) The delivery of hospice services for which the hospice  
383 is licensed under part IV of this chapter, to serve hospice  
384 patients admitted to its service.

385 (j) A hospital that provides services for which it is  
386 licensed under chapter 395.

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387 (k) The delivery of community residential services for  
388 which the community residential home is licensed under chapter  
389 419, to serve the residents in its facility.

390 (l) A not-for-profit, community-based agency that provides  
391 early intervention services to infants and toddlers.

392 (m) Certified rehabilitation agencies and comprehensive  
393 outpatient rehabilitation facilities that are certified under  
394 Title 18 of the Social Security Act.

395 (n) The delivery of adult family-care home services for  
396 which the adult family-care home is licensed under part II of  
397 chapter 429, to serve the residents in its facility.

398 (o) A person that provides skilled care by health care  
399 professionals licensed solely under part I of chapter 464; part  
400 I, part III, or part V of chapter 468; or chapter 486. This  
401 exemption does not entitle an individual to perform home health  
402 services without the required professional license.

403 (p) A person that provides services using only volunteers  
404 or individuals related by blood or marriage to the patient or  
405 client.

406 Section 10. Paragraph (g) of subsection (2) of section  
407 400.471, Florida Statutes, is amended to read:

408 400.471 Application for license; fee.—

409 (2) In addition to the requirements of part II of chapter  
410 408, the initial applicant, the applicant for a change of  
411 ownership, and the applicant for the addition of skilled care

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412 services must file with the application satisfactory proof that  
413 the home health agency is in compliance with this part and  
414 applicable rules, including:

415 (g) In the case of an application for initial licensure,  
416 an application for a change of ownership, or an application for  
417 the addition of skilled care services, documentation of  
418 accreditation, or an application for accreditation, from an  
419 accrediting organization that is recognized by the agency as  
420 having standards comparable to those required by this part and  
421 part II of chapter 408. A home health agency that does not  
422 provide skilled care is exempt from this paragraph.  
423 Notwithstanding s. 408.806, the ~~an initial~~ applicant must  
424 provide proof of accreditation that is not conditional or  
425 provisional and a survey demonstrating compliance with the  
426 requirements of this part, part II of chapter 408, and  
427 applicable rules from an accrediting organization that is  
428 recognized by the agency as having standards comparable to those  
429 required by this part and part II of chapter 408 within 120 days  
430 after the date of the agency's receipt of the application for  
431 licensure. Such accreditation must be continuously maintained by  
432 the home health agency to maintain licensure. The agency shall  
433 accept, in lieu of its own periodic licensure survey, the  
434 submission of the survey of an accrediting organization that is  
435 recognized by the agency if the accreditation of the licensed  
436 home health agency is not provisional and if the licensed home

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437 health agency authorizes release of, and the agency receives the  
438 report of, the accrediting organization.

439 Section 11. Section 400.492, Florida Statutes, is amended  
440 to read:

441 400.492 Provision of services during an emergency.—Each  
442 home health agency shall prepare and maintain a comprehensive  
443 emergency management plan that is consistent with the standards  
444 adopted by national or state accreditation organizations and  
445 consistent with the local special needs plan. The plan shall be  
446 updated annually and shall provide for continuing home health  
447 services during an emergency that interrupts patient care or  
448 services in the patient's home. The plan shall include the means  
449 by which the home health agency will continue to provide staff  
450 to perform the same type and quantity of services to their  
451 patients who evacuate to special needs shelters that were being  
452 provided to those patients prior to evacuation. The plan shall  
453 describe how the home health agency establishes and maintains an  
454 effective response to emergencies and disasters, including:  
455 notifying staff when emergency response measures are initiated;  
456 providing for communication between staff members, county health  
457 departments, and local emergency management agencies, including  
458 a backup system; identifying resources necessary to continue  
459 essential care or services or referrals to other health care  
460 providers ~~organizations~~ subject to written agreement; and

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461 prioritizing and contacting patients who need continued care or  
462 services.

463 (1) Each patient record for patients who are listed in the  
464 registry established pursuant to s. 252.355 shall include a  
465 description of how care or services will be continued in the  
466 event of an emergency or disaster. The home health agency shall  
467 discuss the emergency provisions with the patient and the  
468 patient's caregivers, including where and how the patient is to  
469 evacuate, procedures for notifying the home health agency in the  
470 event that the patient evacuates to a location other than the  
471 shelter identified in the patient record, and a list of  
472 medications and equipment which must either accompany the  
473 patient or will be needed by the patient in the event of an  
474 evacuation.

475 (2) Each home health agency shall maintain a current  
476 prioritized list of patients who need continued services during  
477 an emergency. The list shall indicate how services shall be  
478 continued in the event of an emergency or disaster for each  
479 patient and if the patient is to be transported to a special  
480 needs shelter, and shall indicate if the patient is receiving  
481 skilled nursing services and the patient's medication and  
482 equipment needs. The list shall be furnished to county health  
483 departments and to local emergency management agencies, upon  
484 request.

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485 (3) Home health agencies shall not be required to continue  
486 to provide care to patients in emergency situations that are  
487 beyond their control and that make it impossible to provide  
488 services, such as when roads are impassable or when patients do  
489 not go to the location specified in their patient records. Home  
490 health agencies may establish links to local emergency  
491 operations centers to determine a mechanism by which to approach  
492 specific areas within a disaster area in order for the agency to  
493 reach its clients. Home health agencies shall demonstrate a good  
494 faith effort to comply with the requirements of this subsection  
495 by documenting attempts of staff to follow procedures outlined  
496 in the home health agency's comprehensive emergency management  
497 plan, and by the patient's record, which support a finding that  
498 the provision of continuing care has been attempted for those  
499 patients who have been identified as needing care by the home  
500 health agency and registered under s. 252.355, in the event of  
501 an emergency or disaster under subsection (1).

502 (4) Notwithstanding the provisions of s. 400.464(2) or any  
503 other provision of law to the contrary, a home health agency may  
504 provide services in a special needs shelter located in any  
505 county.

506 Section 12. Subsection (4) of section 400.506, Florida  
507 Statutes, is amended to read:

508 400.506 Licensure of nurse registries; requirements;  
509 penalties.—

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510 (4) A licensee ~~person~~ that provides, offers, or advertises  
511 to the public any service for which licensure is required under  
512 this section must include in such advertisement the license  
513 number issued to it by the Agency for Health Care  
514 Administration. The agency shall assess a fine of not less than  
515 \$100 against a any licensee that ~~who~~ fails to include the  
516 license number when submitting the advertisement for  
517 publication, broadcast, or printing. The fine for a second or  
518 subsequent offense is \$500.

519 Section 13. Subsections (1), (2), (3), (4), and (5) of  
520 section 400.509, Florida Statutes, are amended to read:

521 400.509 Registration of particular service providers  
522 exempt from licensure; certificate of registration; regulation  
523 of registrants.—

524 (1) Any person ~~organization~~ that provides companion  
525 services or homemaker services and does not provide a home  
526 health service to a person is exempt from licensure under this  
527 part. However, any person ~~organization~~ that provides companion  
528 services or homemaker services must register with the agency. A  
529 person ~~An~~ organization under contract with the Agency for  
530 Persons with Disabilities which provides companion services only  
531 for persons with a developmental disability, as defined in s.  
532 393.063, is exempt from registration.

533 (2) The requirements of part II of chapter 408 apply to  
534 the provision of services that require registration or licensure

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535 pursuant to this section and part II of chapter 408 and entities  
536 registered by or applying for such registration from the Agency  
537 for Health Care Administration pursuant to this section. Each  
538 applicant for registration and each registrant must comply with  
539 all provisions of part II of chapter 408. Registration or a  
540 license issued by the agency is required for a person to provide  
541 ~~the operation of an organization that provides~~ companion  
542 services or homemaker services.

543 (3) In accordance with s. 408.805, applicants and  
544 registrants shall pay fees for all registrations issued under  
545 this part, part II of chapter 408, and applicable rules. The  
546 amount of the fee shall be \$50 per biennium.

547 (4) Each registrant must obtain the employment or contract  
548 history of persons who are employed by or under contract with  
549 the person ~~organization~~ and who will have contact at any time  
550 with patients or clients in their homes by:

551 (a) Requiring such persons to submit an employment or  
552 contractual history to the registrant; and

553 (b) Verifying the employment or contractual history,  
554 unless through diligent efforts such verification is not  
555 possible. The agency shall prescribe by rule the minimum  
556 requirements for establishing that diligent efforts have been  
557 made.

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559 There is no monetary liability on the part of, and no cause of  
560 action for damages arises against, a former employer of a  
561 prospective employee of or prospective independent contractor  
562 with a registrant who reasonably and in good faith communicates  
563 his or her honest opinions about the former employee's or  
564 contractor's job performance. This subsection does not affect  
565 the official immunity of an officer or employee of a public  
566 corporation.

567 Section 14. Subsection (3) of section 400.605, Florida  
568 Statutes, is amended to read:

569 400.605 Administration; forms; fees; rules; inspections;  
570 fines.—

571 (3) In accordance with s. 408.811, the agency shall  
572 ~~conduct annual inspections of all licensees, except that~~  
573 ~~licensure inspections may be conducted biennially for hospices~~  
574 ~~having a 3-year record of substantial compliance. The agency~~  
575 ~~shall conduct~~ such inspections and investigations as are  
576 necessary in order to determine the state of compliance with ~~the~~  
577 ~~provisions of~~ this part, part II of chapter 408, and applicable  
578 rules.

579 Section 15. Section 400.60501, Florida Statutes, is  
580 amended to read:

581 400.60501 Outcome measures; adoption of federal quality  
582 measures; public reporting; ~~annual report.~~—

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583 (1) ~~No later than December 31, 2019,~~ The agency shall  
584 adopt the national hospice outcome measures and survey data in  
585 42 C.F.R. part 418 to determine the quality and effectiveness of  
586 hospice care for hospices licensed in the state.

587 (2) The agency shall:

588 ~~(a)~~ make available to the public the national hospice  
589 outcome measures and survey data in a format that is  
590 comprehensible by a layperson and that allows a consumer to  
591 compare such measures of one or more hospices.

592 ~~(b) Develop an annual report that analyzes and evaluates~~  
593 ~~the information collected under this act and any other data~~  
594 ~~collection or reporting provisions of law.~~

595 Section 16. Paragraphs (a), (b), (c), and (d) of  
596 subsection (4) of section 400.9905, Florida Statutes, are  
597 amended, and paragraphs (o), (p), and (q) are added to that  
598 subsection, to read:

599 400.9905 Definitions.—

600 (4) "Clinic" means an entity where health care services  
601 are provided to individuals and which tenders charges for  
602 reimbursement for such services, including a mobile clinic and a  
603 portable equipment provider. As used in this part, the term does  
604 not include and the licensure requirements of this part do not  
605 apply to:

606 (a) Entities licensed or registered by the state under  
607 chapter 395; entities licensed or registered by the state and



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608 providing only health care services within the scope of services  
609 authorized under their respective licenses under ss. 383.30-  
610 383.332, chapter 390, chapter 394, chapter 397, this chapter  
611 except part X, chapter 429, chapter 463, chapter 465, chapter  
612 466, chapter 478, chapter 484, or chapter 651; end-stage renal  
613 disease providers authorized under 42 C.F.R. part 494 405,  
614 ~~subpart U~~; providers certified and providing only health care  
615 services within the scope of services authorized under their  
616 respective certifications under 42 C.F.R. part 485, subpart B,  
617 ~~or~~ subpart H, or subpart J; providers certified and providing  
618 only health care services within the scope of services  
619 authorized under their respective certifications under 42 C.F.R.  
620 part 486, subpart C; providers certified and providing only  
621 health care services within the scope of services authorized  
622 under their respective certifications under 42 C.F.R. part 491,  
623 subpart A; providers certified by the Centers for Medicare and  
624 Medicaid services under the federal Clinical Laboratory  
625 Improvement Amendments and the federal rules adopted thereunder;  
626 or any entity that provides neonatal or pediatric hospital-based  
627 health care services or other health care services by licensed  
628 practitioners solely within a hospital licensed under chapter  
629 395.

630 (b) Entities that own, directly or indirectly, entities  
631 licensed or registered by the state pursuant to chapter 395;  
632 entities that own, directly or indirectly, entities licensed or

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633 registered by the state and providing only health care services  
634 within the scope of services authorized pursuant to their  
635 respective licenses under ss. 383.30-383.332, chapter 390,  
636 chapter 394, chapter 397, this chapter except part X, chapter  
637 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter  
638 484, or chapter 651; end-stage renal disease providers  
639 authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers  
640 certified and providing only health care services within the  
641 scope of services authorized under their respective  
642 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart  
643 H, or subpart J; providers certified and providing only health  
644 care services within the scope of services authorized under  
645 their respective certifications under 42 C.F.R. part 486,  
646 subpart C; providers certified and providing only health care  
647 services within the scope of services authorized under their  
648 respective certifications under 42 C.F.R. part 491, subpart A;  
649 providers certified by the Centers for Medicare and Medicaid  
650 services under the federal Clinical Laboratory Improvement  
651 Amendments and the federal rules adopted thereunder; or any  
652 entity that provides neonatal or pediatric hospital-based health  
653 care services by licensed practitioners solely within a hospital  
654 licensed under chapter 395.

655 (c) Entities that are owned, directly or indirectly, by an  
656 entity licensed or registered by the state pursuant to chapter  
657 395; entities that are owned, directly or indirectly, by an

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658 entity licensed or registered by the state and providing only  
659 health care services within the scope of services authorized  
660 pursuant to their respective licenses under ss. 383.30-383.332,  
661 chapter 390, chapter 394, chapter 397, this chapter except part  
662 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter  
663 478, chapter 484, or chapter 651; end-stage renal disease  
664 providers authorized under 42 C.F.R. part ~~494~~ 405, ~~subpart U~~;  
665 providers certified and providing only health care services  
666 within the scope of services authorized under their respective  
667 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart  
668 H, or subpart J; providers certified and providing only health  
669 care services within the scope of services authorized under  
670 their respective certifications under 42 C.F.R. part 486,  
671 subpart C; providers certified and providing only health care  
672 services within the scope of services authorized under their  
673 respective certifications under 42 C.F.R. part 491, subpart A;  
674 providers certified by the Centers for Medicare and Medicaid  
675 services under the federal Clinical Laboratory Improvement  
676 Amendments and the federal rules adopted thereunder; or any  
677 entity that provides neonatal or pediatric hospital-based health  
678 care services by licensed practitioners solely within a hospital  
679 under chapter 395.

680 (d) Entities that are under common ownership, directly or  
681 indirectly, with an entity licensed or registered by the state  
682 pursuant to chapter 395; entities that are under common

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683 ownership, directly or indirectly, with an entity licensed or  
684 registered by the state and providing only health care services  
685 within the scope of services authorized pursuant to their  
686 respective licenses under ss. 383.30-383.332, chapter 390,  
687 chapter 394, chapter 397, this chapter except part X, chapter  
688 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter  
689 484, or chapter 651; end-stage renal disease providers  
690 authorized under 42 C.F.R. part ~~494 405, subpart U~~; providers  
691 certified and providing only health care services within the  
692 scope of services authorized under their respective  
693 certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart  
694 H, or subpart J; providers certified and providing only health  
695 care services within the scope of services authorized under  
696 their respective certifications under 42 C.F.R. part 486,  
697 subpart C; providers certified and providing only health care  
698 services within the scope of services authorized under their  
699 respective certifications under 42 C.F.R. part 491, subpart A;  
700 providers certified by the Centers for Medicare and Medicaid  
701 services under the federal Clinical Laboratory Improvement  
702 Amendments and the federal rules adopted thereunder; or any  
703 entity that provides neonatal or pediatric hospital-based health  
704 care services by licensed practitioners solely within a hospital  
705 licensed under chapter 395.

706 (o) Entities that are, directly or indirectly, under the  
707 common ownership of or that are subject to common control by a

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708 mutual insurance holding company, as defined in s. 628.703, with  
709 an entity licensed or certified under chapter 627 or chapter 641  
710 which has \$1 billion or more in total annual sales in this  
711 state.

712 (p) Entities that are owned by an entity that is a  
713 behavioral health care service provider in at least five other  
714 states; that, together with its affiliates, have \$90 million or  
715 more in total annual revenues associated with the provision of  
716 behavioral health care services; and wherein one or more of the  
717 persons responsible for the operations of the entity is a health  
718 care practitioner who is licensed in this state, who is  
719 responsible for supervising the business activities of the  
720 entity, and who is responsible for the entity's compliance with  
721 state law for purposes of this part.

722 (q) Medicaid providers.

723  
724 Notwithstanding this subsection, an entity shall be deemed a  
725 clinic and must be licensed under this part in order to receive  
726 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.  
727 627.730-627.7405, unless exempted under s. 627.736(5)(h).

728 Section 17. Paragraph (c) of subsection (3) of section  
729 400.991, Florida Statutes, is amended to read:

730 400.991 License requirements; background screenings;  
731 prohibitions.-

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732 (3) In addition to the requirements of part II of chapter  
733 408, the applicant must file with the application satisfactory  
734 proof that the clinic is in compliance with this part and  
735 applicable rules, including:

736 (c) Proof of financial ability to operate as required  
737 under ss. 408.8065(1) and s. 408.810(8). ~~As an alternative to~~  
738 ~~submitting proof of financial ability to operate as required~~  
739 ~~under s. 408.810(8), the applicant may file a surety bond of at~~  
740 ~~least \$500,000 which guarantees that the clinic will act in full~~  
741 ~~conformity with all legal requirements for operating a clinic,~~  
742 ~~payable to the agency. The agency may adopt rules to specify~~  
743 ~~related requirements for such surety bond.~~

744 Section 18. Paragraph (i) of subsection (1) of section  
745 400.9935, Florida Statutes, is amended to read:

746 400.9935 Clinic responsibilities.—

747 (1) Each clinic shall appoint a medical director or clinic  
748 director who shall agree in writing to accept legal  
749 responsibility for the following activities on behalf of the  
750 clinic. The medical director or the clinic director shall:

751 (i) Ensure that the clinic publishes a schedule of charges  
752 for the medical services offered to patients. The schedule must  
753 include the prices charged to an uninsured person paying for  
754 such services by cash, check, credit card, or debit card. The  
755 schedule may group services by price levels, listing services in  
756 each price level. The schedule must be posted in a conspicuous

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757 place in the reception area of any clinic that is considered an  
758 ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must  
759 include, but is not limited to, the 50 services most frequently  
760 provided by the clinic. ~~The schedule may group services by three~~  
761 ~~price levels, listing services in each price level.~~ The posting  
762 may be a sign that must be at least 15 square feet in size or  
763 through an electronic messaging board that is at least 3 square  
764 feet in size. The failure of a clinic, including a clinic that  
765 is considered an urgent care center, to publish and post a  
766 schedule of charges as required by this section shall result in  
767 a fine of not more than \$1,000, per day, until the schedule is  
768 published and posted.

769 Section 19. Paragraph (a) of subsection (2) of section  
770 408.033, Florida Statutes, is amended to read:

771 408.033 Local and state health planning.—

772 (2) FUNDING.—

773 (a) The Legislature intends that the cost of local health  
774 councils be borne by assessments on selected health care  
775 facilities subject to facility licensure by the Agency for  
776 Health Care Administration, including abortion clinics, assisted  
777 living facilities, ambulatory surgical centers, birth centers,  
778 home health agencies, hospices, hospitals, intermediate care  
779 facilities for the developmentally disabled, nursing homes, and  
780 health care clinics, ~~and multiphasic testing centers~~ and by  
781 assessments on organizations subject to certification by the

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782 agency pursuant to chapter 641, part III, including health  
783 maintenance organizations and prepaid health clinics. Fees  
784 assessed may be collected prospectively at the time of licensure  
785 renewal and prorated for the licensure period.

786 Section 20. Effective January 1, 2021, subsection (3) of  
787 section 408.05, Florida Statutes, is amended to read:

788 408.05 Florida Center for Health Information and  
789 Transparency.—

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

794 (1) By July 1 of each year, publish a report identifying  
795 the health care services with the most significant price  
796 variation both statewide and regionally.

797 Section 21. Paragraph (a) of subsection (1) of section  
798 408.061, Florida Statutes, is amended to read:

799 408.061 Data collection; uniform systems of financial  
800 reporting; information relating to physician charges;  
801 confidential information; immunity.—

802 (1) The agency shall require the submission by health care  
803 facilities, health care providers, and health insurers of data  
804 necessary to carry out the agency's duties and to facilitate  
805 transparency in health care pricing data and quality measures.  
806 Specifications for data to be collected under this section shall

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807 be developed by the agency and applicable contract vendors, with  
808 the assistance of technical advisory panels including  
809 representatives of affected entities, consumers, purchasers, and  
810 such other interested parties as may be determined by the  
811 agency.

812 (a) Data submitted by health care facilities, including  
813 the facilities as defined in chapter 395, shall include, but are  
814 not limited to, ~~case-mix data~~, patient admission and discharge  
815 data, hospital emergency department data which shall include the  
816 number of patients treated in the emergency department of a  
817 licensed hospital reported by patient acuity level, data on  
818 hospital-acquired infections as specified by rule, data on  
819 complications as specified by rule, data on readmissions as  
820 specified by rule, including patient- ~~with patient~~ and provider-  
821 specific identifiers ~~included~~, actual charge data by diagnostic  
822 groups or other bundled groupings as specified by rule,  
823 financial data, accounting data, operating expenses, expenses  
824 incurred for rendering services to patients who cannot or do not  
825 pay, interest charges, depreciation expenses based on the  
826 expected useful life of the property and equipment involved, and  
827 demographic data. The agency shall adopt nationally recognized  
828 risk adjustment methodologies or software consistent with the  
829 standards of the Agency for Healthcare Research and Quality and  
830 as selected by the agency for all data submitted as required by  
831 this section. Data may be obtained from documents including such

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832 ~~as~~, but not limited to, ~~÷~~ leases, contracts, debt instruments,  
833 itemized patient statements or bills, medical record abstracts,  
834 and related diagnostic information. ~~Reported~~ Data elements shall  
835 be reported electronically in accordance with rules adopted by  
836 the agency rule 59E-7.012, Florida Administrative Code. Data  
837 submitted shall be certified by the chief executive officer or  
838 an appropriate and duly authorized representative or employee of  
839 the licensed facility that the information submitted is true and  
840 accurate.

841 Section 22. Subsection (4) of section 408.0611, Florida  
842 Statutes, is amended to read:

843 408.0611 Electronic prescribing clearinghouse.—

844 (4) Pursuant to s. 408.061, the agency shall monitor the  
845 implementation of electronic prescribing by health care  
846 practitioners, health care facilities, and pharmacies. ~~By~~  
847 ~~January 31 of each year,~~ The agency shall annually publish a  
848 report on the progress of implementation of electronic  
849 prescribing on its Internet website to the Governor and the  
850 ~~Legislature~~. Information reported pursuant to this subsection  
851 shall include federal and private sector electronic prescribing  
852 initiatives and, to the extent that data is readily available  
853 from organizations that operate electronic prescribing networks,  
854 the number of health care practitioners using electronic  
855 prescribing and the number of prescriptions electronically  
856 transmitted.

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857 Section 23. Paragraphs (i) and (j) of subsection (1) of  
858 section 408.062, Florida Statutes, are amended to read:

859 408.062 Research, analyses, studies, and reports.—

860 (1) The agency shall conduct research, analyses, and  
861 studies relating to health care costs and access to and quality  
862 of health care services as access and quality are affected by  
863 changes in health care costs. Such research, analyses, and  
864 studies shall include, but not be limited to:

865 (i) The use of emergency department services by patient  
866 acuity level ~~and the implication of increasing hospital cost by~~  
867 ~~providing nonurgent care in emergency departments.~~ The agency  
868 shall annually publish information ~~submit an annual report~~ based  
869 on this monitoring and assessment on its Internet website ~~to the~~  
870 ~~Governor, the Speaker of the House of Representatives, the~~  
871 ~~President of the Senate, and the substantive legislative~~  
872 ~~committees, due January 1.~~

873 (j) The making available on its Internet website, and in a  
874 hard-copy format upon request, of patient charge, volumes,  
875 length of stay, and performance indicators collected from health  
876 care facilities pursuant to s. 408.061(1)(a) for specific  
877 medical conditions, surgeries, and procedures provided in  
878 inpatient and outpatient facilities as determined by the agency.  
879 In making the determination of specific medical conditions,  
880 surgeries, and procedures to include, the agency shall consider  
881 such factors as volume, severity of the illness, urgency of

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882 admission, individual and societal costs, and whether the  
883 condition is acute or chronic. Performance outcome indicators  
884 shall be risk adjusted or severity adjusted, as applicable,  
885 using nationally recognized risk adjustment methodologies or  
886 software consistent with the standards of the Agency for  
887 Healthcare Research and Quality and as selected by the agency.  
888 The website shall also provide an interactive search that allows  
889 consumers to view and compare the information for specific  
890 facilities, a map that allows consumers to select a county or  
891 region, definitions of all of the data, descriptions of each  
892 procedure, and an explanation about why the data may differ from  
893 facility to facility. Such public data shall be updated  
894 quarterly. The agency shall annually publish information  
895 regarding ~~submit an annual status report on~~ the collection of  
896 data and publication of health care quality measures on its  
897 Internet website ~~to the Governor, the Speaker of the House of~~  
898 ~~Representatives, the President of the Senate, and the~~  
899 ~~substantive legislative committees, due January 1.~~

900 Section 24. Subsection (5) of section 408.063, Florida  
901 Statutes, is amended to read:

902 408.063 Dissemination of health care information.—

903 ~~(5) The agency shall publish annually a comprehensive~~  
904 ~~report of state health expenditures. The report shall identify:~~

905 ~~(a) The contribution of health care dollars made by all~~  
906 ~~payors.~~

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907 ~~(b) The dollars expended by type of health care service in~~  
908 ~~Florida.~~

909 Section 25. Section 408.802, Florida Statutes, is amended  
910 to read:

911 408.802 Applicability. ~~The provisions of This part~~ applies  
912 ~~apply~~ to the provision of services that require licensure as  
913 defined in this part and to the following entities licensed,  
914 registered, or certified by the agency, as described in chapters  
915 112, 383, 390, 394, 395, 400, 429, 440, ~~483~~, and 765:

916 (1) Laboratories authorized to perform testing under the  
917 Drug-Free Workplace Act, as provided under ss. 112.0455 and  
918 440.102.

919 (2) Birth centers, as provided under chapter 383.

920 (3) Abortion clinics, as provided under chapter 390.

921 (4) Crisis stabilization units, as provided under parts I  
922 and IV of chapter 394.

923 (5) Short-term residential treatment facilities, as  
924 provided under parts I and IV of chapter 394.

925 (6) Residential treatment facilities, as provided under  
926 part IV of chapter 394.

927 (7) Residential treatment centers for children and  
928 adolescents, as provided under part IV of chapter 394.

929 (8) Hospitals, as provided under part I of chapter 395.

930 (9) Ambulatory surgical centers, as provided under part I  
931 of chapter 395.

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932 (10) Nursing homes, as provided under part II of chapter  
933 400.

934 (11) Assisted living facilities, as provided under part I  
935 of chapter 429.

936 (12) Home health agencies, as provided under part III of  
937 chapter 400.

938 (13) Nurse registries, as provided under part III of  
939 chapter 400.

940 (14) Companion services or homemaker services providers,  
941 as provided under part III of chapter 400.

942 (15) Adult day care centers, as provided under part III of  
943 chapter 429.

944 (16) Hospices, as provided under part IV of chapter 400.

945 (17) Adult family-care homes, as provided under part II of  
946 chapter 429.

947 (18) Homes for special services, as provided under part V  
948 of chapter 400.

949 (19) Transitional living facilities, as provided under  
950 part XI of chapter 400.

951 (20) Prescribed pediatric extended care centers, as  
952 provided under part VI of chapter 400.

953 (21) Home medical equipment providers, as provided under  
954 part VII of chapter 400.

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955 (22) Intermediate care facilities for persons with  
956 developmental disabilities, as provided under part VIII of  
957 chapter 400.

958 (23) Health care services pools, as provided under part IX  
959 of chapter 400.

960 (24) Health care clinics, as provided under part X of  
961 chapter 400.

962 ~~(25) Multiphasic health testing centers, as provided under~~  
963 ~~part I of chapter 483.~~

964 (25)~~(26)~~ Organ, tissue, and eye procurement organizations,  
965 as provided under part V of chapter 765.

966 Section 26. Subsections (10) through (14) of section  
967 408.803, Florida Statutes, are renumbered as subsections (11)  
968 through (15), respectively, subsection (3) is amended, and a new  
969 subsection (10) is added to that section, to read:

970 408.803 Definitions.—As used in this part, the term:

971 (3) "Authorizing statute" means the statute authorizing  
972 the licensed operation of a provider listed in s. 408.802 and  
973 includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~  
974 and 765.

975 (10) "Low-risk provider" means a nonresidential provider,  
976 including a nurse registry, a home medical equipment provider,  
977 or a health care clinic.

978 Section 27. Paragraph (b) of subsection (7) of section  
979 408.806, Florida Statutes, is amended to read:

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980 408.806 License application process.-

981 (7)

982 (b) An initial inspection is not required for companion  
983 services or homemaker services providers, as provided under part  
984 III of chapter 400, ~~or~~ for health care services pools, as  
985 provided under part IX of chapter 400, or for low-risk providers  
986 as provided in s. 408.811(1)(c).

987 Section 28. Subsection (2) of section 408.808, Florida  
988 Statutes, is amended to read:

989 408.808 License categories.-

990 (2) PROVISIONAL LICENSE.-An applicant against whom a  
991 proceeding denying or revoking a license is pending at the time  
992 of license renewal may be issued a provisional license effective  
993 until final action not subject to further appeal. A provisional  
994 license may also be issued to an applicant making initial  
995 application for licensure or making application ~~applying~~ for a  
996 change of ownership. A provisional license must be limited in  
997 duration to a specific period of time, up to 12 months, as  
998 determined by the agency.

999 Section 29. Subsections (6) through (9) of section  
1000 408.809, Florida Statutes, are renumbered as subsections (5)  
1001 through (8), respectively, and subsections (2) and (4) and  
1002 present subsection (5) of that section are amended to read:

1003 408.809 Background screening; prohibited offenses.-

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1004 (2) Every 5 years following his or her licensure,  
1005 employment, or entry into a contract in a capacity that under  
1006 subsection (1) would require level 2 background screening under  
1007 chapter 435, each such person must submit to level 2 background  
1008 rescreening as a condition of retaining such license or  
1009 continuing in such employment or contractual status. For any  
1010 such rescreening, the agency shall request the Department of Law  
1011 Enforcement to forward the person's fingerprints to the Federal  
1012 Bureau of Investigation for a national criminal history record  
1013 check unless the person's fingerprints are enrolled in the  
1014 Federal Bureau of Investigation's national retained print arrest  
1015 notification program. If the fingerprints of such a person are  
1016 not retained by the Department of Law Enforcement under s.  
1017 943.05(2)(g) and (h), the person must submit fingerprints  
1018 electronically to the Department of Law Enforcement for state  
1019 processing, and the Department of Law Enforcement shall forward  
1020 the fingerprints to the Federal Bureau of Investigation for a  
1021 national criminal history record check. The fingerprints shall  
1022 be retained by the Department of Law Enforcement under s.  
1023 943.05(2)(g) and (h) and enrolled in the national retained print  
1024 arrest notification program when the Department of Law  
1025 Enforcement begins participation in the program. The cost of the  
1026 state and national criminal history records checks required by  
1027 level 2 screening may be borne by the licensee or the person  
1028 fingerprinted. ~~Until a specified agency is fully implemented in~~

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1029 ~~the clearinghouse created under s. 435.12,~~ The agency may accept  
1030 as satisfying the requirements of this section proof of  
1031 compliance with level 2 screening standards submitted within the  
1032 previous 5 years to meet any provider or professional licensure  
1033 requirements of ~~the agency, the Department of Health, the~~  
1034 ~~Department of Elderly Affairs, the Agency for Persons with~~  
1035 ~~Disabilities, the Department of Children and Families, or the~~  
1036 Department of Financial Services for an applicant for a  
1037 certificate of authority or provisional certificate of authority  
1038 to operate a continuing care retirement community under chapter  
1039 651, provided that:

1040 (a) The screening standards and disqualifying offenses for  
1041 the prior screening are equivalent to those specified in s.  
1042 435.04 and this section;

1043 (b) The person subject to screening has not had a break in  
1044 service from a position that requires level 2 screening for more  
1045 than 90 days; and

1046 (c) Such proof is accompanied, under penalty of perjury,  
1047 by an attestation of compliance with chapter 435 and this  
1048 section using forms provided by the agency.

1049 (4) In addition to the offenses listed in s. 435.04, all  
1050 persons required to undergo background screening pursuant to  
1051 this part or authorizing statutes must not have an arrest  
1052 awaiting final disposition for, must not have been found guilty  
1053 of, regardless of adjudication, or entered a plea of nolo

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1054 | contendere or guilty to, and must not have been adjudicated  
1055 | delinquent and the record not have been sealed or expunged for  
1056 | any of the following offenses or any similar offense of another  
1057 | jurisdiction:

1058 |       (a) Any authorizing statutes, if the offense was a felony.

1059 |       (b) This chapter, if the offense was a felony.

1060 |       (c) Section 409.920, relating to Medicaid provider fraud.

1061 |       (d) Section 409.9201, relating to Medicaid fraud.

1062 |       (e) Section 741.28, relating to domestic violence.

1063 |       (f) Section 777.04, relating to attempts, solicitation,  
1064 | and conspiracy to commit an offense listed in this subsection.

1065 |       (g) Section 817.034, relating to fraudulent acts through  
1066 | mail, wire, radio, electromagnetic, photoelectronic, or  
1067 | photooptical systems.

1068 |       (h) Section 817.234, relating to false and fraudulent  
1069 | insurance claims.

1070 |       (i) Section 817.481, relating to obtaining goods by using  
1071 | a false or expired credit card or other credit device, if the  
1072 | offense was a felony.

1073 |       (j) Section 817.50, relating to fraudulently obtaining  
1074 | goods or services from a health care provider.

1075 |       (k) Section 817.505, relating to patient brokering.

1076 |       (l) Section 817.568, relating to criminal use of personal  
1077 | identification information.

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- 1078 (m) Section 817.60, relating to obtaining a credit card  
1079 through fraudulent means.
- 1080 (n) Section 817.61, relating to fraudulent use of credit  
1081 cards, if the offense was a felony.
- 1082 (o) Section 831.01, relating to forgery.
- 1083 (p) Section 831.02, relating to uttering forged  
1084 instruments.
- 1085 (q) Section 831.07, relating to forging bank bills,  
1086 checks, drafts, or promissory notes.
- 1087 (r) Section 831.09, relating to uttering forged bank  
1088 bills, checks, drafts, or promissory notes.
- 1089 (s) Section 831.30, relating to fraud in obtaining  
1090 medicinal drugs.
- 1091 (t) Section 831.31, relating to the sale, manufacture,  
1092 delivery, or possession with the intent to sell, manufacture, or  
1093 deliver any counterfeit controlled substance, if the offense was  
1094 a felony.
- 1095 (u) Section 895.03, relating to racketeering and  
1096 collection of unlawful debts.
- 1097 (v) Section 896.101, relating to the Florida Money  
1098 Laundering Act.
- 1099
- 1100 If, upon rescreening, a person who is currently employed or  
1101 contracted with a licensee ~~as of June 30, 2014,~~ and was screened  
1102 and qualified under s. ss. 435.03 and 435.04, has a

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1103 disqualifying offense that was not a disqualifying offense at  
1104 the time of the last screening, but is a current disqualifying  
1105 offense and was committed before the last screening, he or she  
1106 may apply for an exemption from the appropriate licensing agency  
1107 and, if agreed to by the employer, may continue to perform his  
1108 or her duties until the licensing agency renders a decision on  
1109 the application for exemption if the person is eligible to apply  
1110 for an exemption and the exemption request is received by the  
1111 agency no later than 30 days after receipt of the rescreening  
1112 results by the person.

1113 ~~(5) A person who serves as a controlling interest of, is~~  
1114 ~~employed by, or contracts with a licensee on July 31, 2010, who~~  
1115 ~~has been screened and qualified according to standards specified~~  
1116 ~~in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015,~~  
1117 ~~in compliance with the following schedule. If, upon rescreening,~~  
1118 ~~such person has a disqualifying offense that was not a~~  
1119 ~~disqualifying offense at the time of the last screening, but is~~  
1120 ~~a current disqualifying offense and was committed before the~~  
1121 ~~last screening, he or she may apply for an exemption from the~~  
1122 ~~appropriate licensing agency and, if agreed to by the employer,~~  
1123 ~~may continue to perform his or her duties until the licensing~~  
1124 ~~agency renders a decision on the application for exemption if~~  
1125 ~~the person is eligible to apply for an exemption and the~~  
1126 ~~exemption request is received by the agency within 30 days after~~

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1127 ~~receipt of the rescreening results by the person. The~~  
1128 ~~rescreening schedule shall be:~~

1129 ~~(a) Individuals for whom the last screening was conducted~~  
1130 ~~on or before December 31, 2004, must be rescreened by July 31,~~  
1131 ~~2013.~~

1132 ~~(b) Individuals for whom the last screening conducted was~~  
1133 ~~between January 1, 2005, and December 31, 2008, must be~~  
1134 ~~rescreened by July 31, 2014.~~

1135 ~~(c) Individuals for whom the last screening conducted was~~  
1136 ~~between January 1, 2009, through July 31, 2011, must be~~  
1137 ~~rescreened by July 31, 2015.~~

1138 Section 30. Subsection (1) of section 408.811, Florida  
1139 Statutes, is amended to read:

1140 408.811 Right of inspection; copies; inspection reports;  
1141 plan for correction of deficiencies.—

1142 (1) An authorized officer or employee of the agency may  
1143 make or cause to be made any inspection or investigation deemed  
1144 necessary by the agency to determine the state of compliance  
1145 with this part, authorizing statutes, and applicable rules. The  
1146 right of inspection extends to any business that the agency has  
1147 reason to believe is being operated as a provider without a  
1148 license, but inspection of any business suspected of being  
1149 operated without the appropriate license may not be made without  
1150 the permission of the owner or person in charge unless a warrant  
1151 is first obtained from a circuit court. Any application for a

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1152 license issued under this part, authorizing statutes, or  
1153 applicable rules constitutes permission for an appropriate  
1154 inspection to verify the information submitted on or in  
1155 connection with the application.

1156 (a) All inspections shall be unannounced, except as  
1157 specified in s. 408.806.

1158 (b) Inspections for relicensure shall be conducted  
1159 biennially unless otherwise specified by this section,  
1160 authorizing statutes, or applicable rules.

1161 (c) The agency may exempt a low-risk provider from a  
1162 licensure inspection if the provider or a controlling interest  
1163 has an excellent regulatory history with regard to deficiencies,  
1164 sanctions, complaints, or other regulatory actions as defined in  
1165 agency rule. The agency must conduct unannounced licensure  
1166 inspections on at least 10 percent of the exempt low-risk  
1167 providers to verify regulatory compliance.

1168 (d) The agency may adopt rules to waive any inspection,  
1169 including a relicensure inspection, or grant an extended time  
1170 period between relicensure inspections based upon:

1171 1. An excellent regulatory history with regard to  
1172 deficiencies, sanctions, complaints, or other regulatory  
1173 measures.

1174 2. Outcome measures that demonstrate quality performance.

1175 3. Successful participation in a recognized, quality  
1176 program.

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1177 4. Accreditation status.

1178 5. Other measures reflective of quality and safety.

1179 6. The length of time between inspections.

1180  
1181 The agency shall continue to conduct unannounced licensure  
1182 inspections on at least 10 percent of providers that qualify for  
1183 an exemption or extended period between relicensure inspections.

1184 The agency may conduct an inspection of any provider at any time  
1185 to verify regulatory compliance.

1186 Section 31. Subsection (24) of section 408.820, Florida  
1187 Statutes, is amended to read:

1188 408.820 Exemptions.—Except as prescribed in authorizing  
1189 statutes, the following exemptions shall apply to specified  
1190 requirements of this part:

1191 ~~(24) Multiphasic health testing centers, as provided under~~  
1192 ~~part I of chapter 483, are exempt from s. 408.810(5)–(10).~~

1193 Section 32. Subsections (1) and (2) of section 408.821,  
1194 Florida Statutes, are amended to read:

1195 408.821 Emergency management planning; emergency  
1196 operations; inactive license.—

1197 (1) A licensee required by authorizing statutes and agency  
1198 rule to have a comprehensive an emergency management operations  
1199 plan must designate a safety liaison to serve as the primary  
1200 contact for emergency operations. Such licensee shall submit its  
1201 comprehensive emergency management plan to the local emergency



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1202 management agency, county health department, or Department of  
1203 Health as follows:

1204 (a) Submit the plan within 30 days after initial licensure  
1205 and change of ownership, and notify the agency within 30 days  
1206 after submission of the plan.

1207 (b) Submit the plan annually and within 30 days after any  
1208 significant modification, as defined by agency rule, to a  
1209 previously approved plan.

1210 (c) Submit necessary plan revisions within 30 days after  
1211 notification that plan revisions are required.

1212 (d) Notify the agency within 30 days after approval of its  
1213 plan by the local emergency management agency, county health  
1214 department, or Department of Health.

1215 (2) An entity subject to this part may temporarily exceed  
1216 its licensed capacity to act as a receiving provider in  
1217 accordance with an approved comprehensive emergency management  
1218 ~~operations~~ plan for up to 15 days. While in an overcapacity  
1219 status, each provider must furnish or arrange for appropriate  
1220 care and services to all clients. In addition, the agency may  
1221 approve requests for overcapacity in excess of 15 days, which  
1222 approvals may be based upon satisfactory justification and need  
1223 as provided by the receiving and sending providers.

1224 Section 33. Subsection (3) of section 408.831, Florida  
1225 Statutes, is amended to read:

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1226 408.831 Denial, suspension, or revocation of a license,  
1227 registration, certificate, or application.—

1228 (3) This section provides standards of enforcement  
1229 applicable to all entities licensed or regulated by the Agency  
1230 for Health Care Administration. This section controls over any  
1231 conflicting provisions of chapters 39, 383, 390, 391, 394, 395,  
1232 400, 408, 429, 468, ~~483~~, and 765 or rules adopted pursuant to  
1233 those chapters.

1234 Section 34. Section 408.832, Florida Statutes, is amended  
1235 to read:

1236 408.832 Conflicts.—In case of conflict between ~~the~~  
1237 ~~provisions of~~ this part and the authorizing statutes governing  
1238 the licensure of health care providers by the Agency for Health  
1239 Care Administration found in s. 112.0455 and chapters 383, 390,  
1240 394, 395, 400, 429, 440, ~~483~~, and 765, ~~the provisions of this~~  
1241 part shall prevail.

1242 Section 35. Subsection (9) of section 408.909, Florida  
1243 Statutes, is amended to read:

1244 408.909 Health flex plans.—

1245 ~~(9) PROGRAM EVALUATION. The agency and the office shall~~  
1246 ~~evaluate the pilot program and its effect on the entities that~~  
1247 ~~seek approval as health flex plans, on the number of enrollees,~~  
1248 ~~and on the scope of the health care coverage offered under a~~  
1249 ~~health flex plan; shall provide an assessment of the health flex~~  
1250 ~~plans and their potential applicability in other settings; shall~~

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1251 ~~use health flex plans to gather more information to evaluate~~  
1252 ~~low income consumer driven benefit packages; and shall, by~~  
1253 ~~January 15, 2016, and annually thereafter, jointly submit a~~  
1254 ~~report to the Governor, the President of the Senate, and the~~  
1255 ~~Speaker of the House of Representatives.~~

1256 Section 36. Paragraph (d) of subsection (10) of section  
1257 408.9091, Florida Statutes, is amended to read:

1258 408.9091 Cover Florida Health Care Access Program.—

1259 (10) PROGRAM EVALUATION.—The agency and the office shall:

1260 ~~(d) Jointly submit by March 1, annually, a report to the~~  
1261 ~~Governor, the President of the Senate, and the Speaker of the~~  
1262 ~~House of Representatives which provides the information~~  
1263 ~~specified in paragraphs (a)–(c) and recommendations relating to~~  
1264 ~~the successful implementation and administration of the program.~~

1265 Section 37. Effective upon becoming a law, paragraph (a)  
1266 of subsection (5) of section 409.905, Florida Statutes, is  
1267 amended to read:

1268 409.905 Mandatory Medicaid services.—The agency may make  
1269 payments for the following services, which are required of the  
1270 state by Title XIX of the Social Security Act, furnished by  
1271 Medicaid providers to recipients who are determined to be  
1272 eligible on the dates on which the services were provided. Any  
1273 service under this section shall be provided only when medically  
1274 necessary and in accordance with state and federal law.

1275 Mandatory services rendered by providers in mobile units to

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1276 Medicaid recipients may be restricted by the agency. Nothing in  
1277 this section shall be construed to prevent or limit the agency  
1278 from adjusting fees, reimbursement rates, lengths of stay,  
1279 number of visits, number of services, or any other adjustments  
1280 necessary to comply with the availability of moneys and any  
1281 limitations or directions provided for in the General  
1282 Appropriations Act or chapter 216.

1283 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for  
1284 all covered services provided for the medical care and treatment  
1285 of a recipient who is admitted as an inpatient by a licensed  
1286 physician or dentist to a hospital licensed under part I of  
1287 chapter 395. However, the agency shall limit the payment for  
1288 inpatient hospital services for a Medicaid recipient 21 years of  
1289 age or older to 45 days or the number of days necessary to  
1290 comply with the General Appropriations Act.

1291 (a)1. The agency may implement reimbursement and  
1292 utilization management reforms in order to comply with any  
1293 limitations or directions in the General Appropriations Act,  
1294 which may include, but are not limited to: prior authorization  
1295 for inpatient psychiatric days; prior authorization for  
1296 nonemergency hospital inpatient admissions for individuals 21  
1297 years of age and older; authorization of emergency and urgent-  
1298 care admissions within 24 hours after admission; enhanced  
1299 utilization and concurrent review programs for highly utilized  
1300 services; reduction or elimination of covered days of service;

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1301 adjusting reimbursement ceilings for variable costs; adjusting  
1302 reimbursement ceilings for fixed and property costs; and  
1303 implementing target rates of increase.

1304 2. The agency may limit prior authorization for hospital  
1305 inpatient services to selected diagnosis-related groups, based  
1306 on an analysis of the cost and potential for unnecessary  
1307 hospitalizations represented by certain diagnoses. Admissions  
1308 for normal delivery and newborns are exempt from requirements  
1309 for prior authorization.

1310 3. In implementing the provisions of this section related  
1311 to prior authorization, the agency shall ensure that the process  
1312 for authorization is accessible 24 hours per day, 7 days per  
1313 week and authorization is automatically granted when not denied  
1314 within 4 hours after the request. Authorization procedures must  
1315 include steps for review of denials.

1316 4. Upon implementing the prior authorization program for  
1317 hospital inpatient services, the agency shall discontinue its  
1318 hospital retrospective review program. However, this  
1319 subparagraph may not be construed to prevent the agency from  
1320 conducting retrospective reviews under s. 409.913, including,  
1321 but not limited to, reviews in which an overpayment is suspected  
1322 due to a mistake or submission of an improper claim or for other  
1323 reasons that do not rise to the level of fraud or abuse.

1324 Section 38. It is the intent of the Legislature that s.  
1325 409.905(5)(a), Florida Statutes, as amended by this act,

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1326 confirms and clarifies existing law. This section shall take  
1327 effect upon becoming a law.

1328 Section 39. Subsection (8) of section 409.907, Florida  
1329 Statutes, is amended to read:

1330 409.907 Medicaid provider agreements.—The agency may make  
1331 payments for medical assistance and related services rendered to  
1332 Medicaid recipients only to an individual or entity who has a  
1333 provider agreement in effect with the agency, who is performing  
1334 services or supplying goods in accordance with federal, state,  
1335 and local law, and who agrees that no person shall, on the  
1336 grounds of handicap, race, color, or national origin, or for any  
1337 other reason, be subjected to discrimination under any program  
1338 or activity for which the provider receives payment from the  
1339 agency.

1340 (8) (a) A level 2 background screening pursuant to chapter  
1341 435 must be conducted through the agency on each of the  
1342 following:

1343 1. The ~~Each~~ provider, or each principal of the provider if  
1344 the provider is a corporation, partnership, association, or  
1345 other entity, ~~seeking to participate in the Medicaid program~~  
1346 ~~must submit a complete set of his or her fingerprints to the~~  
1347 ~~agency for the purpose of conducting a criminal history record~~  
1348 ~~check.~~

1349 2. Principals of the provider, who include any officer,  
1350 director, billing agent, managing employee, or affiliated

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1351 person, or any partner or shareholder who has an ownership  
1352 interest equal to 5 percent or more in the provider. However,  
1353 for a hospital licensed under chapter 395 or a nursing home  
1354 licensed under chapter 400, principals of the provider are those  
1355 who meet the definition of a controlling interest under s.  
1356 408.803. A director of a not-for-profit corporation or  
1357 organization is not a principal for purposes of a background  
1358 investigation required by this section if the director: serves  
1359 solely in a voluntary capacity for the corporation or  
1360 organization, does not regularly take part in the day-to-day  
1361 operational decisions of the corporation or organization,  
1362 receives no remuneration from the not-for-profit corporation or  
1363 organization for his or her service on the board of directors,  
1364 has no financial interest in the not-for-profit corporation or  
1365 organization, and has no family members with a financial  
1366 interest in the not-for-profit corporation or organization; and  
1367 if the director submits an affidavit, under penalty of perjury,  
1368 to this effect to the agency and the not-for-profit corporation  
1369 or organization submits an affidavit, under penalty of perjury,  
1370 to this effect to the agency as part of the corporation's or  
1371 organization's Medicaid provider agreement application.

1372 3. Any person who participates or seeks to participate in  
1373 the Medicaid program by way of rendering services to Medicaid  
1374 recipients or having direct access to Medicaid recipients,  
1375 recipient living areas, or the financial, medical, or service

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1376 records of a Medicaid recipient or who supervises the delivery  
1377 of goods or services to a Medicaid recipient. This subparagraph  
1378 does not impose additional screening requirements on any  
1379 providers licensed under part II of chapter 408.

1380 4. Non-emergency transportation drivers that are employed  
1381 or contracted with transportation network companies or  
1382 transportation brokers are not subject to level 2 screening, and  
1383 must comply with level 1 background screening pursuant to  
1384 chapter 435 or an equivalent as authorized in s. 381.87.

1385 (b) Notwithstanding paragraph (a) the above, the agency  
1386 may require a background check for any person reasonably  
1387 suspected by the agency to have been convicted of a crime.

1388 (c)-(a) Paragraph (a) This subsection does not apply to:

1389 1. A unit of local government, except that requirements of  
1390 this subsection apply to nongovernmental providers and entities  
1391 contracting with the local government to provide Medicaid  
1392 services. The actual cost of the state and national criminal  
1393 history record checks must be borne by the nongovernmental  
1394 provider or entity; or

1395 2. Any business that derives more than 50 percent of its  
1396 revenue from the sale of goods to the final consumer, and the  
1397 business or its controlling parent is required to file a form  
1398 10-K or other similar statement with the Securities and Exchange  
1399 Commission or has a net worth of \$50 million or more.



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1400            ~~(d)-(b)~~ Background screening shall be conducted in  
1401 accordance with chapter 435 and s. 408.809. The cost of the  
1402 state and national criminal record check shall be borne by the  
1403 provider.

1404            Section 40. Paragraph (a) of subsection (1) of section  
1405 409.908, Florida Statutes, is amended to read:

1406            409.908 Reimbursement of Medicaid providers.—Subject to  
1407 specific appropriations, the agency shall reimburse Medicaid  
1408 providers, in accordance with state and federal law, according  
1409 to methodologies set forth in the rules of the agency and in  
1410 policy manuals and handbooks incorporated by reference therein.  
1411 These methodologies may include fee schedules, reimbursement  
1412 methods based on cost reporting, negotiated fees, competitive  
1413 bidding pursuant to s. 287.057, and other mechanisms the agency  
1414 considers efficient and effective for purchasing services or  
1415 goods on behalf of recipients. If a provider is reimbursed based  
1416 on cost reporting and submits a cost report late and that cost  
1417 report would have been used to set a lower reimbursement rate  
1418 for a rate semester, then the provider's rate for that semester  
1419 shall be retroactively calculated using the new cost report, and  
1420 full payment at the recalculated rate shall be effected  
1421 retroactively. Medicare-granted extensions for filing cost  
1422 reports, if applicable, shall also apply to Medicaid cost  
1423 reports. Payment for Medicaid compensable services made on  
1424 behalf of Medicaid eligible persons is subject to the

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1425 availability of moneys and any limitations or directions  
1426 provided for in the General Appropriations Act or chapter 216.  
1427 Further, nothing in this section shall be construed to prevent  
1428 or limit the agency from adjusting fees, reimbursement rates,  
1429 lengths of stay, number of visits, or number of services, or  
1430 making any other adjustments necessary to comply with the  
1431 availability of moneys and any limitations or directions  
1432 provided for in the General Appropriations Act, provided the  
1433 adjustment is consistent with legislative intent.

1434 (1) Reimbursement to hospitals licensed under part I of  
1435 chapter 395 must be made prospectively or on the basis of  
1436 negotiation.

1437 (a) Reimbursement for inpatient care is limited as  
1438 provided in s. 409.905(5), except as otherwise provided in this  
1439 subsection.

1440 1. If authorized by the General Appropriations Act, the  
1441 agency may modify reimbursement for specific types of services  
1442 or diagnoses, recipient ages, and hospital provider types.

1443 2. The agency may establish an alternative methodology to  
1444 the DRG-based prospective payment system to set reimbursement  
1445 rates for:

- 1446 a. State-owned psychiatric hospitals.
- 1447 b. Newborn hearing screening services.
- 1448 c. Transplant services for which the agency has  
1449 established a global fee.

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1450 d. Recipients who have tuberculosis that is resistant to  
1451 therapy who are in need of long-term, hospital-based treatment  
1452 pursuant to s. 392.62.

1453 ~~e. Class III psychiatric hospitals.~~

1454 3. The agency shall modify reimbursement according to  
1455 other methodologies recognized in the General Appropriations  
1456 Act.

1457  
1458 The agency may receive funds from state entities, including, but  
1459 not limited to, the Department of Health, local governments, and  
1460 other local political subdivisions, for the purpose of making  
1461 special exception payments, including federal matching funds,  
1462 through the Medicaid inpatient reimbursement methodologies.

1463 Funds received for this purpose shall be separately accounted  
1464 for and may not be commingled with other state or local funds in  
1465 any manner. The agency may certify all local governmental funds  
1466 used as state match under Title XIX of the Social Security Act,  
1467 to the extent and in the manner authorized under the General  
1468 Appropriations Act and pursuant to an agreement between the  
1469 agency and the local governmental entity. In order for the  
1470 agency to certify such local governmental funds, a local  
1471 governmental entity must submit a final, executed letter of  
1472 agreement to the agency, which must be received by October 1 of  
1473 each fiscal year and provide the total amount of local  
1474 governmental funds authorized by the entity for that fiscal year

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1475 under this paragraph, paragraph (b), or the General  
1476 Appropriations Act. The local governmental entity shall use a  
1477 certification form prescribed by the agency. At a minimum, the  
1478 certification form must identify the amount being certified and  
1479 describe the relationship between the certifying local  
1480 governmental entity and the local health care provider. The  
1481 agency shall prepare an annual statement of impact which  
1482 documents the specific activities undertaken during the previous  
1483 fiscal year pursuant to this paragraph, to be submitted to the  
1484 Legislature annually by January 1.

1485 Section 41. Section 409.913, Florida Statutes, is amended  
1486 to read:

1487 409.913 Oversight of the integrity of the Medicaid  
1488 program.—The agency shall operate a program to oversee the  
1489 activities of Florida Medicaid recipients, and providers and  
1490 their representatives, to ensure that fraudulent and abusive  
1491 behavior and neglect of recipients occur to the minimum extent  
1492 possible, and to recover overpayments and impose sanctions as  
1493 appropriate. Each January 15 ~~4~~, the agency and the Medicaid  
1494 Fraud Control Unit of the Department of Legal Affairs shall  
1495 submit a ~~joint~~ report to the Legislature documenting the  
1496 effectiveness of the state's efforts to control Medicaid fraud  
1497 and abuse and to recover Medicaid overpayments during the  
1498 previous fiscal year. The report must describe the number of  
1499 cases opened and investigated each year; the sources of the

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1500 cases opened; the disposition of the cases closed each year; the  
1501 amount of overpayments alleged in preliminary and final audit  
1502 letters; the number and amount of fines or penalties imposed;  
1503 any reductions in overpayment amounts negotiated in settlement  
1504 agreements or by other means; the amount of final agency  
1505 determinations of overpayments; the amount deducted from federal  
1506 claiming as a result of overpayments; the amount of overpayments  
1507 recovered each year; the amount of cost of investigation  
1508 recovered each year; the average length of time to collect from  
1509 the time the case was opened until the overpayment is paid in  
1510 full; the amount determined as uncollectible and the portion of  
1511 the uncollectible amount subsequently reclaimed from the Federal  
1512 Government; the number of providers, by type, that are  
1513 terminated from participation in the Medicaid program as a  
1514 result of fraud and abuse; and all costs associated with  
1515 discovering and prosecuting cases of Medicaid overpayments and  
1516 making recoveries in such cases. The report must also document  
1517 actions taken to prevent overpayments and the number of  
1518 providers prevented from enrolling in or reenrolling in the  
1519 Medicaid program as a result of documented Medicaid fraud and  
1520 abuse and must include policy recommendations necessary to  
1521 prevent or recover overpayments and changes necessary to prevent  
1522 and detect Medicaid fraud. All policy recommendations in the  
1523 report must include a detailed fiscal analysis, including, but  
1524 not limited to, implementation costs, estimated savings to the

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1525 Medicaid program, and the return on investment. The agency must  
1526 submit the policy recommendations and fiscal analyses in the  
1527 report to the appropriate estimating conference, pursuant to s.  
1528 216.137, by February 15 of each year. The agency and the  
1529 Medicaid Fraud Control Unit of the Department of Legal Affairs  
1530 each must include detailed unit-specific performance standards,  
1531 benchmarks, and metrics in the report, including projected cost  
1532 savings to the state Medicaid program during the following  
1533 fiscal year.

1534 (1) For the purposes of this section, the term:

1535 (a) "Abuse" means:

1536 1. Provider practices that are inconsistent with generally  
1537 accepted business or medical practices and that result in an  
1538 unnecessary cost to the Medicaid program or in reimbursement for  
1539 goods or services that are not medically necessary or that fail  
1540 to meet professionally recognized standards for health care.

1541 2. Recipient practices that result in unnecessary cost to  
1542 the Medicaid program.

1543 (b) "Complaint" means an allegation that fraud, abuse, or  
1544 an overpayment has occurred.

1545 (c) "Fraud" means an intentional deception or  
1546 misrepresentation made by a person with the knowledge that the  
1547 deception results in unauthorized benefit to herself or himself  
1548 or another person. The term includes any act that constitutes  
1549 fraud under applicable federal or state law.

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1550 (d) "Medical necessity" or "medically necessary" means any  
1551 goods or services necessary to palliate the effects of a  
1552 terminal condition, or to prevent, diagnose, correct, cure,  
1553 alleviate, or preclude deterioration of a condition that  
1554 threatens life, causes pain or suffering, or results in illness  
1555 or infirmity, which goods or services are provided in accordance  
1556 with generally accepted standards of medical practice. For  
1557 purposes of determining Medicaid reimbursement, the agency is  
1558 the final arbiter of medical necessity. Determinations of  
1559 medical necessity must be made by a licensed physician employed  
1560 by or under contract with the agency and must be based upon  
1561 information available at the time the goods or services are  
1562 provided.

1563 (e) "Overpayment" includes any amount that is not  
1564 authorized to be paid by the Medicaid program whether paid as a  
1565 result of inaccurate or improper cost reporting, improper  
1566 claiming, unacceptable practices, fraud, abuse, or mistake.

1567 (f) "Person" means any natural person, corporation,  
1568 partnership, association, clinic, group, or other entity,  
1569 whether or not such person is enrolled in the Medicaid program  
1570 or is a provider of health care.

1571 (2) The agency shall conduct, or cause to be conducted by  
1572 contract or otherwise, reviews, investigations, analyses,  
1573 audits, or any combination thereof, to determine possible fraud,  
1574 abuse, overpayment, or recipient neglect in the Medicaid program

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1575 and shall report the findings of any overpayments in audit  
1576 reports as appropriate. At least 5 percent of all audits shall  
1577 be conducted on a random basis. As part of its ongoing fraud  
1578 detection activities, the agency shall identify and monitor, by  
1579 contract or otherwise, patterns of overutilization of Medicaid  
1580 services based on state averages. The agency shall track  
1581 Medicaid provider prescription and billing patterns and evaluate  
1582 them against Medicaid medical necessity criteria and coverage  
1583 and limitation guidelines adopted by rule. Medical necessity  
1584 determination requires that service be consistent with symptoms  
1585 or confirmed diagnosis of illness or injury under treatment and  
1586 not in excess of the patient's needs. The agency shall conduct  
1587 reviews of provider exceptions to peer group norms and shall,  
1588 using statistical methodologies, provider profiling, and  
1589 analysis of billing patterns, detect and investigate abnormal or  
1590 unusual increases in billing or payment of claims for Medicaid  
1591 services and medically unnecessary provision of services.

1592 (3) The agency may conduct, or may contract for,  
1593 prepayment review of provider claims to ensure cost-effective  
1594 purchasing; to ensure that billing by a provider to the agency  
1595 is in accordance with applicable provisions of all Medicaid  
1596 rules, regulations, handbooks, and policies and in accordance  
1597 with federal, state, and local law; and to ensure that  
1598 appropriate care is rendered to Medicaid recipients. Such  
1599 prepayment reviews may be conducted as determined appropriate by

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1600 the agency, without any suspicion or allegation of fraud, abuse,  
1601 or neglect, and may last for up to 1 year. Unless the agency has  
1602 reliable evidence of fraud, misrepresentation, abuse, or  
1603 neglect, claims shall be adjudicated for denial or payment  
1604 within 90 days after receipt of complete documentation by the  
1605 agency for review. If there is reliable evidence of fraud,  
1606 misrepresentation, abuse, or neglect, claims shall be  
1607 adjudicated for denial of payment within 180 days after receipt  
1608 of complete documentation by the agency for review.

1609 (4) Any suspected criminal violation identified by the  
1610 agency must be referred to the Medicaid Fraud Control Unit of  
1611 the Office of the Attorney General for investigation. The agency  
1612 and the Attorney General shall enter into a memorandum of  
1613 understanding, which must include, but need not be limited to, a  
1614 protocol for regularly sharing information and coordinating  
1615 casework. The protocol must establish a procedure for the  
1616 referral by the agency of cases involving suspected Medicaid  
1617 fraud to the Medicaid Fraud Control Unit for investigation, and  
1618 the return to the agency of those cases where investigation  
1619 determines that administrative action by the agency is  
1620 appropriate. Offices of the Medicaid program integrity program  
1621 and the Medicaid Fraud Control Unit of the Department of Legal  
1622 Affairs, shall, to the extent possible, be collocated. The  
1623 agency and the Department of Legal Affairs shall periodically  
1624 conduct joint training and other joint activities designed to

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1625 increase communication and coordination in recovering  
1626 overpayments.

1627 (5) A Medicaid provider is subject to having goods and  
1628 services that are paid for by the Medicaid program reviewed by  
1629 an appropriate peer-review organization designated by the  
1630 agency. The written findings of the applicable peer-review  
1631 organization are admissible in any court or administrative  
1632 proceeding as evidence of medical necessity or the lack thereof.

1633 (6) Any notice required to be given to a provider under  
1634 this section is presumed to be sufficient notice if sent to the  
1635 address last shown on the provider enrollment file. It is the  
1636 responsibility of the provider to furnish and keep the agency  
1637 informed of the provider's current address. United States Postal  
1638 Service proof of mailing or certified or registered mailing of  
1639 such notice to the provider at the address shown on the provider  
1640 enrollment file constitutes sufficient proof of notice. Any  
1641 notice required to be given to the agency by this section must  
1642 be sent to the agency at an address designated by rule.

1643 (7) When presenting a claim for payment under the Medicaid  
1644 program, a provider has an affirmative duty to supervise the  
1645 provision of, and be responsible for, goods and services claimed  
1646 to have been provided, to supervise and be responsible for  
1647 preparation and submission of the claim, and to present a claim  
1648 that is true and accurate and that is for goods and services  
1649 that:

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1650 (a) Have actually been furnished to the recipient by the  
1651 provider prior to submitting the claim.

1652 (b) Are Medicaid-covered goods or services that are  
1653 medically necessary.

1654 (c) Are of a quality comparable to those furnished to the  
1655 general public by the provider's peers.

1656 (d) Have not been billed in whole or in part to a  
1657 recipient or a recipient's responsible party, except for such  
1658 copayments, coinsurance, or deductibles as are authorized by the  
1659 agency.

1660 (e) Are provided in accord with applicable provisions of  
1661 all Medicaid rules, regulations, handbooks, and policies and in  
1662 accordance with federal, state, and local law.

1663 (f) Are documented by records made at the time the goods  
1664 or services were provided, demonstrating the medical necessity  
1665 for the goods or services rendered. Medicaid goods or services  
1666 are excessive or not medically necessary unless both the medical  
1667 basis and the specific need for them are fully and properly  
1668 documented in the recipient's medical record.

1669  
1670 The agency shall deny payment or require repayment for goods or  
1671 services that are not presented as required in this subsection.

1672 (8) The agency shall not reimburse any person or entity  
1673 for any prescription for medications, medical supplies, or  
1674 medical services if the prescription was written by a physician

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1675 or other prescribing practitioner who is not enrolled in the  
1676 Medicaid program. This section does not apply:

1677 (a) In instances involving bona fide emergency medical  
1678 conditions as determined by the agency;

1679 (b) To a provider of medical services to a patient in a  
1680 hospital emergency department, hospital inpatient or outpatient  
1681 setting, or nursing home;

1682 (c) To bona fide pro bono services by preapproved non-  
1683 Medicaid providers as determined by the agency;

1684 (d) To prescribing physicians who are board-certified  
1685 specialists treating Medicaid recipients referred for treatment  
1686 by a treating physician who is enrolled in the Medicaid program;

1687 (e) To prescriptions written for dually eligible Medicare  
1688 beneficiaries by an authorized Medicare provider who is not  
1689 enrolled in the Medicaid program;

1690 (f) To other physicians who are not enrolled in the  
1691 Medicaid program but who provide a medically necessary service  
1692 or prescription not otherwise reasonably available from a  
1693 Medicaid-enrolled physician; or

1694 (9) A Medicaid provider shall retain medical,  
1695 professional, financial, and business records pertaining to  
1696 services and goods furnished to a Medicaid recipient and billed  
1697 to Medicaid for a period of 5 years after the date of furnishing  
1698 such services or goods. The agency may investigate, review, or  
1699 analyze such records, which must be made available during normal

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1700 business hours. However, 24-hour notice must be provided if  
1701 patient treatment would be disrupted. The provider must keep the  
1702 agency informed of the location of the provider's Medicaid-  
1703 related records. The authority of the agency to obtain Medicaid-  
1704 related records from a provider is neither curtailed nor limited  
1705 during a period of litigation between the agency and the  
1706 provider.

1707 (10) Payments for the services of billing agents or  
1708 persons participating in the preparation of a Medicaid claim  
1709 shall not be based on amounts for which they bill nor based on  
1710 the amount a provider receives from the Medicaid program.

1711 (11) The agency shall deny payment or require repayment  
1712 for inappropriate, medically unnecessary, or excessive goods or  
1713 services from the person furnishing them, the person under whose  
1714 supervision they were furnished, or the person causing them to  
1715 be furnished.

1716 (12) The complaint and all information obtained pursuant  
1717 to an investigation of a Medicaid provider, or the authorized  
1718 representative or agent of a provider, relating to an allegation  
1719 of fraud, abuse, or neglect are confidential and exempt from the  
1720 provisions of s. 119.07(1):

1721 (a) Until the agency takes final agency action with  
1722 respect to the provider and requires repayment of any  
1723 overpayment, or imposes an administrative sanction;

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1724 (b) Until the Attorney General refers the case for  
1725 criminal prosecution;

1726 (c) Until 10 days after the complaint is determined  
1727 without merit; or

1728 (d) At all times if the complaint or information is  
1729 otherwise protected by law.

1730 (13) The agency shall terminate participation of a  
1731 Medicaid provider in the Medicaid program and may seek civil  
1732 remedies or impose other administrative sanctions against a  
1733 Medicaid provider, if the provider or any principal, officer,  
1734 director, agent, managing employee, or affiliated person of the  
1735 provider, or any partner or shareholder having an ownership  
1736 interest in the provider equal to 5 percent or greater, has been  
1737 convicted of a criminal offense under federal law or the law of  
1738 any state relating to the practice of the provider's profession,  
1739 or a criminal offense listed under s. 408.809(4), s.  
1740 409.907(10), or s. 435.04(2). If the agency determines that the  
1741 provider did not participate or acquiesce in the offense,  
1742 termination will not be imposed. If the agency effects a  
1743 termination under this subsection, the agency shall take final  
1744 agency action.

1745 (14) If the provider has been suspended or terminated from  
1746 participation in the Medicaid program or the Medicare program by  
1747 the Federal Government or any state, the agency must immediately  
1748 suspend or terminate, as appropriate, the provider's

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1749 participation in this state's Medicaid program for a period no  
1750 less than that imposed by the Federal Government or any other  
1751 state, and may not enroll such provider in this state's Medicaid  
1752 program while such foreign suspension or termination remains in  
1753 effect. The agency shall also immediately suspend or terminate,  
1754 as appropriate, a provider's participation in this state's  
1755 Medicaid program if the provider participated or acquiesced in  
1756 any action for which any principal, officer, director, agent,  
1757 managing employee, or affiliated person of the provider, or any  
1758 partner or shareholder having an ownership interest in the  
1759 provider equal to 5 percent or greater, was suspended or  
1760 terminated from participating in the Medicaid program or the  
1761 Medicare program by the Federal Government or any state. This  
1762 sanction is in addition to all other remedies provided by law.

1763 (15) The agency shall seek a remedy provided by law,  
1764 including, but not limited to, any remedy provided in  
1765 subsections (13) and (16) and s. 812.035, if:

1766 (a) The provider's license has not been renewed, or has  
1767 been revoked, suspended, or terminated, for cause, by the  
1768 licensing agency of any state;

1769 (b) The provider has failed to make available or has  
1770 refused access to Medicaid-related records to an auditor,  
1771 investigator, or other authorized employee or agent of the  
1772 agency, the Attorney General, a state attorney, or the Federal  
1773 Government;

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1774 (c) The provider has not furnished or has failed to make  
1775 available such Medicaid-related records as the agency has found  
1776 necessary to determine whether Medicaid payments are or were due  
1777 and the amounts thereof;

1778 (d) The provider has failed to maintain medical records  
1779 made at the time of service, or prior to service if prior  
1780 authorization is required, demonstrating the necessity and  
1781 appropriateness of the goods or services rendered;

1782 (e) The provider is not in compliance with provisions of  
1783 Medicaid provider publications that have been adopted by  
1784 reference as rules in the Florida Administrative Code; with  
1785 provisions of state or federal laws, rules, or regulations; with  
1786 provisions of the provider agreement between the agency and the  
1787 provider; or with certifications found on claim forms or on  
1788 transmittal forms for electronically submitted claims that are  
1789 submitted by the provider or authorized representative, as such  
1790 provisions apply to the Medicaid program;

1791 (f) The provider or person who ordered, authorized, or  
1792 prescribed the care, services, or supplies has furnished, or  
1793 ordered or authorized the furnishing of, goods or services to a  
1794 recipient which are inappropriate, unnecessary, excessive, or  
1795 harmful to the recipient or are of inferior quality;

1796 (g) The provider has demonstrated a pattern of failure to  
1797 provide goods or services that are medically necessary;



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1798 (h) The provider or an authorized representative of the  
1799 provider, or a person who ordered, authorized, or prescribed the  
1800 goods or services, has submitted or caused to be submitted false  
1801 or a pattern of erroneous Medicaid claims;

1802 (i) The provider or an authorized representative of the  
1803 provider, or a person who has ordered, authorized, or prescribed  
1804 the goods or services, has submitted or caused to be submitted a  
1805 Medicaid provider enrollment application, a request for prior  
1806 authorization for Medicaid services, a drug exception request,  
1807 or a Medicaid cost report that contains materially false or  
1808 incorrect information;

1809 (j) The provider or an authorized representative of the  
1810 provider has collected from or billed a recipient or a  
1811 recipient's responsible party improperly for amounts that should  
1812 not have been so collected or billed by reason of the provider's  
1813 billing the Medicaid program for the same service;

1814 (k) The provider or an authorized representative of the  
1815 provider has included in a cost report costs that are not  
1816 allowable under a Florida Title XIX reimbursement plan after the  
1817 provider or authorized representative had been advised in an  
1818 audit exit conference or audit report that the costs were not  
1819 allowable;

1820 (l) The provider is charged by information or indictment  
1821 with fraudulent billing practices or an offense referenced in  
1822 subsection (13). The sanction applied for this reason is limited

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1823 to suspension of the provider's participation in the Medicaid  
1824 program for the duration of the indictment unless the provider  
1825 is found guilty pursuant to the information or indictment;

1826 (m) The provider or a person who ordered, authorized, or  
1827 prescribed the goods or services is found liable for negligent  
1828 practice resulting in death or injury to the provider's patient;

1829 (n) The provider fails to demonstrate that it had  
1830 available during a specific audit or review period sufficient  
1831 quantities of goods, or sufficient time in the case of services,  
1832 to support the provider's billings to the Medicaid program;

1833 (o) The provider has failed to comply with the notice and  
1834 reporting requirements of s. 409.907;

1835 (p) The agency has received reliable information of  
1836 patient abuse or neglect or of any act prohibited by s. 409.920;  
1837 or

1838 (q) The provider has failed to comply with an agreed-upon  
1839 repayment schedule.

1840  
1841 A provider is subject to sanctions for violations of this  
1842 subsection as the result of actions or inactions of the  
1843 provider, or actions or inactions of any principal, officer,  
1844 director, agent, managing employee, or affiliated person of the  
1845 provider, or any partner or shareholder having an ownership  
1846 interest in the provider equal to 5 percent or greater, in which  
1847 the provider participated or acquiesced.

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1848 (16) The agency shall impose any of the following  
1849 sanctions or disincentives on a provider or a person for any of  
1850 the acts described in subsection (15):

1851 (a) Suspension for a specific period of time of not more  
1852 than 1 year. Suspension precludes participation in the Medicaid  
1853 program, which includes any action that results in a claim for  
1854 payment to the Medicaid program for furnishing, supervising a  
1855 person who is furnishing, or causing a person to furnish goods  
1856 or services.

1857 (b) Termination for a specific period of time ranging from  
1858 more than 1 year to 20 years. Termination precludes  
1859 participation in the Medicaid program, which includes any action  
1860 that results in a claim for payment to the Medicaid program for  
1861 furnishing, supervising a person who is furnishing, or causing a  
1862 person to furnish goods or services.

1863 (c) Imposition of a fine of up to \$5,000 for each  
1864 violation. Each day that an ongoing violation continues, such as  
1865 refusing to furnish Medicaid-related records or refusing access  
1866 to records, is considered a separate violation. Each instance of  
1867 improper billing of a Medicaid recipient; each instance of  
1868 including an unallowable cost on a hospital or nursing home  
1869 Medicaid cost report after the provider or authorized  
1870 representative has been advised in an audit exit conference or  
1871 previous audit report of the cost unallowability; each instance  
1872 of furnishing a Medicaid recipient goods or professional

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1873 services that are inappropriate or of inferior quality as  
1874 determined by competent peer judgment; each instance of  
1875 knowingly submitting a materially false or erroneous Medicaid  
1876 provider enrollment application, request for prior authorization  
1877 for Medicaid services, drug exception request, or cost report;  
1878 each instance of inappropriate prescribing of drugs for a  
1879 Medicaid recipient as determined by competent peer judgment; and  
1880 each false or erroneous Medicaid claim leading to an overpayment  
1881 to a provider is considered a separate violation.

1882 (d) Immediate suspension, if the agency has received  
1883 information of patient abuse or neglect or of any act prohibited  
1884 by s. 409.920. Upon suspension, the agency must issue an  
1885 immediate final order under s. 120.569(2)(n).

1886 (e) A fine, not to exceed \$10,000, for a violation of  
1887 paragraph (15)(i).

1888 (f) Imposition of liens against provider assets,  
1889 including, but not limited to, financial assets and real  
1890 property, not to exceed the amount of fines or recoveries  
1891 sought, upon entry of an order determining that such moneys are  
1892 due or recoverable.

1893 (g) Prepayment reviews of claims for a specified period of  
1894 time.

1895 (h) Comprehensive followup reviews of providers every 6  
1896 months to ensure that they are billing Medicaid correctly.

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1897 (i) Corrective-action plans that remain in effect for up  
1898 to 3 years and that are monitored by the agency every 6 months  
1899 while in effect.

1900 (j) Other remedies as permitted by law to effect the  
1901 recovery of a fine or overpayment.

1902  
1903 If a provider voluntarily relinquishes its Medicaid provider  
1904 number or an associated license, or allows the associated  
1905 licensure to expire after receiving written notice that the  
1906 agency is conducting, or has conducted, an audit, survey,  
1907 inspection, or investigation and that a sanction of suspension  
1908 or termination will or would be imposed for noncompliance  
1909 discovered as a result of the audit, survey, inspection, or  
1910 investigation, the agency shall impose the sanction of  
1911 termination for cause against the provider. The agency's  
1912 termination with cause is subject to hearing rights as may be  
1913 provided under chapter 120. The Secretary of Health Care  
1914 Administration may make a determination that imposition of a  
1915 sanction or disincentive is not in the best interest of the  
1916 Medicaid program, in which case a sanction or disincentive may  
1917 not be imposed.

1918 (17) In determining the appropriate administrative  
1919 sanction to be applied, or the duration of any suspension or  
1920 termination, the agency shall consider:

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1921 (a) The seriousness and extent of the violation or  
1922 violations.

1923 (b) Any prior history of violations by the provider  
1924 relating to the delivery of health care programs which resulted  
1925 in either a criminal conviction or in administrative sanction or  
1926 penalty.

1927 (c) Evidence of continued violation within the provider's  
1928 management control of Medicaid statutes, rules, regulations, or  
1929 policies after written notification to the provider of improper  
1930 practice or instance of violation.

1931 (d) The effect, if any, on the quality of medical care  
1932 provided to Medicaid recipients as a result of the acts of the  
1933 provider.

1934 (e) Any action by a licensing agency respecting the  
1935 provider in any state in which the provider operates or has  
1936 operated.

1937 (f) The apparent impact on access by recipients to  
1938 Medicaid services if the provider is suspended or terminated, in  
1939 the best judgment of the agency.

1940  
1941 The agency shall document the basis for all sanctioning actions  
1942 and recommendations.

1943 (18) The agency may take action to sanction, suspend, or  
1944 terminate a particular provider working for a group provider,  
1945 and may suspend or terminate Medicaid participation at a

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1946 specific location, rather than or in addition to taking action  
1947 against an entire group.

1948 (19) The agency shall establish a process for conducting  
1949 followup reviews of a sampling of providers who have a history  
1950 of overpayment under the Medicaid program. This process must  
1951 consider the magnitude of previous fraud or abuse and the  
1952 potential effect of continued fraud or abuse on Medicaid costs.

1953 (20) In making a determination of overpayment to a  
1954 provider, the agency must use accepted and valid auditing,  
1955 accounting, analytical, statistical, or peer-review methods, or  
1956 combinations thereof. Appropriate statistical methods may  
1957 include, but are not limited to, sampling and extension to the  
1958 population, parametric and nonparametric statistics, tests of  
1959 hypotheses, and other generally accepted statistical methods.  
1960 Appropriate analytical methods may include, but are not limited  
1961 to, reviews to determine variances between the quantities of  
1962 products that a provider had on hand and available to be  
1963 purveyed to Medicaid recipients during the review period and the  
1964 quantities of the same products paid for by the Medicaid program  
1965 for the same period, taking into appropriate consideration sales  
1966 of the same products to non-Medicaid customers during the same  
1967 period. In meeting its burden of proof in any administrative or  
1968 court proceeding, the agency may introduce the results of such  
1969 statistical methods as evidence of overpayment.

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1970 (21) When making a determination that an overpayment has  
1971 occurred, the agency shall prepare and issue an audit report to  
1972 the provider showing the calculation of overpayments. The  
1973 agency's determination must be based solely upon information  
1974 available to it before issuance of the audit report and, in the  
1975 case of documentation obtained to substantiate claims for  
1976 Medicaid reimbursement, based solely upon contemporaneous  
1977 records. The agency may consider addenda or modifications to a  
1978 note that was made contemporaneously with the patient care  
1979 episode if the addenda or modifications are germane to the note.

1980 (22) The audit report, supported by agency work papers,  
1981 showing an overpayment to a provider constitutes evidence of the  
1982 overpayment. A provider may not present or elicit testimony on  
1983 direct examination or cross-examination in any court or  
1984 administrative proceeding, regarding the purchase or acquisition  
1985 by any means of drugs, goods, or supplies; sales or divestment  
1986 by any means of drugs, goods, or supplies; or inventory of  
1987 drugs, goods, or supplies, unless such acquisition, sales,  
1988 divestment, or inventory is documented by written invoices,  
1989 written inventory records, or other competent written  
1990 documentary evidence maintained in the normal course of the  
1991 provider's business. A provider may not present records to  
1992 contest an overpayment or sanction unless such records are  
1993 contemporaneous and, if requested during the audit process, were  
1994 furnished to the agency or its agent upon request. This

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1995 limitation does not apply to Medicaid cost report audits. This  
1996 limitation does not preclude consideration by the agency of  
1997 addenda or modifications to a note if the addenda or  
1998 modifications are made before notification of the audit, the  
1999 addenda or modifications are germane to the note, and the note  
2000 was made contemporaneously with a patient care episode.

2001 Notwithstanding the applicable rules of discovery, all  
2002 documentation to be offered as evidence at an administrative  
2003 hearing on a Medicaid overpayment or an administrative sanction  
2004 must be exchanged by all parties at least 14 days before the  
2005 administrative hearing or be excluded from consideration.

2006 (23) (a) In an audit, ~~or~~ investigation, or enforcement  
2007 action for ~~of~~ a violation committed by a provider which is  
2008 conducted or taken pursuant to this section, the agency or  
2009 contractor is entitled to recover any and all investigative and  
2010 legal costs incurred as a result of such audit, investigation,  
2011 or enforcement action. Such costs may include, but are not  
2012 limited to, salaries and benefits of personnel, costs related to  
2013 the time spent by an attorney and other personnel working on the  
2014 case, and any other expenses incurred by the agency or  
2015 contractor that are associated with the case, including any, and  
2016 expert witness costs and attorney fees incurred on behalf of the  
2017 agency or contractor if the agency's findings were not contested  
2018 by the provider or, if contested, the agency ultimately  
2019 prevailed.

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2020 (24) If the agency imposes an administrative sanction  
2021 pursuant to subsection (13), subsection (14), or subsection  
2022 (15), except paragraphs (15)(e) and (o), upon any provider or  
2023 any principal, officer, director, agent, managing employee, or  
2024 affiliated person of the provider who is regulated by another  
2025 state entity, the agency shall notify that other entity of the  
2026 imposition of the sanction within 5 business days. Such  
2027 notification must include the provider's or person's name and  
2028 license number and the specific reasons for sanction.

2029 (25)(a) The agency shall withhold Medicaid payments, in  
2030 whole or in part, to a provider upon receipt of reliable  
2031 evidence that the circumstances giving rise to the need for a  
2032 withholding of payments involve fraud, willful  
2033 misrepresentation, or abuse under the Medicaid program, or a  
2034 crime committed while rendering goods or services to Medicaid  
2035 recipients. If it is determined that fraud, willful  
2036 misrepresentation, abuse, or a crime did not occur, the payments  
2037 withheld must be paid to the provider within 14 days after such  
2038 determination. Amounts not paid within 14 days accrue interest  
2039 at the rate of 10 percent per year, beginning after the 14th  
2040 day.

2041 (b) The agency shall deny payment, or require repayment,  
2042 if the goods or services were furnished, supervised, or caused  
2043 to be furnished by a person who has been suspended or terminated

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2044 from the Medicaid program or Medicare program by the Federal  
2045 Government or any state.

2046 (c) Overpayments owed to the agency bear interest at the  
2047 rate of 10 percent per year from the date of final determination  
2048 of the overpayment by the agency, and payment arrangements must  
2049 be made within 30 days after the date of the final order, which  
2050 is not subject to further appeal.

2051 (d) The agency, upon entry of a final agency order, a  
2052 judgment or order of a court of competent jurisdiction, or a  
2053 stipulation or settlement, may collect the moneys owed by all  
2054 means allowable by law, including, but not limited to, notifying  
2055 any fiscal intermediary of Medicare benefits that the state has  
2056 a superior right of payment. Upon receipt of such written  
2057 notification, the Medicare fiscal intermediary shall remit to  
2058 the state the sum claimed.

2059 (e) The agency may institute amnesty programs to allow  
2060 Medicaid providers the opportunity to voluntarily repay  
2061 overpayments. The agency may adopt rules to administer such  
2062 programs.

2063 (26) The agency may impose administrative sanctions  
2064 against a Medicaid recipient, or the agency may seek any other  
2065 remedy provided by law, including, but not limited to, the  
2066 remedies provided in s. 812.035, if the agency finds that a  
2067 recipient has engaged in solicitation in violation of s. 409.920  
2068 or that the recipient has otherwise abused the Medicaid program.

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2069 (27) When the Agency for Health Care Administration has  
2070 made a probable cause determination and alleged that an  
2071 overpayment to a Medicaid provider has occurred, the agency,  
2072 after notice to the provider, shall:

2073 (a) Withhold, and continue to withhold during the pendency  
2074 of an administrative hearing pursuant to chapter 120, any  
2075 medical assistance reimbursement payments until such time as the  
2076 overpayment is recovered, unless within 30 days after receiving  
2077 notice thereof the provider:

- 2078 1. Makes repayment in full; or
- 2079 2. Establishes a repayment plan that is satisfactory to  
2080 the Agency for Health Care Administration.

2081 (b) Withhold, and continue to withhold during the pendency  
2082 of an administrative hearing pursuant to chapter 120, medical  
2083 assistance reimbursement payments if the terms of a repayment  
2084 plan are not adhered to by the provider.

2085 (28) Venue for all Medicaid program integrity cases lies  
2086 in Leon County, at the discretion of the agency.

2087 (29) Notwithstanding other provisions of law, the agency  
2088 and the Medicaid Fraud Control Unit of the Department of Legal  
2089 Affairs may review a provider's Medicaid-related and non-  
2090 Medicaid-related records in order to determine the total output  
2091 of a provider's practice to reconcile quantities of goods or  
2092 services billed to Medicaid with quantities of goods or services  
2093 used in the provider's total practice.

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2094 (30) The agency shall terminate a provider's participation  
2095 in the Medicaid program if the provider fails to reimburse an  
2096 overpayment or pay an agency-imposed fine that has been  
2097 determined by final order, not subject to further appeal, within  
2098 30 days after the date of the final order, unless the provider  
2099 and the agency have entered into a repayment agreement.

2100 (31) If a provider requests an administrative hearing  
2101 pursuant to chapter 120, such hearing must be conducted within  
2102 90 days following assignment of an administrative law judge,  
2103 absent exceptionally good cause shown as determined by the  
2104 administrative law judge or hearing officer. Upon issuance of a  
2105 final order, the outstanding balance of the amount determined to  
2106 constitute the overpayment and fines is due. If a provider fails  
2107 to make payments in full, fails to enter into a satisfactory  
2108 repayment plan, or fails to comply with the terms of a repayment  
2109 plan or settlement agreement, the agency shall withhold  
2110 reimbursement payments for Medicaid services until the amount  
2111 due is paid in full.

2112 (32) Duly authorized agents and employees of the agency  
2113 shall have the power to inspect, during normal business hours,  
2114 the records of any pharmacy, wholesale establishment, or  
2115 manufacturer, or any other place in which drugs and medical  
2116 supplies are manufactured, packed, packaged, made, stored, sold,  
2117 or kept for sale, for the purpose of verifying the amount of  
2118 drugs and medical supplies ordered, delivered, or purchased by a

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2119 provider. The agency shall provide at least 2 business days'  
2120 prior notice of any such inspection. The notice must identify  
2121 the provider whose records will be inspected, and the inspection  
2122 shall include only records specifically related to that  
2123 provider.

2124 (33) In accordance with federal law, Medicaid recipients  
2125 convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be  
2126 limited, restricted, or suspended from Medicaid eligibility for  
2127 a period not to exceed 1 year, as determined by the agency head  
2128 or designee.

2129 (34) To deter fraud and abuse in the Medicaid program, the  
2130 agency may limit the number of Schedule II and Schedule III  
2131 refill prescription claims submitted from a pharmacy provider.  
2132 The agency shall limit the allowable amount of reimbursement of  
2133 prescription refill claims for Schedule II and Schedule III  
2134 pharmaceuticals if the agency or the Medicaid Fraud Control Unit  
2135 determines that the specific prescription refill was not  
2136 requested by the Medicaid recipient or authorized representative  
2137 for whom the refill claim is submitted or was not prescribed by  
2138 the recipient's medical provider or physician. Any such refill  
2139 request must be consistent with the original prescription.

2140 (35) The Office of Program Policy Analysis and Government  
2141 Accountability shall provide a report to the President of the  
2142 Senate and the Speaker of the House of Representatives on a  
2143 biennial basis, beginning January 31, 2006, on the agency's

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2144 efforts to prevent, detect, and deter, as well as recover funds  
2145 lost to, fraud and abuse in the Medicaid program.

2146 (36) The agency may provide to a sample of Medicaid  
2147 recipients or their representatives through the distribution of  
2148 explanations of benefits information about services reimbursed  
2149 by the Medicaid program for goods and services to such  
2150 recipients, including information on how to report inappropriate  
2151 or incorrect billing to the agency or other law enforcement  
2152 entities for review or investigation, information on how to  
2153 report criminal Medicaid fraud to the Medicaid Fraud Control  
2154 Unit's toll-free hotline number, and information about the  
2155 rewards available under s. 409.9203. The explanation of benefits  
2156 may not be mailed for Medicaid independent laboratory services  
2157 as described in s. 409.905(7) or for Medicaid certified match  
2158 services as described in ss. 409.9071 and 1011.70.

2159 (37) The agency shall post on its website a current list  
2160 of each Medicaid provider, including any principal, officer,  
2161 director, agent, managing employee, or affiliated person of the  
2162 provider, or any partner or shareholder having an ownership  
2163 interest in the provider equal to 5 percent or greater, who has  
2164 been terminated for cause from the Medicaid program or  
2165 sanctioned under this section. The list must be searchable by a  
2166 variety of search parameters and provide for the creation of  
2167 formatted lists that may be printed or imported into other

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2168 applications, including spreadsheets. The agency shall update  
2169 the list at least monthly.

2170 (38) In order to improve the detection of health care  
2171 fraud, use technology to prevent and detect fraud, and maximize  
2172 the electronic exchange of health care fraud information, the  
2173 agency shall:

2174 (a) Compile, maintain, and publish on its website a  
2175 detailed list of all state and federal databases that contain  
2176 health care fraud information and update the list at least  
2177 biannually;

2178 (b) Develop a strategic plan to connect all databases that  
2179 contain health care fraud information to facilitate the  
2180 electronic exchange of health information between the agency,  
2181 the Department of Health, the Department of Law Enforcement, and  
2182 the Attorney General's Office. The plan must include recommended  
2183 standard data formats, fraud identification strategies, and  
2184 specifications for the technical interface between state and  
2185 federal health care fraud databases;

2186 (c) Monitor innovations in health information technology,  
2187 specifically as it pertains to Medicaid fraud prevention and  
2188 detection; and

2189 (d) Periodically publish policy briefs that highlight  
2190 available new technology to prevent or detect health care fraud  
2191 and projects implemented by other states, the private sector, or

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2192 the Federal Government which use technology to prevent or detect  
2193 health care fraud.

2194 Section 42. Paragraph (a) of subsection (2) of section  
2195 409.920, Florida Statutes, is amended to read:

2196 409.920 Medicaid provider fraud.—

2197 (2) (a) A person may not:

2198 1. Knowingly make, cause to be made, or aid and abet in  
2199 the making of any false statement or false representation of a  
2200 material fact, by commission or omission, in any claim submitted  
2201 to the agency or its fiscal agent or a managed care plan for  
2202 payment.

2203 2. Knowingly make, cause to be made, or aid and abet in  
2204 the making of a claim for items or services that are not  
2205 authorized to be reimbursed by the Medicaid program.

2206 3. Knowingly charge, solicit, accept, or receive anything  
2207 of value, other than an authorized copayment from a Medicaid  
2208 recipient, from any source in addition to the amount legally  
2209 payable for an item or service provided to a Medicaid recipient  
2210 under the Medicaid program or knowingly fail to credit the  
2211 agency or its fiscal agent for any payment received from a  
2212 third-party source.

2213 4. Knowingly make or in any way cause to be made any false  
2214 statement or false representation of a material fact, by  
2215 commission or omission, in any document containing items of  
2216 income and expense that is or may be used by the agency to

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2217 determine a general or specific rate of payment for an item or  
2218 service provided by a provider.

2219 5. Knowingly solicit, offer, pay, or receive any  
2220 remuneration, including any kickback, bribe, or rebate, directly  
2221 or indirectly, overtly or covertly, in cash or in kind, in  
2222 return for referring an individual to a person for the  
2223 furnishing or arranging for the furnishing of any item or  
2224 service for which payment may be made, in whole or in part,  
2225 under the Medicaid program, or in return for obtaining,  
2226 purchasing, leasing, ordering, or arranging for or recommending,  
2227 obtaining, purchasing, leasing, or ordering any goods, facility,  
2228 item, or service, for which payment may be made, in whole or in  
2229 part, under the Medicaid program. This subparagraph does not  
2230 apply to any discount, payment, waiver of payment, or payment  
2231 practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or  
2232 regulations promulgated thereunder.

2233 6. Knowingly submit false or misleading information or  
2234 statements to the Medicaid program for the purpose of being  
2235 accepted as a Medicaid provider.

2236 7. Knowingly use or endeavor to use a Medicaid provider's  
2237 identification number or a Medicaid recipient's identification  
2238 number to make, cause to be made, or aid and abet in the making  
2239 of a claim for items or services that are not authorized to be  
2240 reimbursed by the Medicaid program.

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2241 Section 43. Subsection (1) of section 409.967, Florida  
2242 Statutes, is amended to read:

2243 409.967 Managed care plan accountability.—

2244 (1) Beginning with the contract procurement process  
2245 initiated during the 2023 calendar year, the agency shall  
2246 establish a 6-year ~~5-year~~ contract with each managed care plan  
2247 selected through the procurement process described in s.  
2248 409.966. A plan contract may not be renewed; however, the agency  
2249 may extend the term of a plan contract to cover any delays  
2250 during the transition to a new plan. The agency shall extend  
2251 until December 31, 2024, the term of existing plan contracts  
2252 awarded pursuant to the invitation to negotiate published in  
2253 July 2017.

2254 Section 44. Paragraph (b) of subsection (5) of section  
2255 409.973, Florida Statutes, is amended to read:

2256 409.973 Benefits.—

2257 (5) PROVISION OF DENTAL SERVICES.—

2258 (b) In the event the Legislature takes no action before  
2259 July 1, 2017, with respect to the report findings required under  
2260 subparagraph (a)2., the agency shall implement a statewide  
2261 Medicaid prepaid dental health program for children and adults  
2262 with a choice of at least two licensed dental managed care  
2263 providers who must have substantial experience in providing  
2264 dental care to Medicaid enrollees and children eligible for  
2265 medical assistance under Title XXI of the Social Security Act

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2266 and who meet all agency standards and requirements. To qualify  
2267 as a provider under the prepaid dental health program, the  
2268 entity must be licensed as a prepaid limited health service  
2269 organization under part I of chapter 636 or as a health  
2270 maintenance organization under part I of chapter 641. The  
2271 contracts for program providers shall be awarded through a  
2272 competitive procurement process. Beginning with the contract  
2273 procurement process initiated during the 2023 calendar year, the  
2274 contracts must be for 6 5 years and may not be renewed; however,  
2275 the agency may extend the term of a plan contract to cover  
2276 delays during a transition to a new plan provider. The agency  
2277 shall include in the contracts a medical loss ratio provision  
2278 consistent with s. 409.967(4). The agency is authorized to seek  
2279 any necessary state plan amendment or federal waiver to commence  
2280 enrollment in the Medicaid prepaid dental health program no  
2281 later than March 1, 2019. The agency shall extend until December  
2282 31, 2024, the term of existing plan contracts awarded pursuant  
2283 to the invitation to negotiate published in October 2017.

2284 Section 45. Subsection (6) of section 429.11, Florida  
2285 Statutes, is amended to read:

2286 429.11 Initial application for license; provisional  
2287 license.—

2288 ~~(6) In addition to the license categories available in s.~~  
2289 ~~408.808, a provisional license may be issued to an applicant~~  
2290 ~~making initial application for licensure or making application~~

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2291 ~~for a change of ownership. A provisional license shall be~~  
2292 ~~limited in duration to a specific period of time not to exceed 6~~  
2293 ~~months, as determined by the agency.~~

2294 Section 46. Subsection (9) of section 429.19, Florida  
2295 Statutes, is amended to read:

2296 429.19 Violations; imposition of administrative fines;  
2297 grounds.—

2298 ~~(9) The agency shall develop and disseminate an annual~~  
2299 ~~list of all facilities sanctioned or fined for violations of~~  
2300 ~~state standards, the number and class of violations involved,~~  
2301 ~~the penalties imposed, and the current status of cases. The list~~  
2302 ~~shall be disseminated, at no charge, to the Department of~~  
2303 ~~Elderly Affairs, the Department of Health, the Department of~~  
2304 ~~Children and Families, the Agency for Persons with Disabilities,~~  
2305 ~~the area agencies on aging, the Florida Statewide Advocacy~~  
2306 ~~Council, the State Long-Term Care Ombudsman Program, and state~~  
2307 ~~and local ombudsman councils. The Department of Children and~~  
2308 ~~Families shall disseminate the list to service providers under~~  
2309 ~~contract to the department who are responsible for referring~~  
2310 ~~persons to a facility for residency. The agency may charge a fee~~  
2311 ~~commensurate with the cost of printing and postage to other~~  
2312 ~~interested parties requesting a copy of this list. This~~  
2313 ~~information may be provided electronically or through the~~  
2314 ~~agency's Internet site.~~

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2315 Section 47. Subsection (2) of section 429.35, Florida  
2316 Statutes, is amended to read:

2317 429.35 Maintenance of records; reports.—

2318 (2) Within 60 days after the date of an ~~the biennial~~  
2319 inspection conducted ~~visit required~~ under s. 408.811 or within  
2320 30 days after the date of an ~~any~~ interim visit, the agency shall  
2321 forward the results of the inspection to the local ombudsman  
2322 council in the district where the facility is located; to at  
2323 least one public library or, in the absence of a public library,  
2324 the county seat in the county in which the inspected assisted  
2325 living facility is located; and, when appropriate, to the  
2326 district Adult Services and Mental Health Program Offices.

2327 Section 48. Subsection (2) of section 429.905, Florida  
2328 Statutes, is amended to read:

2329 429.905 Exemptions; monitoring of adult day care center  
2330 programs colocated with assisted living facilities or licensed  
2331 nursing home facilities.—

2332 (2) A licensed assisted living facility, a licensed  
2333 hospital, or a licensed nursing home facility may provide  
2334 services during the day which include, but are not limited to,  
2335 social, health, therapeutic, recreational, nutritional, and  
2336 respite services, to adults who are not residents. Such a  
2337 facility need not be licensed as an adult day care center;  
2338 however, the agency must monitor the facility during the regular  
2339 inspection ~~and at least biennially~~ to ensure adequate space and

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2340 sufficient staff. If an assisted living facility, a hospital, or  
2341 a nursing home holds itself out to the public as an adult day  
2342 care center, it must be licensed as such and meet all standards  
2343 prescribed by statute and rule. For the purpose of this  
2344 subsection, the term "day" means any portion of a 24-hour day.

2345 Section 49. Subsection (2) of section 429.929, Florida  
2346 Statutes, is amended to read:

2347 429.929 Rules establishing standards.—

2348 ~~(2) Pursuant to this part, s. 408.811, and applicable~~  
2349 ~~rules, the agency may conduct an abbreviated biennial inspection~~  
2350 ~~of key quality of care standards, in lieu of a full inspection,~~  
2351 ~~of a center that has a record of good performance. However, the~~  
2352 ~~agency must conduct a full inspection of a center that has had~~  
2353 ~~one or more confirmed complaints within the licensure period~~  
2354 ~~immediately preceding the inspection or which has a serious~~  
2355 ~~problem identified during the abbreviated inspection. The agency~~  
2356 ~~shall develop the key quality of care standards, taking into~~  
2357 ~~consideration the comments and recommendations of provider~~  
2358 ~~groups. These standards shall be included in rules adopted by~~  
2359 ~~the agency.~~

2360 Section 50. Effective January 1, 2021, paragraph (e) of  
2361 subsection (2) and paragraph (e) of subsection (3) of section  
2362 627.6387, Florida Statutes, are amended to read:

2363 627.6387 Shared savings incentive program.—

2364 (2) As used in this section, the term:

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2365 (e) "Shoppable health care service" means a lower-cost,  
2366 high-quality nonemergency health care service for which a shared  
2367 savings incentive is available for insureds under a health  
2368 insurer's shared savings incentive program. Shoppable health  
2369 care services may be provided within or outside this state and  
2370 include, but are not limited to:

- 2371 1. Clinical laboratory services.
- 2372 2. Infusion therapy.
- 2373 3. Inpatient and outpatient surgical procedures.
- 2374 4. Obstetrical and gynecological services.
- 2375 5. Inpatient and outpatient nonsurgical diagnostic tests  
2376 and procedures.
- 2377 6. Physical and occupational therapy services.
- 2378 7. Radiology and imaging services.
- 2379 8. Prescription drugs.
- 2380 9. Services provided through telehealth.
- 2381 10. Any additional services published by the Agency for  
2382 Health Care Administration that have the most significant price  
2383 variation pursuant to s. 408.05(3)(1).

2384 (3) A health insurer may offer a shared savings incentive  
2385 program to provide incentives to an insured when the insured  
2386 obtains a shoppable health care service from the health  
2387 insurer's shared savings list. An insured may not be required to  
2388 participate in a shared savings incentive program. A health  
2389 insurer that offers a shared savings incentive program must:

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2390 (e) At least quarterly, credit or deposit the shared  
2391 savings incentive amount to the insured's account as a return or  
2392 reduction in premium, or credit the shared savings incentive  
2393 amount to the insured's flexible spending account, health  
2394 savings account, or health reimbursement account, or reward the  
2395 insured directly with cash or a cash equivalent ~~such that the~~  
2396 ~~amount does not constitute income to the insured.~~

2397 Section 51. Effective January 1, 2021, paragraph (e) of  
2398 subsection (2) and paragraph (e) of subsection (3) of section  
2399 627.6648, Florida Statutes, are amended to read:

2400 627.6648 Shared savings incentive program.—

2401 (2) As used in this section, the term:

2402 (e) "Shoppable health care service" means a lower-cost,  
2403 high-quality nonemergency health care service for which a shared  
2404 savings incentive is available for insureds under a health  
2405 insurer's shared savings incentive program. Shoppable health  
2406 care services may be provided within or outside this state and  
2407 include, but are not limited to:

- 2408 1. Clinical laboratory services.
- 2409 2. Infusion therapy.
- 2410 3. Inpatient and outpatient surgical procedures.
- 2411 4. Obstetrical and gynecological services.
- 2412 5. Inpatient and outpatient nonsurgical diagnostic tests  
2413 and procedures.
- 2414 6. Physical and occupational therapy services.

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- 2415 7. Radiology and imaging services.  
2416 8. Prescription drugs.  
2417 9. Services provided through telehealth.  
2418 10. Any additional services published by the Agency for  
2419 Health Care Administration that have the most significant price  
2420 variation pursuant to s. 408.05(3)(1).

2421 (3) A health insurer may offer a shared savings incentive  
2422 program to provide incentives to an insured when the insured  
2423 obtains a shoppable health care service from the health  
2424 insurer's shared savings list. An insured may not be required to  
2425 participate in a shared savings incentive program. A health  
2426 insurer that offers a shared savings incentive program must:

2427 (e) At least quarterly, credit or deposit the shared  
2428 savings incentive amount to the insured's account as a return or  
2429 reduction in premium, or credit the shared savings incentive  
2430 amount to the insured's flexible spending account, health  
2431 savings account, or health reimbursement account, or reward the  
2432 insured directly with cash or a cash equivalent ~~such that the~~  
2433 ~~amount does not constitute income to the insured.~~

2434 Section 52. Effective January 1, 2021, paragraph (e) of  
2435 subsection (2) and paragraph (e) of subsection (3) of section  
2436 641.31076, Florida Statutes, are amended to read:

2437 641.31076 Shared savings incentive program.—

2438 (2) As used in this section, the term:

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2439 (e) "Shoppable health care service" means a lower-cost,  
2440 high-quality nonemergency health care service for which a shared  
2441 savings incentive is available for subscribers under a health  
2442 maintenance organization's shared savings incentive program.  
2443 Shoppable health care services may be provided within or outside  
2444 this state and include, but are not limited to:

- 2445 1. Clinical laboratory services.
- 2446 2. Infusion therapy.
- 2447 3. Inpatient and outpatient surgical procedures.
- 2448 4. Obstetrical and gynecological services.
- 2449 5. Inpatient and outpatient nonsurgical diagnostic tests  
2450 and procedures.
- 2451 6. Physical and occupational therapy services.
- 2452 7. Radiology and imaging services.
- 2453 8. Prescription drugs.
- 2454 9. Services provided through telehealth.
- 2455 10. Any additional services published by the Agency for  
2456 Health Care Administration that have the most significant price  
2457 variation pursuant to s. 408.05(3)(1).

2458 (3) A health maintenance organization may offer a shared  
2459 savings incentive program to provide incentives to a subscriber  
2460 when the subscriber obtains a shoppable health care service from  
2461 the health maintenance organization's shared savings list. A  
2462 subscriber may not be required to participate in a shared

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2463 savings incentive program. A health maintenance organization  
2464 that offers a shared savings incentive program must:

2465 (e) At least quarterly, credit or deposit the shared  
2466 savings incentive amount to the subscriber's account as a return  
2467 or reduction in premium, or credit the shared savings incentive  
2468 amount to the subscriber's flexible spending account, health  
2469 savings account, or health reimbursement account, or reward the  
2470 subscriber directly with cash or a cash equivalent ~~such that the~~  
2471 ~~amount does not constitute income to the subscriber.~~

2472 Section 53. Part I of chapter 483, Florida Statutes, is  
2473 repealed, and part II and part III of that chapter are  
2474 redesignated as part I and part II, respectively.

2475 Section 54. Paragraph (g) of subsection (3) of section  
2476 20.43, Florida Statutes, is amended to read:

2477 20.43 Department of Health.—There is created a Department  
2478 of Health.

2479 (3) The following divisions of the Department of Health  
2480 are established:

2481 (g) Division of Medical Quality Assurance, which is  
2482 responsible for the following boards and professions established  
2483 within the division:

- 2484 1. The Board of Acupuncture, created under chapter 457.
- 2485 2. The Board of Medicine, created under chapter 458.
- 2486 3. The Board of Osteopathic Medicine, created under  
2487 chapter 459.

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- 2488           4. The Board of Chiropractic Medicine, created under  
2489 chapter 460.
- 2490           5. The Board of Podiatric Medicine, created under chapter  
2491 461.
- 2492           6. Naturopathy, as provided under chapter 462.
- 2493           7. The Board of Optometry, created under chapter 463.
- 2494           8. The Board of Nursing, created under part I of chapter  
2495 464.
- 2496           9. Nursing assistants, as provided under part II of  
2497 chapter 464.
- 2498           10. The Board of Pharmacy, created under chapter 465.
- 2499           11. The Board of Dentistry, created under chapter 466.
- 2500           12. Midwifery, as provided under chapter 467.
- 2501           13. The Board of Speech-Language Pathology and Audiology,  
2502 created under part I of chapter 468.
- 2503           14. The Board of Nursing Home Administrators, created  
2504 under part II of chapter 468.
- 2505           15. The Board of Occupational Therapy, created under part  
2506 III of chapter 468.
- 2507           16. Respiratory therapy, as provided under part V of  
2508 chapter 468.
- 2509           17. Dietetics and nutrition practice, as provided under  
2510 part X of chapter 468.
- 2511           18. The Board of Athletic Training, created under part  
2512 XIII of chapter 468.

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- 2513           19. The Board of Orthotists and Prosthetists, created  
2514 under part XIV of chapter 468.
- 2515           20. Electrolysis, as provided under chapter 478.
- 2516           21. The Board of Massage Therapy, created under chapter  
2517 480.
- 2518           22. The Board of Clinical Laboratory Personnel, created  
2519 under part I ~~part II~~ of chapter 483.
- 2520           23. Medical physicists, as provided under part II ~~part III~~  
2521 of chapter 483.
- 2522           24. The Board of Opticianry, created under part I of  
2523 chapter 484.
- 2524           25. The Board of Hearing Aid Specialists, created under  
2525 part II of chapter 484.
- 2526           26. The Board of Physical Therapy Practice, created under  
2527 chapter 486.
- 2528           27. The Board of Psychology, created under chapter 490.
- 2529           28. School psychologists, as provided under chapter 490.
- 2530           29. The Board of Clinical Social Work, Marriage and Family  
2531 Therapy, and Mental Health Counseling, created under chapter  
2532 491.
- 2533           30. Emergency medical technicians and paramedics, as  
2534 provided under part III of chapter 401.
- 2535           Section 55. Subsection (3) of section 381.0034, Florida  
2536 Statutes, is amended to read:
- 2537           381.0034 Requirement for instruction on HIV and AIDS.—

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2538 (3) The department shall require, as a condition of  
2539 granting a license under chapter 467 or part I ~~part II~~ of  
2540 chapter 483, that an applicant making initial application for  
2541 licensure complete an educational course acceptable to the  
2542 department on human immunodeficiency virus and acquired immune  
2543 deficiency syndrome. Upon submission of an affidavit showing  
2544 good cause, an applicant who has not taken a course at the time  
2545 of licensure shall be allowed 6 months to complete this  
2546 requirement.

2547 Section 56. Subsection (4) of section 456.001, Florida  
2548 Statutes, is amended to read:

2549 456.001 Definitions.—As used in this chapter, the term:

2550 (4) "Health care practitioner" means any person licensed  
2551 under chapter 457; chapter 458; chapter 459; chapter 460;  
2552 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;  
2553 chapter 466; chapter 467; part I, part II, part III, part V,  
2554 part X, part XIII, or part XIV of chapter 468; chapter 478;  
2555 chapter 480; part I or part II ~~part II or part III~~ of chapter  
2556 483; chapter 484; chapter 486; chapter 490; or chapter 491.

2557 Section 57. Paragraphs (h) and (i) of subsection (2) of  
2558 section 456.057, Florida Statutes, are amended to read:

2559 456.057 Ownership and control of patient records; report  
2560 or copies of records to be furnished; disclosure of  
2561 information.—

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2562 (2) As used in this section, the terms "records owner,"  
2563 "health care practitioner," and "health care practitioner's  
2564 employer" do not include any of the following persons or  
2565 entities; furthermore, the following persons or entities are not  
2566 authorized to acquire or own medical records, but are authorized  
2567 under the confidentiality and disclosure requirements of this  
2568 section to maintain those documents required by the part or  
2569 chapter under which they are licensed or regulated:

2570 (h) Clinical laboratory personnel licensed under part I  
2571 ~~part II~~ of chapter 483.

2572 (i) Medical physicists licensed under part II ~~part III~~ of  
2573 chapter 483.

2574 Section 58. Paragraph (j) of subsection (1) of section  
2575 456.076, Florida Statutes, is amended to read:

2576 456.076 Impaired practitioner programs.—

2577 (1) As used in this section, the term:

2578 (j) "Practitioner" means a person licensed, registered,  
2579 certified, or regulated by the department under part III of  
2580 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;  
2581 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;  
2582 chapter 466; chapter 467; part I, part II, part III, part V,  
2583 part X, part XIII, or part XIV of chapter 468; chapter 478;  
2584 chapter 480; part I or part II ~~part II or part III~~ of chapter  
2585 483; chapter 484; chapter 486; chapter 490; or chapter 491; or



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2586 an applicant for a license, registration, or certification under  
2587 the same laws.

2588 Section 59. Paragraph (b) of subsection (1) of section  
2589 456.47, Florida Statutes, is amended to read:

2590 456.47 Use of telehealth to provide services.—

2591 (1) DEFINITIONS.—As used in this section, the term:

2592 (b) "Telehealth provider" means any individual who  
2593 provides health care and related services using telehealth and  
2594 who is licensed or certified under s. 393.17; part III of  
2595 chapter 401; chapter 457; chapter 458; chapter 459; chapter 460;  
2596 chapter 461; chapter 463; chapter 464; chapter 465; chapter 466;  
2597 chapter 467; part I, part III, part IV, part V, part X, part  
2598 XIII, or part XIV of chapter 468; chapter 478; chapter 480; part  
2599 I or part II ~~part II or part III~~ of chapter 483; chapter 484;  
2600 chapter 486; chapter 490; or chapter 491; who is licensed under  
2601 a multistate health care licensure compact of which Florida is a  
2602 member state; or who is registered under and complies with  
2603 subsection (4).

2604 Section 60. Except as otherwise expressly provided in this  
2605 act and except for this section, which shall take effect upon  
2606 this act becoming a law, this act shall take effect July 1,  
2607 2020.

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

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2611 Remove everything before the enacting clause and insert:  
2612 A bill to be entitled  
2613 An act relating to the Agency for Health Care Administration;  
2614 amending s. 383.327, F.S.; requiring birth centers to report  
2615 certain deaths and stillbirths to the Agency for Health Care  
2616 Administration; removing a requirement that a certain report be  
2617 submitted annually to the agency; authorizing the agency to  
2618 prescribe by rule the frequency at which such report is  
2619 submitted; amending s. 395.003, F.S.; removing a requirement  
2620 that specified information be listed on licenses for certain  
2621 facilities; amending s. 395.1055, F.S.; requiring the agency to  
2622 adopt specified rules related to ongoing quality improvement  
2623 programs for certain cardiac programs; repealing s. 395.7015,  
2624 F.S., relating to an annual assessment on health care entities;  
2625 amending s. 395.7016, F.S.; conforming a provision to changes  
2626 made by the act; amending s. 400.19, F.S.; revising provisions  
2627 requiring the agency to conduct licensure inspections of nursing  
2628 homes; requiring the agency to conduct additional licensure  
2629 surveys under certain circumstances; revising a provision  
2630 requiring the agency to assess a specified fine for such  
2631 surveys; amending s. 400.462, F.S.; revising definitions;  
2632 amending s. 400.464, F.S.; revising exemptions from licensure  
2633 requirements for home health agencies; amending ss. 400.471,  
2634 400.492, 400.506, and 400.509, F.S.; revising provisions  
2635 relating to licensure requirements for home health agencies to

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COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 731 (2020)

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2636 conform to changes made by the act; exempting certain persons  
2637 and entities from such licensure requirements; amending s.  
2638 400.605, F.S.; removing a requirement that the agency conduct  
2639 specified inspections of certain licensees; amending s.  
2640 400.60501, F.S.; removing an obsolete date and a requirement  
2641 that the agency develop a specified annual report; amending s.  
2642 400.9905, F.S.; revising the definition of the term "clinic";  
2643 amending s. 400.991, F.S.; conforming provisions to changes made  
2644 by the act; removing the option for health care clinics to file  
2645 a surety bond under certain circumstances; amending s. 400.9935,  
2646 F.S.; requiring certain clinics to publish and post a schedule  
2647 of charges; amending s. 408.033, F.S.; conforming a provision to  
2648 changes made by the act; amending s. 408.05, F.S.; requiring the  
2649 agency to publish by a specified date an annual report  
2650 identifying certain health care services; amending s. 408.061,  
2651 F.S.; revising provisions requiring health care facilities to  
2652 submit specified data to the agency; amending s. 408.0611, F.S.;  
2653 requiring the agency to annually publish a report on the  
2654 progress of implementation of electronic prescribing on its  
2655 Internet website; amending s. 408.062, F.S.; requiring the  
2656 agency to annually publish certain information on its Internet  
2657 website; removing a requirement that the agency submit certain  
2658 annual reports to the Governor and Legislature; amending s.  
2659 408.063, F.S.; removing a requirement that the agency annually  
2660 publish certain reports; amending ss. 408.802, 408.820, 408.831,

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2661 and 408.832, F.S.; conforming provisions to changes made by the  
2662 act; amending s. 408.803, F.S.; conforming a provision to  
2663 changes made by the act; providing a definition of the term  
2664 "low-risk provider"; amending s. 408.806, F.S.; exempting  
2665 certain low-risk providers from a specified inspection; amending  
2666 s. 408.808, F.S.; authorizing the issuance of a provisional  
2667 license to certain applicants; amending s. 408.809, F.S.;  
2668 revising provisions relating to background screening  
2669 requirements for certain licensure applicants; removing an  
2670 obsolete date and provisions relating to certain rescreening  
2671 requirements; amending s. 408.811, F.S.; authorizing the agency  
2672 to exempt certain low-risk providers from inspections and  
2673 conduct unannounced licensure inspections of such providers  
2674 under certain circumstances; authorizing the agency to adopt  
2675 rules to waive routine inspections and grant extended time  
2676 periods between relicensure inspections under certain  
2677 conditions; amending s. 408.821, F.S.; revising provisions  
2678 requiring licensees to have a specified plan; providing  
2679 requirements for the submission of such plan; amending s.  
2680 408.909, F.S.; removing a requirement that the agency and Office  
2681 of Insurance Regulation evaluate a specified program; amending  
2682 s. 408.9091, F.S.; removing a requirement that the agency and  
2683 office jointly submit a specified annual report to the Governor  
2684 and Legislature; amending s. 409.905, F.S.; providing  
2685 construction for a provision that requires the agency to

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2686 | discontinue its hospital retrospective review program under  
2687 | certain circumstances; providing legislative intent; amending s.  
2688 | 409.907, F.S.; requiring that a specified background screening  
2689 | be conducted through the agency on certain persons and entities;  
2690 | amending s. 409.908, F.S.; revising provisions related to the  
2691 | prospective payment methodology for certain Medicaid provider  
2692 | reimbursements; amending s. 409.913, F.S.; revising a  
2693 | requirement that the agency and the Medicaid Fraud Control Unit  
2694 | of the Department of Legal Affairs submit a specified report to  
2695 | the Legislature; authorizing the agency to recover specified  
2696 | costs associated with an audit, investigation, or enforcement  
2697 | action relating to provider fraud under the Medicaid program;  
2698 | amending s. 409.920, F.S.; revising provisions related to  
2699 | prohibited referral practices in the Medicaid program; amending  
2700 | ss. 409.967 and 409.973, F.S.; revising the length of managed  
2701 | care plan and Medicaid prepaid dental health program contracts,  
2702 | respectively, procured by the agency beginning during a  
2703 | specified timeframe; requiring the agency to extend the term of  
2704 | certain existing contracts until a specified date; amending s.  
2705 | 429.11, F.S.; removing an authorization for the issuance of a  
2706 | provisional license to certain facilities; amending s. 429.19,  
2707 | F.S.; removing requirements that the agency develop and  
2708 | disseminate a specified list and the Department of Children and  
2709 | Families disseminate such list to certain providers; amending  
2710 | ss. 429.35, 429.905, and 429.929, F.S.; revising provisions

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COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 731 (2020)

Amendment No. 1

2711 requiring a biennial inspection cycle for specified facilities  
2712 and centers, respectively; repealing part I of chapter 483,  
2713 F.S., relating to The Florida Multiphasic Health Testing Center  
2714 Law; amending ss. 627.6387, 627.6648, and 641.31076, F.S.;  
2715 revising the definition of the term "shoppable health care  
2716 service"; revising duties of certain health insurers and health  
2717 maintenance organizations; amending ss. 20.43, 381.0034,  
2718 456.001, 456.057, 456.076, and 456.47, F.S.; conforming cross-  
2719 references; providing effective dates.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 945 Children's Mental Health  
**SPONSOR(S):** Children, Families & Seniors Subcommittee, Silvers  
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1440

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Fontaine	Clark
3) Health & Human Services Committee		Morris	Calamas

### SUMMARY ANALYSIS

Overall, depressive episodes and serious thoughts of suicide are increasing among Florida's children. This may contribute to the over 36,000 involuntary examinations that were initiated under the Baker Act for individuals under the age of 18 between July 1, 2017 and June 30, 2018. Additionally, 22.61% of minors who had involuntary examinations had multiple such examinations in FY 2017-2018, ranging from 2 to 19 instances. The Department of Children and Families (DCF) identified 21 minors who had more than 10 involuntary examinations in FY 2017-2018 with a combined total of 285 initiations.

HB 945 creates a coordinated system of care, the development of which is facilitated by each behavioral health managing entity, which integrates services provided through providers funded by the state's child-serving systems, as well as other systems for which children and adolescents would qualify, and facilitates access by children and adolescents to needed mental health treatment and services at any point of entry.

The bill includes crisis response services provided through mobile response teams (MRT) in the array of services available to children and adolescents who are members of certain target populations and specifies the elements of that service.

The bill revises the required provisions of the plans required for school district funding under the Mental Health Assistance allocation, such as to require a memorandum of understanding with the local managing entity and policies and procedures for referrals for other household members to services available through other delivery systems and payors under certain circumstances. It requires the development and use of a model protocol regarding use of MRTs in schools.

The bill requires DCF and the Agency for Health Care Administration (AHCA) to identify children and adolescents who are the highest users of crisis stabilization services, collaboratively take action to meet the behavioral health needs of such children and submit a joint quarterly report during Fiscal Years 2020-2021 and 2021-2022 to the Legislature. The bill also requires DCF and AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of such services and submit a joint report to the Governor and Legislature.

The bill requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

The bill has an insignificant, negative impact on state government, which can be absorbed within existing resources. The bill has an indeterminate, 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

##### **Mental Health and Mental Illness**

Mental health and mental illness are not synonymous. 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 make a contribution to his or her community.<sup>1</sup>

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 and/or impaired functioning.<sup>2</sup> Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, causing distress and problems getting through the day.<sup>3</sup> The most commonly diagnosed mental disorders in children are attention deficit hyperactivity disorder (ADHD), behavior problems, anxiety, and depression.<sup>4</sup> In 2016-2017, 21% of parents responding to a survey reported that a doctor has told them their child has autism, developmental delays, depression or anxiety, attention deficit disorder/ADHD, or behavioral/conduct problems.<sup>5</sup>

The most recently published data from the National Survey on Drug Use and Health shows 12.5% of children in Florida age 12 to 17 experienced a major depressive episode.<sup>6</sup> Approximately 37.7% of those children received depression care.<sup>7</sup> The Florida Department of Health's 2019 Youth Risk Behavior Survey of Florida's public high school students shows 33.7% experienced periods of persistent feelings of sadness and hopelessness, 15.6% seriously considered attempting suicide and 7.9% attempted suicide.<sup>8</sup> Seventy-six children between the ages of 2 to 17 died by suicide in Florida in 2018.<sup>9</sup>

##### Mental Health Services in Florida

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 for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

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<sup>1</sup> Centers for Disease Control and Prevention, *Learn About Mental Health*, <https://www.cdc.gov/mentalhealth/learn/> (last visited Feb. 21, 2020).

<sup>2</sup> *Id.*

<sup>3</sup> Centers for Disease Control and Prevention, *Data and Statistics on Children's Mental Health*, <https://www.cdc.gov/childrensmentalhealth/data.html> (last visited Feb. 21, 2020).

<sup>4</sup> *Id.*

<sup>5</sup> The Annie E. Casey Foundation Kids Count Data Center, *Children who have one or more emotional, behavioral, or developmental conditions in Florida*, (April 2019) <https://datacenter.kidscount.org/data#FL/2/0/char/0> (last visited Feb. 21, 2020).

<sup>6</sup> Substance Abuse and Mental Health Services Administration, *Behavioral Health Barometer, Florida, Volume 5*, (2019), <https://store.samhsa.gov/system/files/florida-bh-barometervolume5-sma19-baro-17-us.pdf> (last visited Feb. 21, 2020).

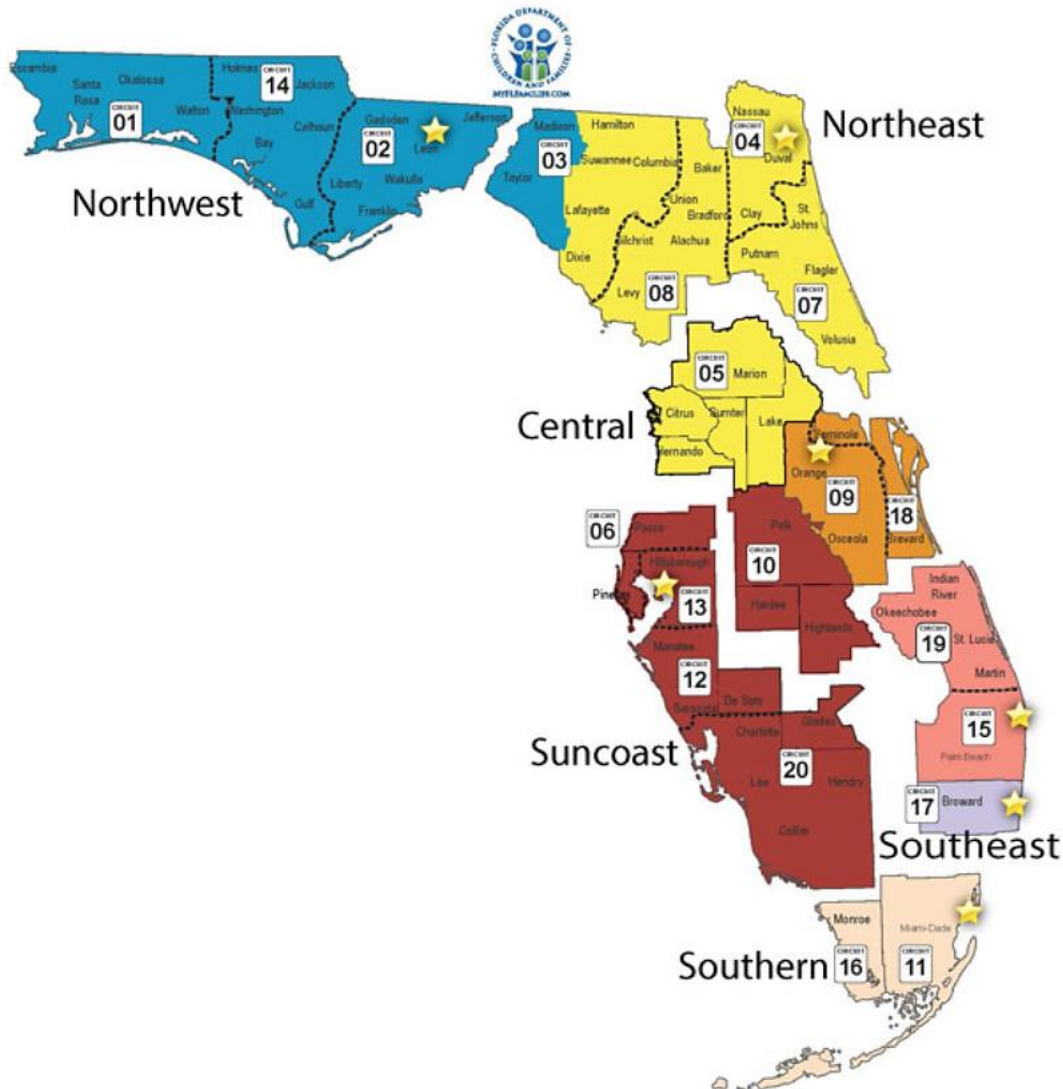
<sup>7</sup> *Id.*

<sup>8</sup> Florida Department of Health, *2019 Florida Risk Behavior Survey Report*, (2019), <http://www.floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/index.html> (last visited Feb. 21, 2020).

<sup>9</sup> Florida Department of Health FLHealthCHARTS, *Suicide Deaths*, <http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116> (last visited Feb. 21, 2020).

## Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.<sup>10</sup> The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.<sup>11</sup> Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.<sup>12</sup> DCF contracts with seven MEs - Big Bend Community Based Care (blue), Lutheran Services Florida (yellow), Central Florida Cares Health System (orange), Central Florida Behavioral Health Network, Inc. (red), Southeast Florida Behavioral Health (pink), Broward Behavioral Health Network, Inc. (purple), and South Florida Behavioral Health Network, Inc. (beige) that in turn contract with local service providers<sup>13</sup> for the delivery of mental health and substance abuse services.<sup>14</sup>



<sup>10</sup> Ch. 2001-191, Laws of Fla.

<sup>11</sup> Ch. 2008-243, Laws of Fla.

<sup>12</sup> *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.

<sup>13</sup> Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

<sup>14</sup> Department of Children and Families, *Managing Entities*, <https://www.myflfamilies.com/service-programs/samh/managing-entities/> (last visited Feb. 21, 2020).

In FY 2018-2019, the network service providers under contract with the MEs served 339,093 individuals.<sup>15</sup>

**FY 2018-2019 Individuals Served by Managing Entities**

ME	Total Served (unduplicated)	Adults Community Mental Health	Children Community Mental Health	Adults Community Substance Abuse	Children Community Substance Abuse
BBCBC	37,874	22,074	7,248	9,493	2,608
BBHC	25,630	14,084	2,560	9,177	2,004
CFBHN	116, 557	71,225	17,564	31,031	8,349
CFCHS	31,586	14,714	2,254	14,523	4,058
LSF	52,707	32,312	5,081	17,261	2,913
SEFBHN	30,390	16,170	5,661	7,542	2,837
SFBHN	44,349	26,811	7,099	8,767	3,749

*Coordinated System of Care*

Managing entities are required to promote the development and implementation of a coordinated system of care.<sup>16</sup> A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.<sup>17</sup> A community or region provides a coordinated system of care for those suffering from mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.<sup>18</sup> MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF’s assessment of behavioral health services in this state.<sup>19</sup> DCF must use performance-based contracts to award grants.<sup>20</sup>

There are several essential elements which make up a coordinated system of care, including:<sup>21</sup>

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and

<sup>15</sup> Department of Children and Families, *Substance Abuse and Mental Health Triennial Plan Update for Fiscal Year*, (Dec. 6, 2019) <https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202018%20Update.pdf> (last visited Feb. 21, 2020).

<sup>16</sup> S. 394.9082(5)(d), F.S.

<sup>17</sup> S. 394.4573(1)(c), F.S.

<sup>18</sup> S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.

<sup>19</sup> Id.

<sup>20</sup> Id.

<sup>21</sup> S. 394.4573(2), F.S.

- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:<sup>22</sup>

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

Current law requires DCF to define the priority populations which would benefit from receiving care coordination, including considerations when defining such population.<sup>23</sup> Considerations include the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.<sup>24</sup> The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.<sup>25</sup>

### Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.<sup>26</sup> The Act includes 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.<sup>27</sup>

#### *Involuntary Examination and Receiving Facilities*

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.<sup>28</sup> An involuntary examination is required if there is reason to believe that the person has a mental illness and has, because of his or her mental illness, refused involuntary

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<sup>22</sup> S. 394.495(4), F.S.

<sup>23</sup> S. 394.9082(3)(c), F.S.

<sup>24</sup> S. 394.9082(5)(b), F.S.

<sup>25</sup> S. 394.75(3), F.S.

<sup>26</sup> Ss. 394.451-394.47892, F.S.

<sup>27</sup> S. 394.459, F.S.

<sup>28</sup> Ss. 394.4625 and 394.463, F.S.

examination, is likely to refuse to care for him or herself, or cause harm to him or herself or others in the near future.<sup>29</sup>

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.<sup>30</sup> A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.<sup>31</sup> Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.<sup>32</sup>

Crisis Stabilization Units (CSUs) are specialized public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.<sup>33</sup> CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.<sup>34</sup> The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.<sup>35</sup> Individuals often enter the public mental health system through CSUs.<sup>36</sup> For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.<sup>37</sup>

As of September 2019, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.<sup>38</sup> Of the 54 public receiving facilities, 40 are CSU's.<sup>39</sup>

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.<sup>40</sup> During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.<sup>41</sup> If the patient is a minor, the examination must be initiated within 12 hours.<sup>42</sup>

Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen:<sup>43</sup>

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<sup>29</sup> S. 394.463(1), F.S.

<sup>30</sup> S. 394.455(39), F.S. This term does not include a county jail.

<sup>31</sup> S. 394.455(37), F.S.

<sup>32</sup> Rule 65E-5.400(2), F.A.C.

<sup>33</sup> S. 394.875(1)(a), F.S.

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), available at <https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf> (last visited Feb. 21, 2020).

<sup>37</sup> *Id.* Sections 394.65-394.9085, F.S.

<sup>38</sup> Department of Children and Families, *Designated Baker Act Receiving Facilities*, (Sept. 9, 2019), <https://www.myflfamilies.com/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Facilities.pdf> (last visited Feb. 21, 2020). Hospitals can also be designated as public receiving facilities.

<sup>39</sup> *Id.*

<sup>40</sup> S. 394.463(2)(g), F.S.

<sup>41</sup> S. 394.463(2)(f), F.S.

<sup>42</sup> S. 394.463(2)(g), F.S.

<sup>43</sup> S. 394.463(2)(g), F.S.

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

#### Involuntary Examinations Fiscal Year 2001-2002 through Fiscal Year 2017-2018<sup>44</sup>

Fiscal Year	All Ages			Minors (< 18)		
	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000
2017-2018	205,781	N/A	1,005	36,078	N/A	1,186
2016-2017	199,944	2.92%	992	32,763	10.12%	1,092
2015-2016	194,354	5.88%	981	32,475	11.09%	1,097
2014-2015	187,999	9.46%	964	32,650	10.50%	1,102
2013-2014	177,006	16.26%	919	30,355	18.85%	1,030
2012-2013	163,850	25.59%	859	26,808	34.58%	914
2011-2012	154,655	33.06%	818	24,836	45.26%	848
2010-2011	145,290	41.63%	773	21,752	65.86%	743
2009-2010	141,284	45.65%	754	21,128	70.76%	702
2008-2009	133,644	53.98%	711	20,258	78.09%	664
2007-2008	127,983	60.79%	685	19,705	83.09%	643
2006-2007	120,082	71.37%	661	19,238	87.54%	652
2005-2006	118,722	73.33%	668	19,019	89.69%	651
2004-2005	114,700	79.41%	660	19,065	89.24%	664
2003-2004	107,705	91.06%	634	18,286	97.30%	648
2002-2003	103,079	99.63%	620	16,845	114.18%	606
2001-2002	95,574	115.31%	586	14,997	140.57%	547

<sup>44</sup> Florida Department of Children and Families, *Report on Involuntary Examination of Minors, 2019*, (Nov. 2019), p. 25, <https://www.myflfamilies.com/service-programs/samh/publications/docs/Report%20on%20Involuntary%20Examination%20of%20Minors.pdf> (last visited Feb. 21, 2020).

## Report on Involuntary Examinations of Minors

In 2017, the Legislature created a task force within DCF<sup>45</sup> to address the issue of involuntary examination of minors age 17 years or younger, specifically by:<sup>46</sup>

- Analyzing data on the initiation of involuntary examinations of minors;
- Researching the root causes of and trends in such involuntary examinations;
- Identifying and evaluating options for expediting the examination process; and
- Identifying recommendations for encouraging alternatives to or eliminating inappropriate initiations of such examinations.

The task force found that specific causes of increases in involuntary examinations of children are unknown. Possible factors cited in the task force report include an increase in mental health concerns, social stressors, and a lack of availability of mental health services.<sup>47</sup>

As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.<sup>48</sup> As part of the report (2019 report), DCF was required to:

- Analyze data on the initiation of involuntary examinations of minors;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations.

### *Multiple Involuntary Examinations*

The 2019 report revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.

The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.<sup>49</sup> From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children.<sup>50</sup> Children have a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%).<sup>51</sup> Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018, ranging from 2 to 19.<sup>52</sup> DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 initiations.<sup>53</sup> DCF's review of medical records found:<sup>54</sup>

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88%);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most had Medicaid health insurance;

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<sup>45</sup> Ch. 2017-151, Laws of Florida.

<sup>46</sup> Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors*, (Nov. 2017), <https://www.myflfamilies.com/service-programs/samh/publications/docs/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf> (last visited Feb. 21, 2020).

<sup>47</sup> Id.

<sup>48</sup> Ch. 2019-134, Laws of Florida.

<sup>49</sup> *Supra*, note 44.

<sup>50</sup> Id. at 2.

<sup>51</sup> Id.

<sup>52</sup> Id.

<sup>53</sup> Id.

<sup>54</sup> Id.

- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;
- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

### *Recommendations*

The 2017 task force made a number of recommendations.<sup>55</sup> The task force recommended an increase in the number of days that the receiving facility has to submit required forms to DCF to capture additional data. It also recommended an expedition of involuntary exams by expanding the list of mental health professionals who can conduct the clinical exam and to increase funding for mobile crisis teams. Additionally, the task force recommended funding an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis. The task force also recommended expanded access to outpatient crisis intervention services and treatment especially for children under 13. Further, the task force recommended encourage school districts to adopt a standardized suicide risk assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination.

Several of these recommendations have been implemented through statutory change or legislative appropriations.

The 2019 task force report recommended increasing care coordination, utilizing wraparound care coordination and existing local review teams, revising DCF rules to gather more information about actions taken after the initiation of exams, and ensuring that parents receive information about mobile crisis teams and other available community resources.<sup>56</sup>

### Mental Health Services for Students

The Florida Department of Education (DOE), through the Bureau of Exceptional Education and Student Services and the Office of Safe Schools, promotes a system of support, policies, and practices that focus on prevention and early intervention to improve student mental health and school safety. Florida law requires instructional personnel to teach comprehensive health education that addresses concepts of mental and emotional health as well as substance use and abuse.<sup>57</sup> Student Services personnel, which includes school psychologists, school social workers, and school counselors, are classified as instructional personnel responsible for advising students regarding personal and social adjustments, and provide direct and indirect services at the district and school level.<sup>58</sup>

State funding for school districts' mental health services is provided primarily by legislative appropriations, the majority of which is distributed through an allocation through the Florida Education Finance Program (FEFP) to each district. In addition to the basic amount for current operations for the FEFP, the Legislature may appropriate categorical funding for specified programs, activities or purposes.<sup>59</sup> Each district school board must include the amount of categorical funds as a part of the district annual financial report to DOE, and DOE must submit a report to the Legislature that identifies by district and by categorical fund the amount transferred and the specific academic classroom activity for which the funds were spent.<sup>60</sup>

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<sup>55</sup> *Supra*, note 46.

<sup>56</sup> *Supra* note 44, at 17-18.

<sup>57</sup> S. 1003.42(2)(n), F.S.

<sup>58</sup> S. 1012.01(2)(b), F.S.

<sup>59</sup> S. 1012.01(6), F.S.

<sup>60</sup> *Id.*



The law allows district school boards and state agencies administering children's mental health funds to form a multiagency network to provide support for students with severe emotional disturbance.<sup>61</sup> The program goals for each component of the multiagency network are to:

- Enable students with severe emotional disturbance to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living;
- Develop individual programs for students with severe emotional disturbance, including necessary educational, residential, and mental health treatment services;
- Provide programs and services as close as possible to the student's home in the least restrictive manner consistent with the student's needs; and
- Integrate a wide range of services necessary to support students with severe emotional disturbances and their families.<sup>62</sup>

DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.<sup>63</sup> SEDNET is a network of 19 regional projects that are composed of major child-serving agencies, community-based service providers, and students and their families. Local school districts serve as fiscal agents for each local regional project.<sup>64</sup> SEDNET focuses on developing interagency collaboration and sustaining partnerships among professionals and families in the education, mental health, substance abuse, child welfare, and juvenile justice systems serving children and youth with and at risk of emotional and behavioral disabilities.<sup>65</sup>

#### *Mental Health Assistance Allocation*

Established in 2018, the mental health assistance allocation within the Florida Education Finance Program (FEFP) provides funds for school-based mental health programs as annually provided in the General Appropriations Act (GAA). The allocation provides each school district at least \$100,000, with the remaining balance allocated based on each district's proportionate share of the state's total unweighted student enrollment. Eligible charter schools are also entitled to a proportionate share of district funding.

At least 90 percent of a school district's allocation must be expended on:

- The provision of mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and students at high risk of such diagnoses; and
- The coordination of such services with a student's primary care provider and with other mental health providers involved in the student's care.

In order to receive allocation funds, a school district must develop and submit a detailed plan outlining the local program and planned expenditures to the district school board for approval. In addition, a charter school must annually develop and submit a detailed plan outlining the local program and planned expenditures of the funds in the plan to its governing body for approval. Once the plan is approved by the governing body, it must be provided to its school district for submission to the Commissioner of Education.

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<sup>61</sup> See s. 1006.04(1)(a), F.S.

<sup>62</sup> S. 1006.04(1)(b), F.S.

<sup>63</sup> S. 1006.04(2), F.S.

<sup>64</sup> Fiscal agents include the Brevard, Broward, Miami-Dade, Duval, Escambia, Hamilton, Highlands, Hillsborough, Lee, Leon, Marion, Orange, Palm Beach, Pinellas, Polk, Putnam, St. Lucie, Sarasota, and Washington school districts. Florida Department of Education, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, at p. 11, <http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf> (last visited Feb. 21, 2020).

<sup>65</sup> Florida Department of Education, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, available at <http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf> (last visited Feb. 21, 2020).

## The Marjory Stoneman Douglas High School Public Safety Commission

The incident of mass violence at Marjory Stoneman Douglas High School in Parkland, Florida was preceded by multiple, repeated interactions between the shooter and law enforcement agencies, social services agencies, and schools, over many years. This history was characterized by a lack of communication and coordination, preventing these many entities from understanding the whole problem and taking action to prevent the mass violence incident.

In response to this problem, the Legislature created the Marjory Stoneman Douglas High School Public Safety Commission (Commission)<sup>66</sup> within the Florida Department of Law Enforcement (FDLE).<sup>67</sup> The Commission is composed of 16 voting members and four nonvoting members.<sup>68</sup> The Governor appoints five voting members to the Commission, including the chair; and President of the Senate and Speaker of the House of Representatives each appoint five voting members to the Commission. The Commissioner of FDLE serves as a member of the Commission. The Secretary of DCF, the Secretary of DJJ, the Secretary of the Agency for Health Care Administration (AHCA) and the Commissioner of Education serve as ex officio, non-voting members of the Commission.

The Commission was tasked with investigating system failures in the Marjory Stoneman Douglas High School shooting and to develop recommendations for system improvements. Regarding children's behavioral health, the Commission stated "serious consideration should be given to how children transition from child services into adult behavioral services, and Florida needs a better safety net for high-risk children."<sup>69</sup> The Commission also expressed concern about uncoordinated care for children receiving services from multiple providers. It found that Florida's mental health system, specifically the Baker Act System, needs better discharge planning, master case management, and care coordination, and that no adequate or effective system exists for tracking or flagging high recidivist Baker Acts.<sup>70</sup>

The Commission recommended:<sup>71</sup>

- The Legislature should require school districts to engage community health providers that receive state funding to participate in the coordination of student treatment plans;
- Programs such as Community Action Treatment teams should be enhanced and expanded, where necessary, to provide better continuity of behavioral health services to close the gap when high-risk children transition into adulthood; and
- The Legislature should require DCF, DJJ and AHCA to develop an alert system to identify those individuals who are repeatedly Baker Acted. The responsible entity must develop a course of action to address why the person is repeatedly Baker Acted.

### Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors at any hour of the day.<sup>72</sup> Family members and caregivers of an individual experiencing a mental health crisis are often ill-

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<sup>66</sup> Commission is defined in s. 20.03, F.S. as a body created by specific statutory enactment within a department, the office of the Governor, or the Executive Office of the Governor and exercising limited quasi-legislative or quasi-judicial powers, or both, independently of the head of the department or the Governor.

<sup>67</sup> Ch. 2018-3, Laws of Florida.

<sup>68</sup> All members of the Commission must serve without compensation, but will be reimbursed for their per diem and travel expenses pursuant to s. 112.061, F.S.

<sup>69</sup> Marjory Stoneman Douglas High School Public Safety Commission, *Report Submitted to the Governor, Speaker of the House of Representatives, and Senate President* (Jan. 2, 2019) <http://www.fdle.state.fl.us/MSDHS/CommissionReport.pdf> (last visited Feb. 21, 2020).

<sup>70</sup> Id.

<sup>71</sup> Id.

<sup>72</sup> Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4, <https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf> (last visited Feb. 21, 2020).

equipped to handle these situations and need the advice and support of professionals.<sup>73</sup> All too frequently, law enforcement or EMTs are called to respond to mental health crises and they often lack the training and experience to effectively handle the situation.<sup>74</sup> Mobile response teams can be beneficial in such instances.

Mobile response teams provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.<sup>75</sup> Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent.<sup>76</sup> Response teams are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.<sup>77</sup> Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring.<sup>78</sup> It can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.<sup>79</sup>

SB 7026 (2018) funded additional mobile response teams to serve areas of the state that were not being served by such teams at a total of \$18.3 million. There are 40 MRTs serving all 67 counties in Florida, targeting services to individuals under the age of 25.<sup>80</sup> Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.<sup>81</sup>

DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:<sup>82</sup>

- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;
- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.

### 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 AHCA and financed by federal and state funds.

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<sup>73</sup> Id.

<sup>74</sup> Id.

<sup>75</sup> Id. at 2

<sup>76</sup> Supra note 72.

<sup>77</sup> Id.

<sup>78</sup> Supra note 72, at 7.

<sup>79</sup> Id.

<sup>80</sup> Supra note 49.

<sup>81</sup> Id.

<sup>82</sup> Supra note 72, at 2-3.

The Florida Medicaid program covers approximately 3.8 million low-income individuals.<sup>83</sup>

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she “finds it to be cost-effective and efficient and not inconsistent with the purposes of this title.” Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) program.<sup>84</sup> Within the SMMC, the Managed Medical Assistance (MMA) program provides acute health care services through managed care plans contracted with AHCA in the 11 regions across the state. Coverage includes preventive care, acute care, therapeutics, pharmacy, transportation services, and behavioral health services.<sup>85</sup>

Current law requires each managed care plan to have an accurate and complete online database of the providers in their networks, including information about their credentials, licensure, hours of operation, and location.<sup>86</sup>

## **Effect of Proposed Changes**

### Coordinated System of Care

The bill requires collaboration and planning between child-serving systems and other stakeholders to create a coordinated system of behavioral health care, facilitated by each managing entity, focused on services for children. The coordinated system of care is to integrate services provided through providers funded by the state’s child-serving systems, as well as other systems for which children and adolescents would qualify, and facilitates access by children and adolescents to needed mental health treatment and services at any point of entry.

Within current resources, the ME and collaborating organizations must create integrated service delivery approaches that allow parents and caregivers to obtain services and support by making referrals to specialized treatment providers, should it be necessary, with follow up to ensure services are received. Each coordinated system of care for children and adolescents must be documented by the ME and collaborating organizations through a memorandum of understanding (MOU) or other binding arrangements.

Plans are required to be completed by the managing entity and submitted to DCF by July 1, 2021. The entities involved in the planning process must implement the coordinated system of care specified in each plan by July 1, 2022. The ME and collaborating organizations are required to review and update the plans, as necessary, at least once every three years after implementation. The ME is responsible for identifying any gaps in the arrays of services available under each plan and include that information in its annual needs assessment submitted to DCF.

The ME is required to lead the planning process, which includes input from at a minimum:

- Children and adolescents with behavioral health needs and their families;
- Behavioral health service providers;
- Law enforcement agencies;

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<sup>83</sup> Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, December 2019, [https://ahca.myflorida.com/medicaid/Finance/data\\_analytics/enrollment\\_report/index.shtml](https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml) (last visited Feb. 21, 2020).

<sup>84</sup> S. 409.964, F.S.

<sup>85</sup> Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program*, [https://ahca.myflorida.com/Medicaid/statewide\\_mc/pdf/mma/SMMC\\_Snapshot.pdf](https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf) (last visited Feb. 21, 2020).

<sup>86</sup> S. 409.967(2)(c)1., F.S.

- School districts or superintendents;
- SEDNET;
- DCF;
- Representatives of the child welfare and juvenile justice systems;
- Representatives of early learning coalitions;
- Representatives of Medicaid managed medical assistance plans; and
- Representatives of AHCA, APD, DJJ, and other community partners.

Organizations that receive state funding must participate in the planning process if requested by the managing entity.

When developing the plan, the ME and collaborating entities must take the geographical distribution of the population, needs, and resources into consideration and create separate plans on an individual county or multi-county basis in order to maximize collaboration and communication at the local level. The plan must integrate with the local plan for a designated receiving system.

### Care Coordination

When defining the priority populations that will benefit from receiving care coordination, the bill requires DCF to also consider whether the individual is an adolescent who requires assistance in transitioning to services provided in the adult system of care.

### Mobile Response Teams

The bill includes crisis response services provided through mobile response teams in the array of services available to children and adolescents who are members of certain target populations. It requires DCF to contract with MEs for MRTs to provide onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25 who:

- Have an emotional disturbance;
- Are experiencing an acute mental or emotional crisis;
- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function normally within their environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

The bill sets standards for MRTs. At a minimum, a MRT must:

- Respond to new requests for services within 60 minutes;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family and enable them to deescalate and respond to behavioral health challenges through evidence-based practices;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Whenever possible, engage the child, adolescent, or young adult and their family as active participants in all phases of the treatment process;
- Develop a care plan for the child, adolescent, or young adult;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure a process for informed consent and confidentiality compliance measures is in place;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the ME and other key entities providing services and supports to the child, adolescent, or young adult and their family.

When procuring a MRT, the managing entity must, at a minimum:

- Collaborate with local sheriff's offices and public schools in the planning, development, evaluation and selection processes;
- Require that services be made available 24 hours per day, 7 days per week, with a response time of 60 minutes;
- Require that the provider establish response protocols with local law enforcement agencies, CBC lead agencies, the child welfare system, and the DJJ;
- Require access to board-certified or board-eligible psychiatrists or psychiatric nurse practitioners; and
- Require MRTs to refer children, adolescents, or young adults and their families to an array of crisis response services that address their individual needs as necessary to address an immediate crisis event.

The bill requires the ME to promote the use of available crisis intervention services by requiring contracted providers to provide contact information for MRTs to parents and caregivers of children, adolescents, and young adults between the ages of 18 and 25, who receive safety-net behavioral health services.

The bill amends the preservice training requirements for licensure as a foster parent to include information about and contact information for the local MRT as a means for addressing a behavioral health crisis or preventing placement disruption. It also requires CBC lead agencies to provide contact information for the local MRT to all individuals providing care for dependent children.

#### Mental Health Services for Students

The bill requires the Louis de la Parte Florida Mental Health Institute within the University of South Florida<sup>87</sup> to develop a model response protocol by August 1, 2020, for schools to use MRTs. When developing the protocol the institute must, at a minimum, consult with:

- School districts that effectively use mobile response teams and those districts that use mobile response teams less often;
- Local law enforcement agencies;
- DCF;
- Managing entities; and
- Mobile response team providers.

#### *Mental Health Assistance Allocation*

The bill revises the requirements for plans that must be submitted by school districts in order to receive mental health assistance allocation funding to include an interagency agreement or MOU with the ME that facilitates referrals of students to community-based services and coordinates care for students served by school-based and community-based providers. The agreement or MOU must address the sharing of records and information, as provided by law, to coordinate care and increase access to appropriate services.

The plans for funding must also include policies and procedures, including contracts with service providers, which will ensure that:

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<sup>87</sup> S. 394.659, F.S. The Louis de la Parte Florida Mental Health Institute's mission is to strengthen mental health and substance use services throughout Florida. The Institute serves as a bridge between university-based research and communities facing a variety of problems related to mental illness by blending elements of service, research, and training.

- Parents are provided information about behavioral health services available through the students' school or local providers, including MRTs. The bill allows schools to meet this requirement by providing information about and website addresses for web-based directories or guides of local services as long as they are easily navigable and provide contact information for local providers;
- School districts use MRTs to the extent available and carry out the model response protocol; and
- Referrals to behavioral health services through other delivery systems or payors are available to individuals or students living in the same house as a student who is receiving services, if those services appear to be needed or would contribute to the improved well-being of the student who is receiving services.

## Reporting Requirements

### *DCF and AHCA*

The bill requires DCF and AHCA to identify children and adolescents who are the highest users of crisis stabilization services, collaboratively take action to meet the behavioral health needs of such children, and submit a joint quarterly report to the Legislature in FY 2020-2021 through FY 2021-2022 on the actions taken by both agencies to better serve these children and adolescents.

The bill also requires DCF and AHCA to assess the quality of care provided in crisis stabilization units (CSUs) to children and adolescents who are high utilizers of such services. DCF and AHCA must:

- Review the current standards of care for mental health receiving and treatment facilities, hospitals, and CSUs;
- Compare these standards to other states' and relevant national standards; and
- Make recommendations for improvements to standards.

At a minimum, the assessment and recommendations must address efforts by each CSU facility to:

- Gather and assess information regarding each child or adolescent;
- Coordinate with other providers treating the child or adolescent; and
- Create discharge plans that comprehensively and effectively address the needs of the child or adolescent in order to avoid or reduce his or her future use of CSU services.

DCF and AHCA must jointly submit a report of their findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2020.

### *Managing Entities*

The bill requires managing entities to list and describe any gaps in the arrays of services for children or adolescents and recommendations for addressing such gaps in its annual needs assessment submitted to DCF.

## Medicaid Behavioral Health Provider Network

The bill requires AHCA to continuously test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

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

## B. SECTION DIRECTORY:

- Section 1:** Amends s. 394.493, F.S., relating to target populations for child and adolescent mental health services funded through the department.
- Section 2:** Amends s. 394.495, F.S., relating to child and adolescent mental health systems of care; programs and services.
- Section 3:** Creates s. 394.4955, F.S., relating to coordinated system of care; child and adolescent mental health treatment and support.
- Section 4:** Amends s. 394.9082, F.S., relating to behavioral health managing entities.
- Section 5:** Amends s. 409.175, F.S., relating to licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.
- Section 6:** Amends s. 409.967, F.S., relating to managed care plan accountability.
- Section 7:** Amends s. 409.988, F.S., relating to lead agency duties; general provisions.
- Section 8:** Amends s. 985.601, F.S., relating to administering the juvenile justice continuum.
- Section 9:** Amends s. 1003.02, F.S., relating to district school board operation and control of public K-12 education within the school district.
- Section 10:** Amends s. 1004.44, F.S., relating to Louis de la Parte Florida Mental Health Institute.
- Section 11:** Amends s. 1006.04, F.S., relating to educational multiagency services for students with severe emotional disturbance.
- Section 12:** Amends s. 1011.62, F.S., relating to funds for operation of schools.
- Section 13:** Requires AHCA and DCF to submit a joint report to the Governor and Legislature.
- Section 14:** Provides an effective date of July 1, 2020.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

None.

#### 2. Expenditures:

The bill requires DCF to collaborate with AHCA to assess the quality of care provided to children and adolescents who are high utilizers of crisis stabilization services. The agencies will be required to submit quarterly reports of their findings and recommendations through June 2022. Both agencies indicate there will be an increased workload associated with these requirements and that additional personnel resources will be needed to perform the collaborative analysis and subsequent reports. The reporting requirement is through Fiscal Year 2021-2022, and a review of DCF and AHCA's other personnel services (OPS) base budget shows a sufficient balance to cover two years.

The bill requires AHCA to test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems. AHCA has sufficient contracted services base budget to perform this requirement.

### B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

#### 1. Revenues:

None.



2. Expenditures:

School districts may incur expenses related to establishing policies and procedures to carry out the model response protocol, participating in the planning process for promoting a coordinated system of care for children and adolescents, and developing an interagency agreement or MOU with the managing entity. The impact is indeterminate and insignificant, but can be absorbed within each district's mental health assistance allocation.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Managing entities may experience an increase in workload within the scope of their current responsibilities associated with the proposed changes in the bill, the extent of which cannot be determined, but is likely insignificant.

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 the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

### IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 16, 2020, the Children, Families and Seniors Subcommittee adopted an amendment that requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems. 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.

1                                   A bill to be entitled  
2           An act relating to children's mental health; amending  
3           s. 394.493, F.S.; requiring the Department of Children  
4           and Families and the Agency for Health Care  
5           Administration to identify certain children and  
6           adolescents who use crisis stabilization services  
7           during specified fiscal years; requiring the  
8           department and agency to collaboratively meet the  
9           behavioral health needs of such children and  
10          adolescents and submit a quarterly report to the  
11          Legislature; amending s. 394.495, F.S.; including  
12          crisis response services provided through mobile  
13          response teams in the array of services available to  
14          children and adolescents; requiring the department to  
15          contract with managing entities for mobile response  
16          teams to provide certain services to certain children,  
17          adolescents, and young adults; providing requirements  
18          for such mobile response teams; providing requirements  
19          for managing entities when procuring mobile response  
20          teams; creating s. 394.4955, F.S.; requiring managing  
21          entities to develop a plan promoting the development  
22          of a coordinated system of care for certain services;  
23          providing requirements for the planning process;  
24          requiring each managing entity to submit such plan by  
25          a specified date; requiring the entities involved in

26 | the planning process to implement such plan by a  
27 | specified date; requiring that such plan be reviewed  
28 | and updated periodically; amending s. 394.9082, F.S.;  
29 | revising the duties of the department relating to  
30 | priority populations that will benefit from care  
31 | coordination; requiring that a managing entity's  
32 | behavioral health care needs assessment include  
33 | certain information regarding gaps in certain  
34 | services; requiring a managing entity to promote the  
35 | use of available crisis intervention services;  
36 | amending s. 409.175, F.S.; revising requirements  
37 | relating to preservice training for foster parents;  
38 | amending s. 409.967, F.S.; requiring the Agency for  
39 | Health Care Administration to conduct, or contract  
40 | for, the testing of provider network databases  
41 | maintained by Medicaid managed care plans for  
42 | specified purposes; amending s. 409.988, F.S.;  
43 | revising the duties of a lead agency relating to  
44 | individuals providing care for dependent children;  
45 | amending s. 985.601, F.S.; requiring the Department of  
46 | Juvenile Justice to participate in the planning  
47 | process for promoting a coordinated system of care for  
48 | children and adolescents; amending s. 1003.02, F.S.;  
49 | requiring each district school board to participate in  
50 | the planning process for promoting a coordinated

51 system of care; amending s. 1004.44, F.S.; requiring  
 52 the Louis de la Parte Florida Mental Health Institute  
 53 to develop, in consultation with other entities, a  
 54 model response protocol for schools; amending s.  
 55 1006.04, F.S.; requiring the educational multiagency  
 56 network to participate in the planning process for  
 57 promoting a coordinated system of care; amending s.  
 58 1011.62, F.S.; revising the elements of a plan  
 59 required for school district funding under the mental  
 60 health assistance allocation; requiring the Department  
 61 of Children and Families and Agency for Health Care  
 62 Administration to assess the quality of care provided  
 63 in crisis stabilization units to certain children and  
 64 adolescents; requiring the department and agency to  
 65 review current standards of care for certain settings  
 66 and make recommendations; requiring the department and  
 67 agency to jointly submit a report to the Governor and  
 68 Legislature by a specified date; providing an  
 69 effective date.

70  
 71 Be It Enacted by the Legislature of the State of Florida:

72  
 73 Section 1. Subsection (4) is added to section 394.493,  
 74 Florida Statutes, to read:  
 75 394.493 Target populations for child and adolescent mental

76 health services funded through the department.-

77 (4) Beginning with fiscal year 2020-2021 through fiscal  
 78 year 2021-2022, the department and the Agency for Health Care  
 79 Administration shall identify children and adolescents who are  
 80 the highest utilizers of crisis stabilization services. The  
 81 department and agency shall collaboratively take appropriate  
 82 action within available resources to meet the behavioral health  
 83 needs of such children and adolescents more effectively, and  
 84 shall jointly submit to the Legislature a quarterly report  
 85 listing the actions taken by both agencies to better serve such  
 86 children and adolescents.

87 Section 2. Paragraph (q) is added to subsection (4) of  
 88 section 394.495, Florida Statutes, and subsection (7) is added  
 89 to that section, to read:

90 394.495 Child and adolescent mental health system of care;  
 91 programs and services.-

92 (4) The array of services may include, but is not limited  
 93 to:

94 (q) Crisis response services provided through mobile  
 95 response teams.

96 (7) (a) The department shall contract with managing  
 97 entities for mobile response teams throughout the state to  
 98 provide immediate, onsite behavioral health crisis services to  
 99 children, adolescents, and young adults ages 18 to 25,  
 100 inclusive, who:

- 101        1. Have an emotional disturbance;  
102        2. Are experiencing an acute mental or emotional crisis;  
103        3. Are experiencing escalating emotional or behavioral  
104 reactions and symptoms that impact their ability to function  
105 typically within the family, living situation, or community  
106 environment; or  
107        4. Are served by the child welfare system and are  
108 experiencing or are at high risk of placement instability.  
109        (b) A mobile response team shall, at a minimum:  
110        1. Respond to new requests for services within 60 minutes  
111 after such requests are made.  
112        2. Respond to a crisis in the location where the crisis is  
113 occurring.  
114        3. Provide behavioral health crisis-oriented services that  
115 are responsive to the needs of the child, adolescent, or young  
116 adult and his or her family.  
117        4. Provide evidence-based practices to children,  
118 adolescents, young adults, and families to enable them to  
119 independently and effectively deescalate and respond to  
120 behavioral challenges that they are facing and to reduce the  
121 potential for future crises.  
122        5. Provide screening, standardized assessments, early  
123 identification, and referrals to community services.  
124        6. Engage the child, adolescent, or young adult and his or  
125 her family as active participants in every phase of the

126 treatment process whenever possible.

127 7. Develop a care plan for the child, adolescent, or young  
128 adult.

129 8. Provide care coordination by facilitating the  
130 transition to ongoing services.

131 9. Ensure there is a process in place for informed consent  
132 and confidentiality compliance measures.

133 10. Promote information sharing and the use of innovative  
134 technology.

135 11. Coordinate with the managing entity within the service  
136 location and other key entities providing services and supports  
137 to the child, adolescent, or young adult and his or her family,  
138 including, but not limited to, the child, adolescent, or young  
139 adult's school, the local educational multiagency network for  
140 severely emotionally disturbed students under s. 1006.04, the  
141 child welfare system, and the juvenile justice system.

142 (c) When procuring mobile response teams, the managing  
143 entity must, at a minimum:

144 1. Collaborate with local sheriff's offices and public  
145 schools in the planning, development, evaluation, and selection  
146 processes.

147 2. Require that services be made available 24 hours per  
148 day, 7 days per week, with onsite response time to the location  
149 of the referred crisis within 60 minutes after the request for  
150 services is made.

151       3. Require the provider to establish response protocols  
152 with local law enforcement agencies, local community-based care  
153 lead agencies as defined in s. 409.986(3), the child welfare  
154 system, and the Department of Juvenile Justice. The response  
155 protocol with a school district shall be consistent with the  
156 model response protocol developed under s. 1004.44.

157       4. Require access to a board-certified or board-eligible  
158 psychiatrist or psychiatric nurse practitioner.

159       5. Require mobile response teams to refer children,  
160 adolescents, or young adults and their families to an array of  
161 crisis response services that address individual and family  
162 needs, including screening, standardized assessments, early  
163 identification, and community services as necessary to address  
164 the immediate crisis event.

165       Section 3. Section 394.4955, Florida Statutes, is created  
166 to read:

167       394.4955 Coordinated system of care; child and adolescent  
168 mental health treatment and support.-

169       (1) Pursuant to s. 394.9082(5)(d), each managing entity  
170 shall develop a plan that promotes the development and effective  
171 implementation of a coordinated system of care which integrates  
172 services provided through providers funded by the state's child-  
173 serving systems and facilitates access by children and  
174 adolescents, as resources permit, to needed mental health  
175 treatment and services at any point of entry regardless of the



176 time of year, intensity, or complexity of the need, and other  
177 systems with which such children and adolescents are involved,  
178 as well as treatment and services available through other  
179 systems for which they would qualify.

180 (2) (a) The managing entity shall lead a planning process  
181 that includes, but is not limited to, children and adolescents  
182 with behavioral health needs and their families; behavioral  
183 health service providers; law enforcement agencies; school  
184 districts or superintendents; the multiagency network for  
185 students with emotional or behavioral disabilities; the  
186 department; and representatives of the child welfare and  
187 juvenile justice systems, early learning coalitions, the Agency  
188 for Health Care Administration, Medicaid managed medical  
189 assistance plans, the Agency for Persons with Disabilities, the  
190 Department of Juvenile Justice, and other community partners. An  
191 organization receiving state funding must participate in the  
192 planning process if requested by the managing entity.

193 (b) The managing entity and collaborating organizations  
194 shall take into consideration the geographical distribution of  
195 the population, needs, and resources, and create separate plans  
196 on an individual county or multi-county basis, as needed, to  
197 maximize collaboration and communication at the local level.

198 (c) To the extent permitted by available resources, the  
199 coordinated system of care shall include the array of services  
200 listed in s. 394.495.

201        (d) Each plan shall integrate with the local plan  
202 developed under s. 394.4573.

203        (3) By July 1, 2021, the managing entity shall complete  
204 the plans developed under this section and submit them to the  
205 department. By July 1, 2022, the entities involved in the  
206 planning process shall implement the coordinated system of care  
207 specified in each plan. The managing entity and collaborating  
208 organizations shall review and update the plans, as necessary,  
209 at least every 3 years thereafter.

210        (4) The managing entity and collaborating organizations  
211 shall create integrated service delivery approaches within  
212 current resources that facilitate parents and caregivers  
213 obtaining services and support by making referrals to  
214 specialized treatment providers, if necessary, with follow up to  
215 ensure services are received.

216        (5) The managing entity and collaborating organizations  
217 shall document each coordinated system of care for children and  
218 adolescents through written memoranda of understanding or other  
219 binding arrangements.

220        (6) The managing entity shall identify gaps in the arrays  
221 of services for children and adolescents listed in s. 394.495  
222 available under each plan and include relevant information in  
223 its annual needs assessment required by s. 394.9082.

224        Section 4. Paragraph (c) of subsection (3) and paragraphs  
225 (b) and (d) of subsection (5) of section 394.9082, Florida

226 Statutes, are amended, and paragraph (t) is added to subsection  
 227 (5) of that section, to read:

228 394.9082 Behavioral health managing entities.—

229 (3) DEPARTMENT DUTIES.—The department shall:

230 (c) Define the priority populations that will benefit from  
 231 receiving care coordination. In defining such populations, the  
 232 department shall take into account the availability of resources  
 233 and consider:

234 1. The number and duration of involuntary admissions  
 235 within a specified time.

236 2. The degree of involvement with the criminal justice  
 237 system and the risk to public safety posed by the individual.

238 3. Whether the individual has recently resided in or is  
 239 currently awaiting admission to or discharge from a treatment  
 240 facility as defined in s. 394.455.

241 4. The degree of utilization of behavioral health  
 242 services.

243 5. Whether the individual is a parent or caregiver who is  
 244 involved with the child welfare system.

245 6. Whether the individual is an adolescent, as defined in  
 246 s. 394.492, who requires assistance in transitioning to services  
 247 provided in the adult system of care.

248 (5) MANAGING ENTITY DUTIES.—A managing entity shall:

249 (b) Conduct a community behavioral health care needs  
 250 assessment every 3 years in the geographic area served by the

251 managing entity which identifies needs by subregion. The process  
252 for conducting the needs assessment shall include an opportunity  
253 for public participation. The assessment shall include, at a  
254 minimum, the information the department needs for its annual  
255 report to the Governor and Legislature pursuant to s. 394.4573.  
256 The assessment shall also include a list and descriptions of any  
257 gaps in the arrays of services for children or adolescents  
258 identified pursuant to s. 394.4955 and recommendations for  
259 addressing such gaps. The managing entity shall provide the  
260 needs assessment to the department.

261 (d) Promote the development and effective implementation  
262 of a coordinated system of care pursuant to ss. 394.4573 and  
263 394.495 ~~s. 394.4573~~.

264 (t) Promote the use of available crisis intervention  
265 services by requiring contracted providers to provide contact  
266 information for mobile response teams established under s.  
267 394.495 to parents and caregivers of children, adolescents, and  
268 young adults between ages 18 and 25, inclusive, who receive  
269 safety-net behavioral health services.

270 Section 5. Paragraph (b) of subsection (14) of section  
271 409.175, Florida Statutes, is amended to read:

272 409.175 Licensure of family foster homes, residential  
273 child-caring agencies, and child-placing agencies; public  
274 records exemption.—

275 (14)

276 (b) As a condition of licensure, foster parents shall  
277 successfully complete preservice training. The preservice  
278 training shall be uniform statewide and shall include, but not  
279 be limited to, such areas as:

- 280 1. Orientation regarding agency purpose, objectives,  
281 resources, policies, and services;
- 282 2. Role of the foster parent as a treatment team member;
- 283 3. Transition of a child into and out of foster care,  
284 including issues of separation, loss, and attachment;
- 285 4. Management of difficult child behavior that can be  
286 intensified by placement, by prior abuse or neglect, and by  
287 prior placement disruptions;
- 288 5. Prevention of placement disruptions;
- 289 6. Care of children at various developmental levels,  
290 including appropriate discipline; ~~and~~
- 291 7. Effects of foster parenting on the family of the foster  
292 parent; and
- 293 8. Information about and contact information for the local  
294 mobile response team as a means for addressing a behavioral  
295 health crisis or preventing placement disruption.

296 Section 6. Paragraph (c) of subsection (2) of section  
297 409.967, Florida Statutes, is amended to read:

298 409.967 Managed care plan accountability.—

299 (2) The agency shall establish such contract requirements  
300 as are necessary for the operation of the statewide managed care

301 program. In addition to any other provisions the agency may deem  
302 necessary, the contract must require:

303 (c) Access.—

304 1. The agency shall establish specific standards for the  
305 number, type, and regional distribution of providers in managed  
306 care plan networks to ensure access to care for both adults and  
307 children. Each plan must maintain a regionwide network of  
308 providers in sufficient numbers to meet the access standards for  
309 specific medical services for all recipients enrolled in the  
310 plan. The exclusive use of mail-order pharmacies may not be  
311 sufficient to meet network access standards. Consistent with the  
312 standards established by the agency, provider networks may  
313 include providers located outside the region. A plan may  
314 contract with a new hospital facility before the date the  
315 hospital becomes operational if the hospital has commenced  
316 construction, will be licensed and operational by January 1,  
317 2013, and a final order has issued in any civil or  
318 administrative challenge. Each plan shall establish and maintain  
319 an accurate and complete electronic database of contracted  
320 providers, including information about licensure or  
321 registration, locations and hours of operation, specialty  
322 credentials and other certifications, specific performance  
323 indicators, and such other information as the agency deems  
324 necessary. The database must be available online to both the  
325 agency and the public and have the capability to compare the

326 availability of providers to network adequacy standards and to  
327 accept and display feedback from each provider's patients. Each  
328 plan shall submit quarterly reports to the agency identifying  
329 the number of enrollees assigned to each primary care provider.  
330 The agency shall conduct, or contract for, systematic and  
331 continuous testing of the provider network databases maintained  
332 by each plan to confirm accuracy, confirm that behavioral health  
333 providers are accepting enrollees, and confirm that enrollees  
334 have access to behavioral health services.

335         2. Each managed care plan must publish any prescribed drug  
336 formulary or preferred drug list on the plan's website in a  
337 manner that is accessible to and searchable by enrollees and  
338 providers. The plan must update the list within 24 hours after  
339 making a change. Each plan must ensure that the prior  
340 authorization process for prescribed drugs is readily accessible  
341 to health care providers, including posting appropriate contact  
342 information on its website and providing timely responses to  
343 providers. For Medicaid recipients diagnosed with hemophilia who  
344 have been prescribed anti-hemophilic-factor replacement  
345 products, the agency shall provide for those products and  
346 hemophilia overlay services through the agency's hemophilia  
347 disease management program.

348         3. Managed care plans, and their fiscal agents or  
349 intermediaries, must accept prior authorization requests for any  
350 service electronically.

351 4. Managed care plans serving children in the care and  
352 custody of the Department of Children and Families must maintain  
353 complete medical, dental, and behavioral health encounter  
354 information and participate in making such information available  
355 to the department or the applicable contracted community-based  
356 care lead agency for use in providing comprehensive and  
357 coordinated case management. The agency and the department shall  
358 establish an interagency agreement to provide guidance for the  
359 format, confidentiality, recipient, scope, and method of  
360 information to be made available and the deadlines for  
361 submission of the data. The scope of information available to  
362 the department shall be the data that managed care plans are  
363 required to submit to the agency. The agency shall determine the  
364 plan's compliance with standards for access to medical, dental,  
365 and behavioral health services; the use of medications; and  
366 followup on all medically necessary services recommended as a  
367 result of early and periodic screening, diagnosis, and  
368 treatment.

369 Section 7. Paragraph (f) of subsection (1) of section  
370 409.988, Florida Statutes, is amended to read:

371 409.988 Lead agency duties; general provisions.—

372 (1) DUTIES.—A lead agency:

373 (f) Shall ensure that all individuals providing care for  
374 dependent children receive:

375 1. Appropriate training and meet the minimum employment



376 standards established by the department.

377 2. Contact information for the local mobile response team  
 378 established under s. 394.495.

379 Section 8. Subsection (4) of section 985.601, Florida  
 380 Statutes, is amended to read:

381 985.601 Administering the juvenile justice continuum.—

382 (4) The department shall maintain continuing cooperation  
 383 with the Department of Education, the Department of Children and  
 384 Families, the Department of Economic Opportunity, and the  
 385 Department of Corrections for the purpose of participating in  
 386 agreements with respect to dropout prevention and the reduction  
 387 of suspensions, expulsions, and truancy; increased access to and  
 388 participation in high school equivalency diploma, vocational,  
 389 and alternative education programs; and employment training and  
 390 placement assistance. The cooperative agreements between the  
 391 departments shall include an interdepartmental plan to cooperate  
 392 in accomplishing the reduction of inappropriate transfers of  
 393 children into the adult criminal justice and correctional  
 394 systems. As part of its continuing cooperation, the department  
 395 shall participate in the planning process for promoting a  
 396 coordinated system of care for children and adolescents pursuant  
 397 to s. 394.4955.

398 Section 9. Subsection (5) is added to section 1003.02,  
 399 Florida Statutes, to read:

400 1003.02 District school board operation and control of

401 public K-12 education within the school district.—As provided in  
402 part II of chapter 1001, district school boards are  
403 constitutionally and statutorily charged with the operation and  
404 control of public K-12 education within their school district.  
405 The district school boards must establish, organize, and operate  
406 their public K-12 schools and educational programs, employees,  
407 and facilities. Their responsibilities include staff  
408 development, public K-12 school student education including  
409 education for exceptional students and students in juvenile  
410 justice programs, special programs, adult education programs,  
411 and career education programs. Additionally, district school  
412 boards must:

413 (5) Participate in the planning process for promoting a  
414 coordinated system of care for children and adolescents pursuant  
415 to s. 394.4955.

416 Section 10. Subsection (4) of section 1004.44, Florida  
417 Statutes, is renumbered as subsection (5), and a new subsection  
418 (4) is added to that section, to read:

419 1004.44 Louis de la Parte Florida Mental Health  
420 Institute.—There is established the Louis de la Parte Florida  
421 Mental Health Institute within the University of South Florida.

422 (4) By August 1, 2020, the institute shall develop a model  
423 response protocol for schools to use mobile response teams  
424 established under s. 394.495. In developing the protocol, the  
425 institute shall, at a minimum, consult with school districts

426 | that effectively use such teams, school districts that use such  
 427 | teams less often, local law enforcement agencies, the Department  
 428 | of Children and Families, managing entities as defined in s.  
 429 | 394.9082(2), and mobile response team providers.

430 | Section 11. Paragraph (c) of subsection (1) of section  
 431 | 1006.04, Florida Statutes, is amended to read:

432 | 1006.04 Educational multiagency services for students with  
 433 | severe emotional disturbance.—

434 | (1)

435 | (c) The multiagency network shall:

436 | 1. Support and represent the needs of students in each  
 437 | school district in joint planning with fiscal agents of  
 438 | children's mental health funds, including the expansion of  
 439 | school-based mental health services, transition services, and  
 440 | integrated education and treatment programs.

441 | 2. Improve coordination of services for children with or  
 442 | at risk of emotional or behavioral disabilities and their  
 443 | families by assisting multi-agency collaborative initiatives to  
 444 | identify critical issues and barriers of mutual concern and  
 445 | develop local response systems that increase home and school  
 446 | connections and family engagement.

447 | 3. Increase parent and youth involvement and development  
 448 | with local systems of care.

449 | 4. Facilitate student and family access to effective  
 450 | services and programs for students with and at risk of emotional

451 or behavioral disabilities that include necessary educational,  
452 residential, and mental health treatment services, enabling  
453 these students to learn appropriate behaviors, reduce  
454 dependency, and fully participate in all aspects of school and  
455 community living.

456 5. Participate in the planning process for promoting a  
457 coordinated system of care for children and adolescents pursuant  
458 to s. 394.4955.

459 Section 12. Paragraph (b) of subsection (16) of section  
460 1011.62, Florida Statutes, is amended to read:

461 1011.62 Funds for operation of schools.—If the annual  
462 allocation from the Florida Education Finance Program to each  
463 district for operation of schools is not determined in the  
464 annual appropriations act or the substantive bill implementing  
465 the annual appropriations act, it shall be determined as  
466 follows:

467 (16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental  
468 health assistance allocation is created to provide funding to  
469 assist school districts in establishing or expanding school-  
470 based mental health care; train educators and other school staff  
471 in detecting and responding to mental health issues; and connect  
472 children, youth, and families who may experience behavioral  
473 health issues with appropriate services. These funds shall be  
474 allocated annually in the General Appropriations Act or other  
475 law to each eligible school district. Each school district shall

476 receive a minimum of \$100,000, with the remaining balance  
477 allocated based on each school district's proportionate share of  
478 the state's total unweighted full-time equivalent student  
479 enrollment. Charter schools that submit a plan separate from the  
480 school district are entitled to a proportionate share of  
481 district funding. The allocated funds may not supplant funds  
482 that are provided for this purpose from other operating funds  
483 and may not be used to increase salaries or provide bonuses.  
484 School districts are encouraged to maximize third-party health  
485 insurance benefits and Medicaid claiming for services, where  
486 appropriate.

487 (b) The plans required under paragraph (a) must be focused  
488 on a multitiered system of supports to deliver evidence-based  
489 mental health care assessment, diagnosis, intervention,  
490 treatment, and recovery services to students with one or more  
491 mental health or co-occurring substance abuse diagnoses and to  
492 students at high risk of such diagnoses. The provision of these  
493 services must be coordinated with a student's primary mental  
494 health care provider and with other mental health providers  
495 involved in the student's care. At a minimum, the plans must  
496 include the following elements:

497 1. Direct employment of school-based mental health  
498 services providers to expand and enhance school-based student  
499 services and to reduce the ratio of students to staff in order  
500 to better align with nationally recommended ratio models. These

501 providers include, but are not limited to, certified school  
502 counselors, school psychologists, school social workers, and  
503 other licensed mental health professionals. The plan also must  
504 identify strategies to increase the amount of time that school-  
505 based student services personnel spend providing direct services  
506 to students, which may include the review and revision of  
507 district staffing resource allocations based on school or  
508 student mental health assistance needs.

509 2. An interagency agreement or memorandum of understanding  
510 with the managing entity, as defined in s. 394.9082(2), that  
511 facilitates referrals of students to community-based services  
512 and coordinates care for students served by school-based and  
513 community-based providers. Such agreement or memorandum of  
514 understanding must address the sharing of records and  
515 information as authorized under s. 1006.07(7)(d) to coordinate  
516 care and increase access to appropriate services.

517 ~~3.2.~~ Contracts or interagency agreements with one or more  
518 local community behavioral health providers or providers of  
519 Community Action Team services to provide a behavioral health  
520 staff presence and services at district schools. Services may  
521 include, but are not limited to, mental health screenings and  
522 assessments, individual counseling, family counseling, group  
523 counseling, psychiatric or psychological services, trauma-  
524 informed care, mobile crisis services, and behavior  
525 modification. These behavioral health services may be provided

526 on or off the school campus and may be supplemented by  
527 telehealth.

528 ~~4.3.~~ Policies and procedures, including contracts with  
529 service providers, which will ensure that:

530 a. Parents of students are provided information about  
531 behavioral health services available through the students'  
532 school or local community-based behavioral health services  
533 providers, including, but not limited to, the mobile response  
534 team as established in s. 394.495 serving their area. A school  
535 may meet this requirement by providing information about and  
536 internet addresses for web-based directories or guides of local  
537 behavioral health services as long as such directories or guides  
538 are easily navigated and understood by individuals unfamiliar  
539 with behavioral health delivery systems or services and include  
540 specific contact information for local behavioral health  
541 providers.

542 b. School districts use the services of the mobile  
543 response teams to the extent that such services are available.  
544 Each school district shall establish policies and procedures to  
545 carry out the model response protocol developed under s.  
546 1004.44.

547 c. Students who are referred to a school-based or  
548 community-based mental health service provider for mental health  
549 screening for the identification of mental health concerns and  
550 ensure that the assessment of students at risk for mental health

551 disorders occurs within 15 days of referral. School-based mental  
552 health services must be initiated within 15 days after  
553 identification and assessment, and support by community-based  
554 mental health service providers for students who are referred  
555 for community-based mental health services must be initiated  
556 within 30 days after the school or district makes a referral.

557 d. Referrals to behavioral health services available  
558 through other delivery systems or payors for which a student or  
559 individuals living in the household of a student receiving  
560 services under this subsection may qualify, if such services  
561 appear to be needed or enhancements in those individuals'  
562 behavioral health would contribute to the improved well-being of  
563 the student.

564 ~~5.4.~~ Strategies or programs to reduce the likelihood of  
565 at-risk students developing social, emotional, or behavioral  
566 health problems, depression, anxiety disorders, suicidal  
567 tendencies, or substance use disorders.

568 ~~6.5.~~ Strategies to improve the early identification of  
569 social, emotional, or behavioral problems or substance use  
570 disorders, to improve the provision of early intervention  
571 services, and to assist students in dealing with trauma and  
572 violence.

573 Section 13. The Department of Children and Families and  
574 the Agency for Health Care Administration shall assess the  
575 quality of care provided in crisis stabilization units to



576 | children and adolescents who are high utilizers of crisis  
577 | stabilization services. The department and agency shall review  
578 | current standards of care for such settings applicable to  
579 | licensure under chapters 394 and 408, Florida Statutes, and  
580 | designation under s. 394.461, Florida Statutes; compare the  
581 | standards to other states' standards and relevant national  
582 | standards; and make recommendations for improvements to such  
583 | standards. The assessment and recommendations shall address, at  
584 | a minimum, efforts by each facility to gather and assess  
585 | information regarding each child or adolescent, to coordinate  
586 | with other providers treating the child or adolescent, and to  
587 | create discharge plans that comprehensively and effectively  
588 | address the needs of the child or adolescent to avoid or reduce  
589 | his or her future use of crisis stabilization services. The  
590 | department and agency shall jointly submit a report of their  
591 | findings and recommendations to the Governor, the President of  
592 | the Senate, and the Speaker of the House of Representatives by  
593 | November 15, 2020.

594 | Section 14. 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                                          

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1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Silvers offered the following:

4  
5 **Amendment (with title amendment)**

6 Remove lines 109-572 and insert:

7 (b) A mobile response team shall, at a minimum:

8 1. Triage new requests to determine the level of severity  
9 and prioritize new requests that meet the clinical threshold for  
10 an in-person response. To the extent permitted by available  
11 resources, teams must provide in-person responses to such calls  
12 meeting that clinical level of response within 60 minutes after  
13 prioritization.

14 2. Respond to a crisis in the location where the crisis is  
15 occurring.

Amendment No. 1

16 3. Provide behavioral health crisis-oriented services that  
17 are responsive to the needs of the child, adolescent, or young  
18 adult and his or her family.

19 4. Provide evidence-based practices to children,  
20 adolescents, young adults, and families to enable them to  
21 deescalate and respond to behavioral challenges that they are  
22 facing and to reduce the potential for future crises.

23 5. Provide screening, standardized assessments, early  
24 identification, and referrals to community services.

25 6. Provide care coordination by facilitating the  
26 transition to ongoing services.

27 7. Ensure there is a process in place for informed consent  
28 and confidentiality compliance measures.

29 8. Promote information sharing and the use of innovative  
30 technology.

31 9. Coordinate with the applicable managing entity to  
32 establish informal partnerships with key entities providing  
33 behavioral health services and supports to children,  
34 adolescents, or young adults and their families to facilitate  
35 continuity of care.

36 (c) When procuring mobile response teams, the managing  
37 entity must, at a minimum:

38 1. Collaborate with local sheriff's offices and public  
39 schools in the planning, development, evaluation, and selection  
40 processes.

Amendment No. 1

41 2. Require that services be made available 24 hours per  
42 day, 7 days per week.

43 3. Require the provider to establish response protocols  
44 with local law enforcement agencies, local community-based care  
45 lead agencies as defined in s. 409.986(3), the child welfare  
46 system, and the Department of Juvenile Justice. The response  
47 protocol with a school district shall be consistent with the  
48 model response protocol developed under s. 1004.44.

49 4. Require access to a board-certified or board-eligible  
50 psychiatrist or psychiatric nurse practitioner.

51 5. Require mobile response teams to refer children,  
52 adolescents, or young adults and their families to an array of  
53 crisis response services that address individual and family  
54 needs, including screening, standardized assessments, early  
55 identification, and community services as necessary to address  
56 the immediate crisis event.

57 Section 3. Section 394.4955, Florida Statutes, is created  
58 to read:

59 394.4955 Coordinated system of care; child and adolescent  
60 mental health treatment and support.—

61 (1) Pursuant to s. 394.9082(5)(d), each managing entity  
62 shall lead the development of a plan that promotes the  
63 development and effective implementation of a coordinated system  
64 of care which integrates services provided through providers  
65 funded by the state's child-serving systems and facilitates

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66 access by children and adolescents, as resources permit, to  
67 needed mental health treatment and services at any point of  
68 entry regardless of the time of year, intensity, or complexity  
69 of the need, and other systems with which such children and  
70 adolescents are involved, as well as treatment and services  
71 available through other systems for which they would qualify.

72 (2) (a) The planning process shall include, but is not  
73 limited to, children and adolescents with behavioral health  
74 needs and their families; behavioral health service providers;  
75 law enforcement agencies; school districts or superintendents;  
76 the multiagency network for students with emotional or  
77 behavioral disabilities; the department; and representatives of  
78 the child welfare and juvenile justice systems, early learning  
79 coalitions, the Agency for Health Care Administration, Medicaid  
80 managed medical assistance plans, the Agency for Persons with  
81 Disabilities, the Department of Juvenile Justice, and other  
82 community partners. An organization receiving state funding must  
83 participate in the planning process if requested by the  
84 managing entity. State agencies shall provide reasonable staff  
85 support to the planning process if requested by the managing  
86 entity.

87 (b) The planning process shall take into consideration the  
88 geographical distribution of the population, needs, and  
89 resources, and create separate plans on an individual county or

Amendment No. 1

90 multi-county basis, as needed, to maximize collaboration and  
91 communication at the local level.

92 (c) To the extent permitted by available resources, the  
93 coordinated system of care shall include the array of services  
94 listed in s. 394.495.

95 (d) Each plan shall integrate with the local plan  
96 developed under s. 394.4573.

97 (3) By January 1, 2022, the managing entity shall complete  
98 the plans developed under this section and submit them to the  
99 department. By January 1, 2023, the entities involved in the  
100 planning process shall implement the coordinated system of care  
101 specified in each plan. The managing entity and collaborating  
102 organizations shall review and update the plans, as necessary,  
103 at least every 3 years thereafter.

104 (4) The managing entity and collaborating organizations  
105 shall create integrated service delivery approaches within  
106 current resources that facilitate parents and caregivers  
107 obtaining services and support by making referrals to  
108 specialized treatment providers, if necessary, with follow up to  
109 ensure services are received.

110 (5) The managing entity and collaborating organizations  
111 shall document each coordinated system of care for children and  
112 adolescents through written memoranda of understanding or other  
113 binding arrangements.

Amendment No. 1

114       (6) The managing entity shall identify gaps in the arrays  
115 of services for children and adolescents listed in s. 394.495  
116 available under each plan and include relevant information in  
117 its annual needs assessment required by s. 394.9082.

118       Section 4. Paragraph (c) of subsection (3) and paragraphs  
119 (b) and (d) of subsection (5) of section 394.9082, Florida  
120 Statutes, are amended, and paragraph (t) is added to subsection  
121 (5) of that section, to read:

122       394.9082 Behavioral health managing entities.—

123       (3) DEPARTMENT DUTIES.—The department shall:

124       (c) Define the priority populations that will benefit from  
125 receiving care coordination. In defining such populations, the  
126 department shall take into account the availability of resources  
127 and consider:

128       1. The number and duration of involuntary admissions  
129 within a specified time.

130       2. The degree of involvement with the criminal justice  
131 system and the risk to public safety posed by the individual.

132       3. Whether the individual has recently resided in or is  
133 currently awaiting admission to or discharge from a treatment  
134 facility as defined in s. 394.455.

135       4. The degree of utilization of behavioral health  
136 services.

137       5. Whether the individual is a parent or caregiver who is  
138 involved with the child welfare system.

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139 6. Whether the individual is an adolescent, as defined in  
140 s. 394.492, who requires assistance in transitioning to services  
141 provided in the adult system of care.

142 (5) MANAGING ENTITY DUTIES.—A managing entity shall:

143 (b) Conduct a community behavioral health care needs  
144 assessment every 3 years in the geographic area served by the  
145 managing entity which identifies needs by subregion. The process  
146 for conducting the needs assessment shall include an opportunity  
147 for public participation. The assessment shall include, at a  
148 minimum, the information the department needs for its annual  
149 report to the Governor and Legislature pursuant to s. 394.4573.  
150 The assessment shall also include a list and descriptions of any  
151 gaps in the arrays of services for children or adolescents  
152 identified pursuant to s. 394.4955 and recommendations for  
153 addressing such gaps. The managing entity shall provide the  
154 needs assessment to the department.

155 (d) Promote the development and effective implementation  
156 of a coordinated system of care pursuant to ss. 394.4573 and  
157 394.495 ~~s. 394.4573~~.

158 (t) Promote the use of available crisis intervention  
159 services by requiring contracted providers to provide contact  
160 information for mobile response teams established under s.  
161 394.495 to parents and caregivers of children, adolescents, and  
162 young adults between ages 18 and 25, inclusive, who receive  
163 safety-net behavioral health services.



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164 Section 5. Paragraph (b) of subsection (14) of section  
165 409.175, Florida Statutes, is amended to read:

166 409.175 Licensure of family foster homes, residential  
167 child-caring agencies, and child-placing agencies; public  
168 records exemption.—

169 (14)

170 (b) As a condition of licensure, foster parents shall  
171 successfully complete preservice training. The preservice  
172 training shall be uniform statewide and shall include, but not  
173 be limited to, such areas as:

- 174 1. Orientation regarding agency purpose, objectives,  
175 resources, policies, and services;
- 176 2. Role of the foster parent as a treatment team member;
- 177 3. Transition of a child into and out of foster care,  
178 including issues of separation, loss, and attachment;
- 179 4. Management of difficult child behavior that can be  
180 intensified by placement, by prior abuse or neglect, and by  
181 prior placement disruptions;
- 182 5. Prevention of placement disruptions;
- 183 6. Care of children at various developmental levels,  
184 including appropriate discipline; ~~and~~
- 185 7. Effects of foster parenting on the family of the foster  
186 parent; and

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187 8. Information about and contact information for the local  
188 mobile response team as a means for addressing a behavioral  
189 health crisis or preventing placement disruption.

190 Section 6. Paragraph (c) of subsection (2) of section  
191 409.967, Florida Statutes, is amended to read:

192 409.967 Managed care plan accountability.—

193 (2) The agency shall establish such contract requirements  
194 as are necessary for the operation of the statewide managed care  
195 program. In addition to any other provisions the agency may deem  
196 necessary, the contract must require:

197 (c) Access.—

198 1. The agency shall establish specific standards for the  
199 number, type, and regional distribution of providers in managed  
200 care plan networks to ensure access to care for both adults and  
201 children. Each plan must maintain a regionwide network of  
202 providers in sufficient numbers to meet the access standards for  
203 specific medical services for all recipients enrolled in the  
204 plan. The exclusive use of mail-order pharmacies may not be  
205 sufficient to meet network access standards. Consistent with the  
206 standards established by the agency, provider networks may  
207 include providers located outside the region. A plan may  
208 contract with a new hospital facility before the date the  
209 hospital becomes operational if the hospital has commenced  
210 construction, will be licensed and operational by January 1,  
211 2013, and a final order has issued in any civil or

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212 administrative challenge. Each plan shall establish and maintain  
213 an accurate and complete electronic database of contracted  
214 providers, including information about licensure or  
215 registration, locations and hours of operation, specialty  
216 credentials and other certifications, specific performance  
217 indicators, and such other information as the agency deems  
218 necessary. The database must be available online to both the  
219 agency and the public and have the capability to compare the  
220 availability of providers to network adequacy standards and to  
221 accept and display feedback from each provider's patients. Each  
222 plan shall submit quarterly reports to the agency identifying  
223 the number of enrollees assigned to each primary care provider.  
224 The agency shall conduct, or contract for, systematic and  
225 continuous testing of the provider network databases maintained  
226 by each plan to confirm accuracy, confirm that behavioral health  
227 providers are accepting enrollees, and confirm that enrollees  
228 have access to behavioral health services.

229 2. Each managed care plan must publish any prescribed drug  
230 formulary or preferred drug list on the plan's website in a  
231 manner that is accessible to and searchable by enrollees and  
232 providers. The plan must update the list within 24 hours after  
233 making a change. Each plan must ensure that the prior  
234 authorization process for prescribed drugs is readily accessible  
235 to health care providers, including posting appropriate contact  
236 information on its website and providing timely responses to

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237 providers. For Medicaid recipients diagnosed with hemophilia who  
238 have been prescribed anti-hemophilic-factor replacement  
239 products, the agency shall provide for those products and  
240 hemophilia overlay services through the agency's hemophilia  
241 disease management program.

242 3. Managed care plans, and their fiscal agents or  
243 intermediaries, must accept prior authorization requests for any  
244 service electronically.

245 4. Managed care plans serving children in the care and  
246 custody of the Department of Children and Families must maintain  
247 complete medical, dental, and behavioral health encounter  
248 information and participate in making such information available  
249 to the department or the applicable contracted community-based  
250 care lead agency for use in providing comprehensive and  
251 coordinated case management. The agency and the department shall  
252 establish an interagency agreement to provide guidance for the  
253 format, confidentiality, recipient, scope, and method of  
254 information to be made available and the deadlines for  
255 submission of the data. The scope of information available to  
256 the department shall be the data that managed care plans are  
257 required to submit to the agency. The agency shall determine the  
258 plan's compliance with standards for access to medical, dental,  
259 and behavioral health services; the use of medications; and  
260 followup on all medically necessary services recommended as a

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261 result of early and periodic screening, diagnosis, and  
262 treatment.

263 Section 7. Paragraph (f) of subsection (1) of section  
264 409.988, Florida Statutes, is amended to read:

265 409.988 Lead agency duties; general provisions.—

266 (1) DUTIES.—A lead agency:

267 (f) Shall ensure that all individuals providing care for  
268 dependent children receive:

269 1. Appropriate training and meet the minimum employment  
270 standards established by the department.

271 2. Contact information for the local mobile response team  
272 established under s. 394.495.

273 Section 8. Subsection (4) of section 985.601, Florida  
274 Statutes, is amended to read:

275 985.601 Administering the juvenile justice continuum.—

276 (4) The department shall maintain continuing cooperation  
277 with the Department of Education, the Department of Children and  
278 Families, the Department of Economic Opportunity, and the  
279 Department of Corrections for the purpose of participating in  
280 agreements with respect to dropout prevention and the reduction  
281 of suspensions, expulsions, and truancy; increased access to and  
282 participation in high school equivalency diploma, vocational,  
283 and alternative education programs; and employment training and  
284 placement assistance. The cooperative agreements between the  
285 departments shall include an interdepartmental plan to cooperate

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286 in accomplishing the reduction of inappropriate transfers of  
287 children into the adult criminal justice and correctional  
288 systems. As part of its continuing cooperation, the department  
289 shall participate in the planning process for promoting a  
290 coordinated system of care for children and adolescents pursuant  
291 to s. 394.4955.

292 Section 9. Subsection (5) is added to section 1003.02,  
293 Florida Statutes, to read:

294 1003.02 District school board operation and control of  
295 public K-12 education within the school district.—As provided in  
296 part II of chapter 1001, district school boards are  
297 constitutionally and statutorily charged with the operation and  
298 control of public K-12 education within their school district.  
299 The district school boards must establish, organize, and operate  
300 their public K-12 schools and educational programs, employees,  
301 and facilities. Their responsibilities include staff  
302 development, public K-12 school student education including  
303 education for exceptional students and students in juvenile  
304 justice programs, special programs, adult education programs,  
305 and career education programs. Additionally, district school  
306 boards must:

307 (5) Participate in the planning process for promoting a  
308 coordinated system of care for children and adolescents pursuant  
309 to s. 394.4955.

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310 Section 10. Subsection (4) of section 1004.44, Florida  
311 Statutes, is renumbered as subsection (5), and a new subsection  
312 (4) is added to that section, to read:

313 1004.44 Louis de la Parte Florida Mental Health  
314 Institute.—There is established the Louis de la Parte Florida  
315 Mental Health Institute within the University of South Florida.

316 (4) By August 1, 2020, the institute shall develop a model  
317 response protocol for schools to use mobile response teams  
318 established under s. 394.495. In developing the protocol, the  
319 institute shall, at a minimum, consult with school districts  
320 that effectively use such teams, school districts that use such  
321 teams less often, local law enforcement agencies, the Department  
322 of Children and Families, managing entities as defined in s.  
323 394.9082(2), and mobile response team providers.

324 Section 11. Paragraph (c) of subsection (1) of section  
325 1006.04, Florida Statutes, is amended to read:

326 1006.04 Educational multiagency services for students with  
327 severe emotional disturbance.—

328 (1)

329 (c) The multiagency network shall:

330 1. Support and represent the needs of students in each  
331 school district in joint planning with fiscal agents of  
332 children's mental health funds, including the expansion of  
333 school-based mental health services, transition services, and  
334 integrated education and treatment programs.

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335           2. Improve coordination of services for children with or  
336 at risk of emotional or behavioral disabilities and their  
337 families by assisting multi-agency collaborative initiatives to  
338 identify critical issues and barriers of mutual concern and  
339 develop local response systems that increase home and school  
340 connections and family engagement.

341           3. Increase parent and youth involvement and development  
342 with local systems of care.

343           4. Facilitate student and family access to effective  
344 services and programs for students with and at risk of emotional  
345 or behavioral disabilities that include necessary educational,  
346 residential, and mental health treatment services, enabling  
347 these students to learn appropriate behaviors, reduce  
348 dependency, and fully participate in all aspects of school and  
349 community living.

350           5. Participate in the planning process for promoting a  
351 coordinated system of care for children and adolescents pursuant  
352 to s. 394.4955.

353           Section 12. Paragraph (b) of subsection (16) of section  
354 1011.62, Florida Statutes, is amended to read:

355           1011.62 Funds for operation of schools.—If the annual  
356 allocation from the Florida Education Finance Program to each  
357 district for operation of schools is not determined in the  
358 annual appropriations act or the substantive bill implementing



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359 the annual appropriations act, it shall be determined as  
360 follows:

361 (16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental  
362 health assistance allocation is created to provide funding to  
363 assist school districts in establishing or expanding school-  
364 based mental health care; train educators and other school staff  
365 in detecting and responding to mental health issues; and connect  
366 children, youth, and families who may experience behavioral  
367 health issues with appropriate services. These funds shall be  
368 allocated annually in the General Appropriations Act or other  
369 law to each eligible school district. Each school district shall  
370 receive a minimum of \$100,000, with the remaining balance  
371 allocated based on each school district's proportionate share of  
372 the state's total unweighted full-time equivalent student  
373 enrollment. Charter schools that submit a plan separate from the  
374 school district are entitled to a proportionate share of  
375 district funding. The allocated funds may not supplant funds  
376 that are provided for this purpose from other operating funds  
377 and may not be used to increase salaries or provide bonuses.  
378 School districts are encouraged to maximize third-party health  
379 insurance benefits and Medicaid claiming for services, where  
380 appropriate.

381 (b) The plans required under paragraph (a) must be focused  
382 on a multitiered system of supports to deliver evidence-based  
383 mental health care assessment, diagnosis, intervention,

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384 treatment, and recovery services to students with one or more  
385 mental health or co-occurring substance abuse diagnoses and to  
386 students at high risk of such diagnoses. The provision of these  
387 services must be coordinated with a student's primary mental  
388 health care provider and with other mental health providers  
389 involved in the student's care. At a minimum, the plans must  
390 include the following elements:

391 1. Direct employment of school-based mental health  
392 services providers to expand and enhance school-based student  
393 services and to reduce the ratio of students to staff in order  
394 to better align with nationally recommended ratio models. These  
395 providers include, but are not limited to, certified school  
396 counselors, school psychologists, school social workers, and  
397 other licensed mental health professionals. The plan also must  
398 identify strategies to increase the amount of time that school-  
399 based student services personnel spend providing direct services  
400 to students, which may include the review and revision of  
401 district staffing resource allocations based on school or  
402 student mental health assistance needs.

403 2. Contracts or interagency agreements with one or more  
404 local community behavioral health providers or providers of  
405 Community Action Team services to provide a behavioral health  
406 staff presence and services at district schools. Services may  
407 include, but are not limited to, mental health screenings and  
408 assessments, individual counseling, family counseling, group

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409 counseling, psychiatric or psychological services, trauma-  
410 informed care, mobile crisis services, and behavior  
411 modification. These behavioral health services may be provided  
412 on or off the school campus and may be supplemented by  
413 telehealth.

414 3. Policies and procedures, including contracts with  
415 service providers, which will ensure that:

416 a. Parents of students are provided information about  
417 behavioral health services available through the students'  
418 school or local community-based behavioral health services  
419 providers, including, but not limited to, the mobile response  
420 team as established in s. 394.495 serving their area. A school  
421 may meet this requirement by providing information about and  
422 internet addresses for web-based directories or guides of local  
423 behavioral health services as long as such directories or guides  
424 are easily navigated and understood by individuals unfamiliar  
425 with behavioral health delivery systems or services and include  
426 specific contact information for local behavioral health  
427 providers.

428 b. School districts use the services of the mobile  
429 response teams to the extent that such services are available.  
430 Each school district shall establish policies and procedures to  
431 carry out the model response protocol developed under s.  
432 1004.44.

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433           c. Students who are referred to a school-based or  
434 community-based mental health service provider for mental health  
435 screening for the identification of mental health concerns and  
436 ensure that the assessment of students at risk for mental health  
437 disorders occurs within 15 days of referral. School-based mental  
438 health services must be initiated within 15 days after  
439 identification and assessment, and support by community-based  
440 mental health service providers for students who are referred  
441 for community-based mental health services must be initiated  
442 within 30 days after the school or district makes a referral.

443           d. Referrals to behavioral health services available  
444 through other delivery systems or payors for which a student or  
445 individuals living in the household of a student receiving  
446 services under this subsection may qualify, if such services  
447 appear to be needed or enhancements in those individuals'  
448 behavioral health would contribute to the improved well-being of  
449 the student.

450           4. Strategies or programs to reduce the likelihood of at-  
451 risk students developing social, emotional, or behavioral health  
452 problems, depression, anxiety disorders, suicidal tendencies, or  
453 substance use disorders.

454           5. Strategies to improve the early identification of  
455 social, emotional, or behavioral problems or substance use  
456 disorders, to improve the provision of early intervention

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457 services, and to assist students in dealing with trauma and  
458 violence.

459 Section 13. Paragraph (1) of subsection (3) of section  
460 1002.20, Florida Statutes, is amended to read:

461 1002.20 K-12 student and parent rights.—Parents of public  
462 school students must receive accurate and timely information  
463 regarding their child's academic progress and must be informed  
464 of ways they can help their child to succeed in school. K-12  
465 students and their parents are afforded numerous statutory  
466 rights including, but not limited to, the following:

467 (3) HEALTH ISSUES.—

468 (1) Notification of involuntary examinations.—The public  
469 school principal or the principal's designee shall immediately  
470 notify the parent of a student who is removed from school,  
471 school transportation, or a school-sponsored activity and taken  
472 to a receiving facility for an involuntary examination pursuant  
473 to s. 394.463. The principal or the principal's designee may  
474 delay notification for no more than 24 hours after the student  
475 is removed if the principal or the principal's designee deems  
476 the delay to be in the student's best interest and if a report  
477 has been submitted to the central abuse hotline, pursuant to s.  
478 39.201, based upon knowledge or suspicion of abuse, abandonment,  
479 or neglect. Before a student is removed from school, school  
480 transportation, or a school-sponsored activity, the principal or  
481 the principal's designee must verify that de-escalation

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482 strategies have been utilized and outreach to a mobile response  
483 team has been initiated under policies and procedures  
484 established under s. 1011.62(16), unless the principal or the  
485 principal's designee reasonably believes that any delay in  
486 removing the student will increase the likelihood of harm to the  
487 student or others. Each district school board shall develop a  
488 policy and procedures for notification under this paragraph.

489 Section 14. Paragraph (q) of subsection (9) of section  
490 1002.33, Florida Statutes, is amended to read:

491 1002.33 Charter schools.—

492 (9) CHARTER SCHOOL REQUIREMENTS.—

493 (q) The charter school principal or the principal's  
494 designee shall immediately notify the parent of a student who is  
495 removed from school, school transportation, or a school-  
496 sponsored activity and taken to a receiving facility for an  
497 involuntary examination pursuant to s. 394.463. The principal or  
498 the principal's designee may delay notification for no more than  
499 24 hours after the student is removed if the principal or the  
500 principal's designee deems the delay to be in the student's best  
501 interest and if a report has been submitted to the central abuse  
502 hotline, pursuant to s. 39.201, based upon knowledge or  
503 suspicion of abuse, abandonment, or neglect. Before a student is  
504 removed from school, school transportation, or a school-  
505 sponsored activity, the principal or the principal's designee  
506 must verify that de-escalation strategies have been utilized and

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507 outreach to a mobile response team has been initiated under  
508 policies and procedures established under s. 1011.62(16), unless  
509 the principal or the principal's designee reasonably believes  
510 that any delay in removing the student will increase the  
511 likelihood of harm to the student or others. Each charter school  
512 governing board shall develop a policy and procedures for  
513 notification under this paragraph.

514 -----

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

516 Remove lines 21-60 and insert:

517 entities to lead the development of a plan promoting the  
518 development of a coordinated system of care for certain  
519 services; providing requirements for the planning process;  
520 requiring each managing entity to submit such plan by a  
521 specified date; requiring the entities involved in the planning  
522 process to implement such plan by a specified date; requiring  
523 that such plan be reviewed and updated periodically; amending s.  
524 394.9082, F.S.; revising the duties of the department relating  
525 to priority populations that will benefit from care  
526 coordination; requiring that a managing entity's behavioral  
527 health care needs assessment include certain information  
528 regarding gaps in certain services; requiring a managing entity  
529 to promote the use of available crisis intervention services;  
530 amending s. 409.175, F.S.; revising requirements relating to  
531 preservice training for foster parents; amending s. 409.967,

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532 F.S.; requiring the Agency for Health Care Administration to  
533 conduct, or contract for, the testing of provider network  
534 databases maintained by Medicaid managed care plans for  
535 specified purposes; amending s. 409.988, F.S.; revising the  
536 duties of a lead agency relating to individuals providing care  
537 for dependent children; amending s. 985.601, F.S.; requiring the  
538 Department of Juvenile Justice to participate in the planning  
539 process for promoting a coordinated system of care for children  
540 and adolescents; amending s. 1003.02, F.S.; requiring each  
541 district school board to participate in the planning process for  
542 promoting a coordinated system of care; amending s. 1004.44,  
543 F.S.; requiring the Louis de la Parte Florida Mental Health  
544 Institute to develop, in consultation with other entities, a  
545 model response protocol for schools; amending s. 1006.04, F.S.;  
546 requiring the educational multiagency network to participate in  
547 the planning process for promoting a coordinated system of care;  
548 amending s. 1011.62, F.S.; revising the elements of a plan  
549 required for school district funding under the mental health  
550 assistance allocation; amending ss. 1002.20 and 1002.33, F.S.;  
551 requiring verification that certain strategies have been  
552 utilized and certain outreach has been initiated before a  
553 student is removed from school, school transportation, or a  
554 school-sponsored activity under specified circumstances;  
555 requiring the Department





## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 1163 Intermediate Care Facilities  
**SPONSOR(S):** Health Market Reform Subcommittee, Burton  
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1344

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N, As CS	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	10 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Guzzo	Calamas

### SUMMARY ANALYSIS

An intermediate care facility for the developmentally disabled (ICFDD) provides intensive care and rehabilitative services in a residential setting to individuals with developmental disabilities. Medicaid is the only payer for ICFDD services, so current law requires a need assessment and a certificate of need (CON) from the Agency for Health Care Administration (AHCA), to build a new ICFDD or add beds to an existing ICFDD.

HB 1163 creates a CON exemption for a new ICFDD that meets specific criteria. It must have a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight. To obtain an exemption, an applicant must not have had a license denied, revoked, or suspended within the 36 months preceding the request for exemption and must have at least 10 years of experience serving individuals with severe maladaptive behaviors in Florida.

The bill prohibits AHCA from granting an additional CON exemption to an applicant that has been granted an exemption under these provisions unless the facility has been licensed and operational for a period of at least two years.

The bill also establishes certain continued licensure requirements for an ICFDD that has been granted the CON exemption created by the bill.

The bill may have a significant, indeterminate, negative fiscal impact on AHCA. 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:

##### **Background**

##### Intermediate Care Facilities for the Developmentally Disabled

An intermediate care facility for the developmentally disabled (ICFDD) provides institutional care for individuals with developmental disabilities. A developmental disability is a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.<sup>1</sup>

ICFDDs are licensed and regulated by the Agency for Health Care Administration (AHCA) under Part VIII of ch. 400, F.S., and Chapter 59A-26, F.A.C. ICFDDs provide the following services: nursing services, activity services, dental services, dietary services, pharmacy services, physician services, rehabilitative care services, room/bed and maintenance services and social services.<sup>2</sup> ICFDD services are only covered by the Medicaid program. Individuals who have a developmental disability and who meet Medicaid eligibility requirements may receive services in an ICFDD.

While the majority of individuals who have a developmental disability live in the community, a small number live in ICFDDs. Currently, there are 88 privately owned ICF/DD facilities in Florida. As of January 2020, the ICFDDs were 95.7 percent occupied, with 1,971 individuals in 2,060 possible beds.<sup>3</sup> There are also 11 ICFDDs that are operated by the state.

ICFDDs are institutional placements and are reimbursed for two levels of care, which are based on the client's mobility:

- ICF Level of Reimbursement One – for recipients who are ambulatory or self-mobile using mechanical devices and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation; and
- ICF Level of Reimbursement Two – for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision.<sup>4</sup>

##### Maladaptive Behaviors

Maladaptive behaviors are those behaviors by persons with developmental disabilities that are disruptive, destructive, aggressive, or significantly repetitive.<sup>5</sup>

The Agency for Persons with Disabilities (APD) developed a Global Behavioral Service Need Matrix (Matrix) to classify the severity of a person's maladaptive behavior for purposes of its home and community based waiver services, or iBudget, program, which is the Medicaid waiver program for

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<sup>1</sup> See s. 393.063(12), F.S.

<sup>2</sup> Agency for Health Care Administration, *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/DD) Services*, available at: [https://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/behavioral\\_health\\_coverage/bhfu/Intermediate\\_Care.shtml](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/bhfu/Intermediate_Care.shtml) (last visited February 2, 2020).

<sup>3</sup> Florida Medicaid ICF/IID Rate Study Report, prepared by Navigant for the Florida Agency for Health Care Administration, January 27, 2020 (on file with Health Market Reform Subcommittee staff).

<sup>4</sup> S. 408.038, F.S.

<sup>5</sup> Fulton, Elizabeth et al. "Reducing maladaptive behaviors in preschool-aged children with autism spectrum disorder using the early start denver model." *Frontiers in pediatrics* vol. 2 40. available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023017/> (last visited February 2, 2020).

persons with developmental disabilities.<sup>6</sup> The Matrix categorizes symptoms of maladaptive behaviors such as behavior frequency, behavioral impact, physical aggression to others, police involvement, property destruction, and elopement/wandering, among others. Each symptom is ranked on a scale of one to six, with one being the least severe and six being the most severe. If a symptom is not present, it is ranked as a zero. Based on a person’s behavior score, the person will be evaluated for services. The initial evaluation period is 12 months and then the frequency of evaluations afterwards depends on the severity of the person’s score, with a need level of six being evaluated more frequently than a need level of one.<sup>7</sup>

According to APD, 661 people within its iBudget program have higher level Matrix scores of 4, 5 or 6. The table below shows the average annual cost for individuals at these levels within the APD home- and-community-based services program.<sup>8</sup>

Global Behavioral Service Need Matrix Level	Average Annual APD Cost
4	\$132,777.73
5	\$138,476.51
6	\$158,823.46

### Certificates of Need (CON)

Florida’s CON program was created in 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 (“the Act”), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.<sup>9</sup> Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986.

In Florida, a CON is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service.<sup>10</sup> The current CON program only applies to nursing homes, hospices, and ICFDDs.

A CON is predicated on a determination of need. The future need for services and projects is known as the “fixed need pool”<sup>11</sup>, which AHCA publishes for each batching cycle. A batching cycle is a means of grouping of, for comparative review, CON applications submitted for beds, services or programs having a like CON need methodology, or licensing category in the same planning horizon and the same applicable district or sub-district.<sup>12</sup>

Upon determining that a need exists, AHCA accepts applications for CON based on batching cycles for each district. Section 408.032(5), F.S., establishes the 11 district service areas in Florida.<sup>13</sup> The CON

<sup>6</sup> Available at <http://apdcares.org/news/news/2011/ib-matrix-instructions.pdf> (last visited February 2, 2020). ICFDD services are not included in this program, which was created to provide home and community-based services, not institutional services. APD waiver clients who require or choose institutionalization can leave the waiver program and be placed in an ICFDD covered by the traditional Medicaid program.

<sup>7</sup> *Id.*

<sup>8</sup> Agency for Persons with Disabilities, email from Jeff Ivey, Legislative Affairs Director, Feb. 3, 2020 (on file with staff of the Health Market Reform Subcommittee).

<sup>9</sup> Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.

<sup>10</sup> S. 408.036, F.S.

<sup>11</sup> Rule 59C-1.002(19), F.A.C., defines “fixed need pool” as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by AHCA in accordance with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.

<sup>12</sup> Rule 59C-1.002(5), F.A.C.

<sup>13</sup> District 1.—Escambia, Santa Rosa, Okaloosa, and Walton Counties; District 2.—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties; District 3.—Hamilton, Suwannee, Lafayette, Dixie,

review process consists of two batching cycles each year for ICFDDs, nursing homes, hospice programs, and hospice inpatient facilities.

At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with AHCA.<sup>14</sup> A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.<sup>15</sup> Applications for CON review must be submitted by the specified deadline for the particular batch cycle.<sup>16</sup> AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.<sup>17</sup> The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.<sup>18</sup>

Within 60 days of receipt of the completed applications for that batch, AHCA must issue a State Agency Action Report and Notice of Intent to Award a CON for a project in its entirety, to award a CON for identifiable portions of a project, or to deny a CON for a project.<sup>19</sup> AHCA must then publish the decision within 14 days.<sup>20</sup> If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent to Award the CON become a final order of AHCA.<sup>21</sup>

An applicant for CON review must pay a fee to AHCA when the application is submitted. The minimum CON application filing fee is \$10,000.<sup>22</sup> In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however, the total fee may not exceed \$50,000.<sup>23</sup> A request for a CON exemption must be accompanied by a \$250 fee payable to AHCA.<sup>24</sup>

#### *CON for ICFDDs*

Prior to obtaining a license, an ICFDD applicant must obtain CON approval from AHCA. CON is required for new ICFDDs, and for adding beds to existing ICFDDs.<sup>25</sup> Since Medicaid is the only payer, the CON requirement is used to manage the Medicaid provider network of ICFDD services.

Rule 59C-1.034, F.A.C., requires the proposal of a CON applicant for a new ICFDD to:

- Be justified in context with current legislative Medicaid appropriations for ICFDD placements;
- Be determined by AHCA to be justified in context with the applicable review criteria; and
- Have not more than 60 beds divided into living units of not more than 15 beds.

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Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties; District 4.—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties;

District 5.—Pasco and Pinellas Counties; District 6.—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties;

District 7.—Seminole, Orange, Osceola, and Brevard Counties; District 8.—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties; District 9.—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

District 10.—Broward County; District 11.—Miami-Dade and Monroe Counties.

<sup>14</sup> S. 408.039(2)(a), F.S.

<sup>15</sup> S. 408.039(2)(c), F.S.

<sup>16</sup> Rule 59C-1.008(1)(g), F.A.C.

<sup>17</sup> S. 408.039(3)(a), F.S.

<sup>18</sup> Id.

<sup>19</sup> S. 408.039(4)(b), F.S.

<sup>20</sup> S. 408.039(4)(c), F.S.

<sup>21</sup> S. 408.039(4)(d), F.S.

<sup>22</sup> S. 408.038, F.S.

<sup>23</sup> Id.

<sup>24</sup> S. 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.

<sup>25</sup> S. 408.036(1)(a), F.S.

Since 2010, there have been six ICFDD CON applications, of which five were to replace an existing facility. The one CON application for a new ICFDD project was submitted by Sunrise Community, Inc., in 2018, to establish a new 24-bed facility in Hardee County. AHCA denied the application, finding:<sup>26</sup>

- The applicant failed to demonstrate the new ICFDD project would work in harmony with APD's efforts to meet the needs of APD's clients;
- The applicant failed to demonstrate the stated need could be met by the proposed new ICFDD beds on the timeline of the stated need; and
- Funding for the new ICFDD is doubtful and awarding a CON cannot be justified in the context of legislative appropriations.

### **Effect of the Bill**

The bill amends s. 408.036, F.S., to create a CON exemption for a new ICFDD which has a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight.

To obtain the exemption, the applicant must not have had a license denied, revoked, or suspended within the 36 months preceding the request for exemption and must have at least 10 years of experience serving individuals with severe maladaptive behaviors in this state. It is unknown how many providers would meet these two criteria, and be eligible to apply for a CON exemption under the bill. The bill prohibits AHCA from granting an additional exemption to an applicant that has been granted an exemption under these provisions unless the facility has been licensed and operational for a period of at least two years. This prevents multiple concurrent, or subsequent applications from a single provider.

The bill also amends s. 400.962, F.S., to establish additional licensure and application requirements for an ICFDD with a CON exemption under the bill, including:

- Each eight-bed home must be co-located on the same property with two other eight-bed homes and must serve individuals with severe maladaptive behaviors and co-occurring psychiatric diagnoses.
- The total number of beds per home within the facility may not exceed eight, with each resident having his or her own bedroom and bathroom.
- A minimum of 16 beds within the facility must be designated for individuals with severe maladaptive behaviors who have been assessed using the Matrix with a score of at least Level 4 through Level 6, or assessed using criteria deemed appropriate by the AHCA regarding the need for a specialized placement in an ICFDD.
- A state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.
- Available medical and nursing services 24 hours per day, 7 days per week.
- Demonstration of a history of using interventions that are least restrictive and that follow a behavioral hierarchy.
- Maintenance of a policy prohibiting the use of mechanical restraints.

The bill specifies that the exemption does not require a specific appropriation. This overrides the AHCA rule requirement that a CON for an ICFDD be issued only if AHCA can justify the new CON in light of legislative Medicaid appropriations for ICFDD services; that is, a determination that Medicaid has the funds to cover services in the new ICFDD beds.

Finally, the bill provides an effective date of July 1, 2020.

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<sup>26</sup> AHCA, State Agency Action Report on Application for Certificate of Need, Sunrise Community, Inc., August 17, 2018, CON #10541, available at [https://ahca.myflorida.com/MCHQ/CON\\_FA/Batching/pdf/10541.pdf](https://ahca.myflorida.com/MCHQ/CON_FA/Batching/pdf/10541.pdf) (last visited February 2, 2020).

B. SECTION DIRECTORY:

**Section 1:** Amends s. 400.962, F.S., relating to license required; license application.

**Section 2:** Amends s. 408.036, F.S., relating to projects subject to review; exemptions.

**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 will have a significant, but indeterminate, negative fiscal impact on AHCA. It is unknown how many providers will apply for the CON exemption, or how many CONs will be issued.

The Legislature appropriates specific allocations for Medicaid ICFDD payments, so the establishment of new ICFDDs under the bill would be paid for with the existing allocation unless the Legislature appropriates additional funds. According to AHCA, if more facilities and recipients are added to the program, the per day reimbursement rate for facilities would decrease without an additional appropriation.<sup>27</sup>

The weighted average rate for a resident in an ICFDD in FY 2019-20 is \$395.27 per day, and facilities currently have an average occupancy rate of 95%. Based on these figures, the additional estimated annual funding for each new, 24 bed facility is \$3,289,437. (24 beds x .95 occupancy = 22.8 beds x \$395.27 per day = \$9,012.16 x 365 days = \$3,289,436.94.)

The House proposed budget for FY 2020-21 includes a new payment rate to ICFDDs of \$562 per day for individuals with severe behavioral needs.<sup>28</sup> If this provision is adopted in the budget for FY 2020-21, the additional estimated annual funding for a 24 bed facility is \$4,676,964.

In addition, Medicaid ICFDD services cost more than home and community based services. Assuming new ICFDD facilities and beds will be utilized by APD iBudget clients currently living in the community, the Medicaid program will experience costs for their care, rather than APD, and will experience greater costs than APD currently incurs.

The average annual cost for the 661 APD clients with scores of 4 or higher on the global behavioral matrix is \$143,359.23.<sup>29</sup> The annual cost for a Medicaid recipient in an ICFDD under the current daily reimbursement rate is \$144,274, or \$205,130 under the new payment rate in the House budget.<sup>30</sup> If passed, the bill would result in additional annual Medicaid expenditures of \$914.77 under the current reimbursement rate, and \$61,770.77 under the new proposed reimbursement rate, for each individual that switches from home and community-based care to institutional ICFDD care.

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<sup>27</sup> Agency for Health Care Administration, 2020 Agency Legislative Bill Analysis, HB 1163, January 4, 2020 (on file with Health & Human Services Committee staff).

<sup>28</sup> 2020 General Appropriations Act, HB 5001, specific appropriation 224.

<sup>29</sup> SUPRA FN 8.

<sup>30</sup> SUPRA FN 27.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

1. Revenues:

None.

2. Expenditures:

None.

**C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

None.

**D. FISCAL COMMENTS:**

None.

**III. COMMENTS**

**A. CONSTITUTIONAL ISSUES:**

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

**B. RULE-MAKING AUTHORITY:**

AHCA has sufficient rule-making authority in existent law 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 two amendments and reported the bill favorably as a committee substitute. The amendments:

- Change the APD maladaptive behavior Global Behavioral Service Need Matrix score threshold for the minimum designated beds required by the bill for new CON recipients, from 3 to 6, to 4 through 6; and
- Replace the term “facility” with the term “applicant” as it relates to qualifying criteria established for the CON exemption.

The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.



1                                   A bill to be entitled  
 2           An act relating to intermediate care facilities;  
 3           amending s. 400.962, F.S.; requiring certain  
 4           facilities that have been granted a certificate-of-  
 5           need exemption to demonstrate and maintain compliance  
 6           with specified criteria; amending s. 408.036, F.S.;  
 7           providing an exemption from a certificate-of-need  
 8           requirement for certain intermediate care facilities;  
 9           prohibiting the Agency of Health Care Administration  
 10          from granting an exemption to an applicant unless a  
 11          certain condition is met; providing that a specific  
 12          legislative appropriation is not required for such  
 13          exemption; providing an effective date.

14  
 15   Be It Enacted by the Legislature of the State of Florida:

16  
 17           Section 1. Subsection (6) is added to section 400.962,  
 18   Florida Statutes, to read:

19           400.962 License required; license application.—

20           (6) An applicant that has been granted a certificate-of-  
 21           need exemption under s. 408.036(3)(o) must also demonstrate and  
 22           maintain compliance with the following criteria:

23           (a) The total number of beds per home within the facility  
 24           may not exceed eight, with each resident having his or her own  
 25           bedroom and bathroom. Each eight-bed home must be colocated on

26 | the same property with two other eight-bed homes and must serve  
27 | individuals with severe maladaptive behaviors and co-occurring  
28 | psychiatric diagnoses.

29 | (b) A minimum of 16 beds within the facility must be  
30 | designated for individuals with severe maladaptive behaviors who  
31 | have been assessed using the Agency for Persons with  
32 | Disabilities' Global Behavioral Service Need Matrix with a score  
33 | of Level 4 through Level 6, or assessed using the criteria  
34 | deemed appropriate by the Agency for Health Care Administration  
35 | regarding the need for a specialized placement in an  
36 | intermediate care facility for the developmentally disabled.

37 | (c) The applicant has not had a facility license denied,  
38 | revoked, or suspended within the 36 months preceding the request  
39 | for exemption.

40 | (d) The applicant must have at least 10 years of  
41 | experience serving individuals with severe maladaptive behaviors  
42 | in the state.

43 | (e) The applicant must implement a state-approved staff  
44 | training curriculum and monitoring requirements specific to the  
45 | individuals whose behaviors require higher intensity, frequency,  
46 | and duration of services.

47 | (f) The applicant must make available medical and nursing  
48 | services 24 hours per day, 7 days per week.

49 | (g) The applicant must demonstrate a history of using  
50 | interventions that are least restrictive following a behavioral

51 hierarchy.

52 (h) The applicant must maintain a policy prohibiting the  
53 use of mechanical restraints.

54 Section 2. Paragraph (o) is added to subsection (3) of  
55 section 408.036, Florida Statutes, to read:

56 408.036 Projects subject to review; exemptions.—

57 (3) EXEMPTIONS.—Upon request, the following projects are  
58 subject to exemption from subsection (1):

59 (o) For a new intermediate care facility for the  
60 developmentally disabled that has a total of 24 beds, comprised  
61 of three eight-bed homes, for use by individuals exhibiting  
62 severe maladaptive behaviors and co-occurring psychiatric  
63 diagnoses requiring increased levels of behavioral, medical, and  
64 therapeutic oversight. The applicant must not have had a license  
65 denied, revoked, or suspended within the 36 months preceding the  
66 request for exemption and must have at least 10 years of  
67 experience serving individuals with severe maladaptive behaviors  
68 in this state. The agency may not grant an exemption to an  
69 applicant that has been granted an exemption under this  
70 paragraph unless the facility, awarded by exemption, has been  
71 licensed and operational for a period of at least 2 years. The  
72 exemption under this paragraph does not require a specific  
73 legislative appropriation.

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

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Burton offered the following:

4  
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16

**Amendment (with title amendment)**

Remove lines 68-73 and insert:

in this state. The agency may grant no more than three  
exemptions under this paragraph.

1. The exemption under this paragraph does not require a  
specific legislative appropriation.

2. An exemption under this paragraph shall terminate 18  
months after the date of issuance unless the exemption holder  
has commenced construction. The agency shall monitor the  
progress of the holder of the certificate of exemption in  
meeting the timetable for project development specified in the  
application for exemption. The agency shall extend the time

Amendment No. 1

17 period for a project, if the exemption holder demonstrates to  
18 the satisfaction of the agency that good-faith commencement of  
19 the project is being delayed by litigation or by governmental  
20 action or inaction with respect to regulations or permitting  
21 precluding commencement of the project.

22 3. This paragraph and subsection (6) of s. 400.962 are  
23 repealed July 1, 2022, unless reviewed and saved from repeal by  
24 the Legislature.

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28

**T I T L E   A M E N D M E N T**

29

Remove lines 9-13 and insert:

30

limiting the number of exemptions to be issued under the bill;

31

providing that a specific legislative appropriation is not

32

required for such exemption; providing timeframes and a

33

monitoring process for any exemption issued under the provisions

34

of the bill; providing a sunset provision; providing an

35

effective date.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1341 Massage Therapy  
**SPONSOR(S):** Goff-Marcil  
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 390

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

Massage practice is the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, and may be aided by hydrotherapy, including colonic irrigation or thermal therapy, or any electrical or mechanical device, or the application of a chemical or herbal preparation to the human body. The Board of Massage Therapy (Board), within the Department of Health (DOH), regulates massage practice in this state.

HB 1341 expands the scope of practice for massage therapy by allowing massage therapists to apply over-the-counter topical agents or a topical agent prescribed by a health care practitioner in accordance with board rules. The bill also authorizes a massage therapist to assess a patient for massage therapy treatment.

Currently, there are two paths to licensure as a massage therapist: completion of a board-approved education program or completion of an apprenticeship. The bill eliminates a massage apprenticeship as a path to licensure. However, the bill grandfathers those individuals who have been issued a license as a massage apprentice before July 1, 2020, so that these apprentices may apply for licensure if the apprenticeship is completed before July 1, 2022.

Currently, DOH is statutorily required to administer a licensure examination. The bill authorizes the Board to designate a national examination for licensure and repeals provisions requiring DOH to administer a licensure examination.

The bill changes the term "massage" to "massage therapy" throughout statutes to standardize terminology.

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

##### Massage Therapy

Massage practice is the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy, or any electrical or mechanical device, or the application of a chemical or herbal preparation to the human body.<sup>1</sup> Massage is therapeutic and a massage therapist must know anatomy and physiology and understand the relationship between the structure and function of the tissues being treated and the total function of the body.<sup>2</sup>

Chapter 480, F.S., entitled the "Massage Practice Act" governs the practice of massage therapy in Florida. The Board of Massage Therapy (Board), within the Department of Health (DOH), regulates massage practice, including massage therapists and massage establishments.<sup>3</sup>

##### *Massage Therapist Licensure*

A massage therapist is a person who administers massage for compensation.<sup>4</sup> To qualify for licensure as a massage therapist, an applicant must:<sup>5</sup>

- Be at least 18 years of age or have received a high school diploma or graduate equivalency diploma;
- Complete a course of study at a Board-approved massage school or apprentice program;
- Pass a background screening; and
- Pass an examination administered by DOH.

Current law requires DOH to administer a licensure examination. However, DOH does not administer the examination. Instead, the Board chose to approve the use of several licensure examinations administered by private entities,<sup>6</sup>

- Massage and Bodywork Licensing Examination administered by the Federation of State Massage Therapy Boards;
- National Certification Board for Therapeutic Massage and Bodywork Examination administered by the National Certification Board for Therapeutic Massage and Bodywork;
- National Certification Examination for Therapeutic Massage administered by the National Certification Board for Therapeutic Massage and Bodywork;
- National Exam for State Licensure administered by the National Certification Board for Therapeutic Massage and Bodywork; and
- National Board for Colon Hydrotherapy Examination for colonic irrigation.

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<sup>1</sup> Section 480.033(3), F.S.

<sup>2</sup> Section 480.032, F.S.

<sup>3</sup> Section 480.035, F.S.

<sup>4</sup> Section 480.033(4), F.S.

<sup>5</sup> Section 480.041, F.S. DOH must deny an application if the applicant has been convicted or found guilty of, or entered a plea of nolo contendere to a crime related to prostitution or a felony offense related to certain other crimes.

<sup>6</sup> Rule 64B27-25.001(3), F.A.C.



## *Massage Schools*

A person seeking licensure as a massage therapist may complete a course of study at a Board-approved massage school. The Board requires the course of study comprised of at least 500 classroom hours, completed at a rate of no more than six hours per day and no more than 30 classroom hours per calendar week.<sup>7</sup> Classroom education must include:<sup>8</sup>

- 150 hours of anatomy and physiology;
- 100 hours of basic massage theory and history;
- 125 hours of clinical practicum;
- 76 hours of allied modalities;
- 15 hours of business;
- 15 hours of theory and practice of hydrotherapy;
- 10 hours of Florida laws and rules;
- 4 hours of professional ethics;
- 3 hours of HIV/AIDS education; and
- 2 hours of medical errors.

A massage therapy student may also complete a course of study in colonic training in addition to the training above. Such course of study must include a minimum of 100 classroom hours, consisting of 50 hours in theory, anatomy, physiology, pathology of the colon and digestive system and principles of colon hygiene, 45 hours of clinical practicum that includes 20 treatments, and five hours in sterilization techniques.<sup>9</sup>

## *Massage Apprenticeship Programs*

Currently, a person seeking licensure as a massage therapist may complete a massage apprenticeship in lieu of attending massage school. A massage apprenticeship must be completed at a qualified establishment<sup>10</sup> and must be completed within 12 months, in four quarters.<sup>11</sup> A massage therapist must complete training of no more than 500 hours per quarter. The training must include:<sup>12</sup>

- 300 hours of anatomy;
- 300 hours of physiology;
- 20 basic massage theory and history;
- 50 hours of theory and practice of hydrotherapy;
- 25 hours of Florida laws and rules;
- 50 hours of allied modalities;
- 700 hours of clinical practicum; and
- 3 hours of HIV/AIDS instruction.

The massage apprentice must complete 100 hours of anatomy, 100 hours of physiology, and 15 hours of Florida laws and rules regulating the practice of massage therapy during the first quarter of the apprenticeship.<sup>13</sup>

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<sup>7</sup> Rule 64B7-32.003, F.A.C.

<sup>8</sup> Id.

<sup>9</sup> Rule 64B7-32.005, F.A.C.

<sup>10</sup> A "qualified establishment" is one that meets the requirements for licensure, complies with board rules for massage establishments, and is equipped with massage tables, linens and linen storage areas, hydrotherapy equipment, textbooks and teaching materials. If the apprenticeship include colonic irrigation, the establishment must also have colonic irrigation equipment, sterilization equipment if non-disposable colonic attachments are use, and textbooks and teaching materials on colonic irrigation. See r. 64B7-29.001(6), F.A.C.

<sup>11</sup> Rule 64B7-29.003, F.A.C.

<sup>12</sup> Id.

<sup>13</sup> Id.

In the 2017-2018 fiscal year, 3,380 individuals were granted licensure as massage therapists, 13 of which qualified for licensure by completing an approved massage apprenticeship program.<sup>14</sup> Florida is one of a very small number of states that continue to allow apprenticeship as an acceptable course of study for licensure as a massage therapist.<sup>15</sup> Massage therapy education has become more formalized and massage therapists are trained in licensed massage schools.

### *Colonic Irrigation Apprenticeship Programs*

A massage therapist, a massage apprentice, or a student in a board-approved massage therapy school may study colonic irrigation<sup>16</sup> under the direct supervision of a sponsor.<sup>17</sup> The sponsor must be licensed to practice massage, authorized to practice colonic irrigation, and have practiced colonic irrigation for at least three years.<sup>18</sup> The apprenticeship must be completed within 12 months of commencement<sup>19</sup> and must consist of at least 100 hours of training, including 45 hours of clinical practicum with a minimum of 20 treatments given.<sup>20</sup> Few schools in Florida offer a colonic irrigation program so apprenticeships are the primary method of training. Currently, there are 21 licensed apprentices in Florida.<sup>21</sup>

### **Effect of Proposed Changes**

HB 1341 expands the scope of practice for massage therapy by allowing massage therapists to apply over-the-counter topical agents or a topical agent prescribed by a health care practitioner in accordance with Board rules. Currently, application of topical agents is not within the scope of practice for a massage therapist. The bill also authorizes a massage therapist to assess a patient for massage therapy treatment. Although a massage therapist may perform a massage on a patient, there is no statutory authority for a massage therapist to assess the patient to evaluate a patient for treatment.

The bill eliminates massage therapy apprenticeship as a path to licensure. However, if an individual has been issued a license as a massage therapy apprentice before July 1, 2020, he or she may continue the apprenticeship until the license expires. A massage therapist apprentice must apply for full licensure before July 1, 2022. The bill maintains apprenticeships for colonic irrigations, but requires a licensed massage therapist practicing colonic irrigation to supervise a colonic irrigation apprentice.

The bill also requires licensure applicants to obtain a passing score on a national examination designated by the Board and repeals provisions requiring DOH to administer a licensure examination. This will align statute with the Board's current practice.

The bill changes the term "massage" to "massage therapy" throughout statutes to standardize terminology, including revising the title of ch. 480, F.S., from "Massage Practice" to "Massage Therapy Practice."

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

#### **B. SECTION DIRECTORY:**

**Section 1:** Changes the title of ch. 490, F.S., from "Massage Practice" to "Massage Therapy Practice."

**Section 2:** Amends s. 480.031, F.S., relating to short title.

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<sup>14</sup> Department of Health, *2020 Agency Legislative Analysis for HB 713*, (Nov. 19, 2019), on file with the Health Quality Subcommittee. HB 713 has substantively similar provisions.

<sup>15</sup> Department of Health, *2019 Agency Legislative Analysis for HB 7031*, on file with the Health Quality Subcommittee.

<sup>16</sup> Colonic irrigation is a method of hydrotherapy used to cleanse the colon with the aid of a mechanical device and water (s. 480.033(6), F.S.).

<sup>17</sup> Rule 64B7-29.001, F.A.C.

<sup>18</sup> *Id.*

<sup>19</sup> Rule 64B7-29.007, F.A.C.

<sup>20</sup> Rule 64B7-25.001, F.A.C.

<sup>21</sup> *Supra* note 14.

- Section 3:** Amends s. 480.032, F.S., relating to purpose.
- Section 4:** Amends s. 480.033, F.S., relating to definitions.
- Section 5:** Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure; endorsement.
- Section 6:** Repeals s. 480.042, F.S., relating to examinations.
- Section 7:** Amends s. 477.013, F.S., relating to definitions.
- Section 8:** Amends s. 477.1035, F.S., relating to exemptions.
- Section 9:** Amends s. 480.034, F.S., relating to exemptions.
- Section 10:** Amends s. 480.035, F.S., relating to Board of Massage Therapy.
- Section 11:** Amends s. 480.043, F.S., relating to massage establishments; requisites; licensure; inspection; human trafficking awareness training and policies.
- Section 12:** Amends s. 480.046, F.S., relating to grounds for disciplinary action by the board.
- Section 13:** Amends s. 480.0465, F.S., relating to advertisement.
- Section 14:** Amends s. 480.047, F.S., relating to penalties.
- Section 15:** Amends s. 480.052, F.S., relating to power of county or municipality to regulate massage.
- Section 16:** Amends s. 480.0535, F.S., relating to documents required while working in a massage establishment.
- Section 17:** Amends s. 627.6407, F.S., relating to massage.
- Section 18:** Amends s. 627.6619, F.S., relating to massage.
- Section 19:** Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.
- Section 20:** Amends s. 641.31, F.S., relating to health maintenance contracts.
- Section 21:** Provides an effective date of July 1, 2020.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DOH will incur insignificant costs related to adopting rules to expand the scope of practice for massage therapy and repealing rules on massage apprenticeships. Current resources can absorb these costs.

### 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 Board has sufficient rulemaking authority to implement the bill.

#### **C. DRAFTING ISSUES OR OTHER COMMENTS:**

None.

### **IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**



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26           480.031 Short title.—This act ~~shall be known and~~ may be  
27 cited as the "Massage Therapy Practice Act."

28           Section 3. Section 480.032, Florida Statutes, is amended  
29 to read:

30           480.032 Purpose.—The Legislature recognizes that the  
31 practice of massage therapy is potentially dangerous to the  
32 public in that massage therapists must have a knowledge of  
33 anatomy and physiology and an understanding of the relationship  
34 between the structure and the function of the tissues being  
35 treated and the total function of the body. Massage therapy is a  
36 therapeutic health care practice, and regulations are necessary  
37 to protect the public from unqualified practitioners. It is  
38 therefore deemed necessary in the interest of public health,  
39 safety, and welfare to regulate the practice of massage therapy  
40 in this state; however, restrictions shall be imposed to the  
41 extent necessary to protect the public from significant and  
42 discernible danger to health and yet not in such a manner which  
43 will unreasonably affect the competitive market. Further,  
44 consumer protection for both health and economic matters shall  
45 be afforded the public through legal remedies provided for in  
46 this act.

47           Section 4. Subsections (3), (4), (5), (7), and (9) of  
48 section 480.033, Florida Statutes, are amended to read:

49           480.033 Definitions.—As used in this act:

50           (3) "Massage therapy" means the manipulation of the soft

51 tissues of the human body with the hand, foot, knee, arm, or  
52 elbow, regardless of whether ~~or not~~ such manipulation is aided  
53 by hydrotherapy, including colonic irrigation, or thermal  
54 therapy; any electrical or mechanical device; or the application  
55 to the human body of a chemical or herbal preparation, an over-  
56 the-counter topical agent, or a topical agent prescribed by a  
57 health care practitioner applied in accordance with board rule.

58 (4) "Massage therapist" means a person licensed as  
59 required by this act, who administers massage therapy for  
60 compensation and assesses or evaluates persons for massage  
61 therapy treatment.

62 (5) "Apprentice" means a person approved by the board to  
63 study colon irrigation ~~massage~~ under the instruction of a  
64 licensed massage therapist practicing colon irrigation.

65 (7) "Establishment" or "massage establishment" means a  
66 site or premises, or portion thereof, wherein a massage  
67 therapist practices massage therapy.

68 (9) "Board-approved massage therapy school" means a  
69 facility that meets minimum standards for training and  
70 curriculum as determined by rule of the board and that is  
71 licensed by the Department of Education pursuant to chapter 1005  
72 or the equivalent licensing authority of another state or is  
73 within the public school system of this state or a college or  
74 university that is eligible to participate in the William L.  
75 Boyd, IV, Effective Access to Student Education Grant Program.

76 Section 5. Subsections (1), (2), and (4) of section  
 77 480.041, Florida Statutes, are amended, and subsection (8) is  
 78 added to that section, to read:

79 480.041 Massage therapists; qualifications; licensure;  
 80 endorsement.—

81 (1) Any person is qualified for licensure as a massage  
 82 therapist under this act who:

83 (a) Is at least 18 years of age or has received a high  
 84 school diploma or high school equivalency diploma;

85 (b) Has completed a course of study at a board-approved  
 86 massage therapy school ~~or has completed an apprenticeship~~  
 87 ~~program that meets standards adopted by the board; and~~

88 (c) Has received a passing grade on a national ~~an~~  
 89 examination designated ~~administered~~ by the board ~~department~~.

90 (2) Every person desiring to be examined for licensure as  
 91 a massage therapist shall apply to the department in writing  
 92 upon forms prepared and furnished by the department. Such  
 93 applicants are ~~shall be~~ subject to ~~the provisions of s.~~

94 ~~480.046(1). Applicants may take an examination administered by~~  
 95 ~~the department only upon meeting the requirements of this~~  
 96 ~~section as determined by the board.~~

97 (4) Upon an applicant's passing the examination and paying  
 98 the initial licensure fee, the department shall issue to the  
 99 applicant a license, valid until the next scheduled renewal  
 100 date, to practice massage therapy.



101       (8) A person issued a license as a massage apprentice  
102 before July 1, 2020, may continue that apprenticeship and  
103 perform massage therapy as authorized under that license until  
104 its expiration. After completing his or her apprenticeship and  
105 before July 1, 2022, a massage apprentice may apply to the board  
106 for full licensure and the board must grant the application if  
107 the applicant meets all other applicable licensure requirements.

108       Section 6. Section 480.042, Florida Statutes, is repealed.

109       Section 7. Subsection (13) of section 477.013, Florida  
110 Statutes, is amended to read:

111       477.013 Definitions.—As used in this chapter:

112       (13) "Skin care services" means the treatment of the skin  
113 of the body, other than the head, face, and scalp, by the use of  
114 a sponge, brush, cloth, or similar device to apply or remove a  
115 chemical preparation or other substance, except that chemical  
116 peels may be removed by peeling an applied preparation from the  
117 skin by hand. Skin care services must be performed by a licensed  
118 cosmetologist or facial specialist within a licensed cosmetology  
119 or specialty salon, and such services may not involve massage  
120 therapy, as defined in s. 480.033(3), through manipulation of  
121 the superficial tissue.

122       Section 8. Paragraph (a) of subsection (1) of section  
123 477.0135, Florida Statutes, is amended to read:

124       477.0135 Exemptions.—

125       (1) This chapter does not apply to the following persons

126 | when practicing pursuant to their professional or occupational  
 127 | responsibilities and duties:

128 |       (a) Persons authorized under the laws of this state to  
 129 | practice medicine, surgery, osteopathic medicine, chiropractic  
 130 | medicine, massage therapy, naturopathy, or podiatric medicine.

131 |       Section 9. Subsection (4) of section 480.034, Florida  
 132 | Statutes, is amended to read:

133 |             480.034 Exemptions.—

134 |       (4) An exemption granted is effective to the extent that  
 135 | an exempted person's practice or profession overlaps with the  
 136 | practice of massage therapy.

137 |       Section 10. Subsection (2) of section 480.035, Florida  
 138 | Statutes, is amended to read:

139 |             480.035 Board of Massage Therapy.—

140 |       (2) Five members of the board shall be licensed massage  
 141 | therapists and shall have been engaged in the practice of  
 142 | massage therapy for not less than 5 consecutive years prior to  
 143 | the date of appointment to the board. The Governor shall appoint  
 144 | each member for a term of 4 years. Two members of the board  
 145 | shall be laypersons. Each board member shall be a high school  
 146 | graduate or shall have received a high school equivalency  
 147 | diploma. Each board member shall be a citizen of the United  
 148 | States and a resident of this state for not less than 5 years.  
 149 | The appointments are ~~will be~~ subject to confirmation by the  
 150 | Senate.

151 Section 11. Subsection (14) of section 480.043, Florida  
152 Statutes, is amended to read:

153 480.043 Massage establishments; requisites; licensure;  
154 inspection; human trafficking awareness training and policies.—

155 (14) Except for the requirements of subsection (13), this  
156 section does not apply to a physician licensed under chapter  
157 457, chapter 458, chapter 459, or chapter 460 who employs a  
158 licensed massage therapist to perform massage therapy on the  
159 physician's patients at the physician's place of practice. This  
160 subsection does not restrict investigations by the department  
161 for violations of chapter 456 or this chapter.

162 Section 12. Paragraphs (a), (b), (c), (f), (g), (h), (i),  
163 and (o) of subsection (1) of section 480.046, Florida Statutes,  
164 are amended to read:

165 480.046 Grounds for disciplinary action by the board.—

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

168 (a) Attempting to procure a license to practice massage  
169 therapy by bribery or fraudulent misrepresentation.

170 (b) Having a license to practice massage therapy revoked,  
171 suspended, or otherwise acted against, including the denial of  
172 licensure, by the licensing authority of another state,  
173 territory, or country.

174 (c) Being convicted or found guilty, regardless of  
175 adjudication, of a crime in any jurisdiction which directly

176 | relates to the practice of massage therapy or to the ability to  
 177 | practice massage therapy. Any plea of nolo contendere shall be  
 178 | considered a conviction for purposes of this chapter.

179 | (f) Aiding, assisting, procuring, or advising any  
 180 | unlicensed person to practice massage therapy contrary to ~~the~~  
 181 | ~~provisions of~~ this chapter or to department or board a rule ~~of~~  
 182 | ~~the department or the board~~.

183 | (g) Making deceptive, untrue, or fraudulent  
 184 | representations in the practice of massage therapy.

185 | (h) Being unable to practice massage therapy with  
 186 | reasonable skill and safety by reason of illness or use of  
 187 | alcohol, drugs, narcotics, chemicals, or any other type of  
 188 | material or as a result of any mental or physical condition. In  
 189 | enforcing this paragraph, the department ~~shall have~~, upon  
 190 | probable cause, may ~~authority to~~ compel a massage therapist to  
 191 | submit to a mental or physical examination by physicians  
 192 | designated by the department. Failure of a massage therapist to  
 193 | submit to such examination when so directed, unless the failure  
 194 | was due to circumstances beyond her or his control, constitutes  
 195 | ~~shall constitute~~ an admission of the allegations against her or  
 196 | him, consequent upon which a default and final order may be  
 197 | entered without the taking of testimony or presentation of  
 198 | evidence. A massage therapist affected under this paragraph  
 199 | shall at reasonable intervals be afforded an opportunity to  
 200 | demonstrate that she or he can resume the competent practice of

201 massage therapy with reasonable skill and safety to clients.

202 (i) Gross or repeated malpractice or the failure to  
203 practice massage therapy with that level of care, skill, and  
204 treatment which is recognized by a reasonably prudent massage  
205 therapist as being acceptable under similar conditions and  
206 circumstances.

207 (o) Practicing massage therapy at a site, location, or  
208 place which is not duly licensed as a massage establishment,  
209 except that a massage therapist, as provided by ~~rules adopted by~~  
210 ~~the board~~ rule, may provide massage therapy services, excluding  
211 colonic irrigation, at the residence of a client, at the office  
212 of the client, at a sports event, at a convention, or at a trade  
213 show.

214 Section 13. Section 480.0465, Florida Statutes, is amended  
215 to read:

216 480.0465 Advertisement.—Each massage therapist or massage  
217 establishment licensed under ~~the provisions of~~ this act shall  
218 include the number of the license in any advertisement of  
219 massage therapy services appearing in a newspaper, airwave  
220 transmission, telephone directory, or other advertising medium.  
221 Pending licensure of a new massage establishment pursuant to ~~the~~  
222 ~~provisions of~~ s. 480.043(7), the license number of a licensed  
223 massage therapist who is an owner or principal officer of the  
224 establishment may be used in lieu of the license number for the  
225 establishment.

226 Section 14. Paragraphs (a), (b), and (c) of subsection (1)  
 227 of section 480.047, Florida Statutes, are amended to read:

228 480.047 Penalties.—

229 (1) It is unlawful for any person to:

230 (a) Hold himself or herself out as a massage therapist or  
 231 to practice massage therapy unless duly licensed under this  
 232 chapter or unless otherwise specifically exempted from licensure  
 233 under this chapter.

234 (b) Operate any massage establishment unless it has been  
 235 duly licensed as provided herein, except that nothing herein  
 236 shall be construed to prevent the teaching of massage therapy in  
 237 this state at a board-approved massage therapy school.

238 (c) Permit an employed person to practice massage therapy  
 239 unless duly licensed as provided herein.

240 Section 15. Section 480.052, Florida Statutes, is amended  
 241 to read:

242 480.052 Power of county or municipality to regulate  
 243 massage therapy.—A county or municipality, within its  
 244 jurisdiction, may regulate persons and establishments licensed  
 245 under this chapter. Such regulation shall not exceed the powers  
 246 of the state under this act or be inconsistent with this act.  
 247 This section shall not be construed to prohibit a county or  
 248 municipality from enacting any regulation of persons or  
 249 establishments not licensed pursuant to this act.

250 Section 16. Subsections (1) and (2) of section 480.0535,

251 Florida Statutes, are amended to read:

252 480.0535 Documents required while working in a massage  
253 establishment.—

254 (1) In order to provide the department and law enforcement  
255 agencies the means to more effectively identify, investigate,  
256 and arrest persons engaging in human trafficking, a person  
257 employed by a massage establishment and any person performing  
258 massage therapy therein must immediately present, upon the  
259 request of an investigator of the department or a law  
260 enforcement officer, valid government identification while in  
261 the establishment. A valid government identification for the  
262 purposes of this section is:

263 (a) A valid, unexpired driver license issued by any state,  
264 territory, or district of the United States;

265 (b) A valid, unexpired identification card issued by any  
266 state, territory, or district of the United States;

267 (c) A valid, unexpired United States passport;

268 (d) A naturalization certificate issued by the United  
269 States Department of Homeland Security;

270 (e) A valid, unexpired alien registration receipt card  
271 (green card); or

272 (f) A valid, unexpired employment authorization card  
273 issued by the United States Department of Homeland Security.

274 (2) A person operating a massage establishment must:

275 (a) Immediately present, upon the request of an

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276 investigator of the department or a law enforcement officer:

277 1. Valid government identification while in the  
278 establishment.

279 2. A copy of the documentation specified in paragraph  
280 (1) (a) for each employee and any person performing massage  
281 therapy in the establishment.

282 (b) Ensure that each employee and any person performing  
283 massage therapy in the massage establishment is able to  
284 immediately present, upon the request of an investigator of the  
285 department or a law enforcement officer, valid government  
286 identification while in the establishment.

287 Section 17. Section 627.6407, Florida Statutes, is amended  
288 to read:

289 627.6407 Massage.—Any policy of health insurance that  
290 provides coverage for massage shall also cover the services of  
291 persons licensed to practice massage therapy pursuant to chapter  
292 480, where the massage therapy, as defined in chapter 480, has  
293 been prescribed by a physician licensed under chapter 458,  
294 chapter 459, chapter 460, or chapter 461, as being medically  
295 necessary and the prescription specifies the number of  
296 treatments.

297 Section 18. Section 627.6619, Florida Statutes, is amended  
298 to read:

299 627.6619 Massage.—Any policy of health insurance that  
300 provides coverage for massage shall also cover the services of



301 persons licensed to practice massage therapy pursuant to chapter  
302 480, where the massage therapy, as defined in chapter 480, has  
303 been prescribed by a physician licensed under chapter 458,  
304 chapter 459, chapter 460, or chapter 461, as being medically  
305 necessary and the prescription specifies the number of  
306 treatments.

307 Section 19. Paragraph (a) of subsection (1) of section  
308 627.736, Florida Statutes, is amended to read:

309 627.736 Required personal injury protection benefits;  
310 exclusions; priority; claims.—

311 (1) REQUIRED BENEFITS.—An insurance policy complying with  
312 the security requirements of s. 627.733 must provide personal  
313 injury protection to the named insured, relatives residing in  
314 the same household, persons operating the insured motor vehicle,  
315 passengers in the motor vehicle, and other persons struck by the  
316 motor vehicle and suffering bodily injury while not an occupant  
317 of a self-propelled vehicle, subject to subsection (2) and  
318 paragraph (4) (e), to a limit of \$10,000 in medical and  
319 disability benefits and \$5,000 in death benefits resulting from  
320 bodily injury, sickness, disease, or death arising out of the  
321 ownership, maintenance, or use of a motor vehicle as follows:

322 (a) Medical benefits.—Eighty percent of all reasonable  
323 expenses for medically necessary medical, surgical, X-ray,  
324 dental, and rehabilitative services, including prosthetic  
325 devices and medically necessary ambulance, hospital, and nursing

326 services if the individual receives initial services and care  
327 pursuant to subparagraph 1. within 14 days after the motor  
328 vehicle accident. The medical benefits provide reimbursement  
329 only for:

330 1. Initial services and care that are lawfully provided,  
331 supervised, ordered, or prescribed by a physician licensed under  
332 chapter 458 or chapter 459, a dentist licensed under chapter  
333 466, or a chiropractic physician licensed under chapter 460 or  
334 that are provided in a hospital or in a facility that owns, or  
335 is wholly owned by, a hospital. Initial services and care may  
336 also be provided by a person or entity licensed under part III  
337 of chapter 401 which provides emergency transportation and  
338 treatment.

339 2. Upon referral by a provider described in subparagraph  
340 1., followup services and care consistent with the underlying  
341 medical diagnosis rendered pursuant to subparagraph 1. which may  
342 be provided, supervised, ordered, or prescribed only by a  
343 physician licensed under chapter 458 or chapter 459, a  
344 chiropractic physician licensed under chapter 460, a dentist  
345 licensed under chapter 466, or, to the extent permitted by  
346 applicable law and under the supervision of such physician,  
347 osteopathic physician, chiropractic physician, or dentist, by a  
348 physician assistant licensed under chapter 458 or chapter 459 or  
349 an advanced practice registered nurse licensed under chapter  
350 464. Followup services and care may also be provided by the

351 following persons or entities:

352       a. A hospital or ambulatory surgical center licensed under  
353 chapter 395.

354       b. An entity wholly owned by one or more physicians  
355 licensed under chapter 458 or chapter 459, chiropractic  
356 physicians licensed under chapter 460, or dentists licensed  
357 under chapter 466 or by such practitioners and the spouse,  
358 parent, child, or sibling of such practitioners.

359       c. An entity that owns or is wholly owned, directly or  
360 indirectly, by a hospital or hospitals.

361       d. A physical therapist licensed under chapter 486, based  
362 upon a referral by a provider described in this subparagraph.

363       e. A health care clinic licensed under part X of chapter  
364 400 which is accredited by an accrediting organization whose  
365 standards incorporate comparable regulations required by this  
366 state, or

367           (I) Has a medical director licensed under chapter 458,  
368 chapter 459, or chapter 460;

369           (II) Has been continuously licensed for more than 3 years  
370 or is a publicly traded corporation that issues securities  
371 traded on an exchange registered with the United States  
372 Securities and Exchange Commission as a national securities  
373 exchange; and

374           (III) Provides at least four of the following medical  
375 specialties:

- 376 (A) General medicine.
- 377 (B) Radiography.
- 378 (C) Orthopedic medicine.
- 379 (D) Physical medicine.
- 380 (E) Physical therapy.
- 381 (F) Physical rehabilitation.
- 382 (G) Prescribing or dispensing outpatient prescription
- 383 medication.
- 384 (H) Laboratory services.

385 3. Reimbursement for services and care provided in  
 386 subparagraph 1. or subparagraph 2. up to \$10,000 if a physician  
 387 licensed under chapter 458 or chapter 459, a dentist licensed  
 388 under chapter 466, a physician assistant licensed under chapter  
 389 458 or chapter 459, or an advanced practice registered nurse  
 390 licensed under chapter 464 has determined that the injured  
 391 person had an emergency medical condition.

392 4. Reimbursement for services and care provided in  
 393 subparagraph 1. or subparagraph 2. is limited to \$2,500 if a  
 394 provider listed in subparagraph 1. or subparagraph 2. determines  
 395 that the injured person did not have an emergency medical  
 396 condition.

397 5. Medical benefits do not include massage therapy as  
 398 defined in s. 480.033 or acupuncture as defined in s. 457.102,  
 399 regardless of the person, entity, or licensee providing massage  
 400 therapy or acupuncture, and a licensed massage therapist or

401 licensed acupuncturist may not be reimbursed for medical  
402 benefits under this section.

403         6. The Financial Services Commission shall adopt by rule  
404 the form that must be used by an insurer and a health care  
405 provider specified in sub-subparagraph 2.b., sub-subparagraph  
406 2.c., or sub-subparagraph 2.e. to document that the health care  
407 provider meets the criteria of this paragraph. Such rule must  
408 include a requirement for a sworn statement or affidavit.

409

410 Only insurers writing motor vehicle liability insurance in this  
411 state may provide the required benefits of this section, and  
412 such insurer may not require the purchase of any other motor  
413 vehicle coverage other than the purchase of property damage  
414 liability coverage as required by s. 627.7275 as a condition for  
415 providing such benefits. Insurers may not require that property  
416 damage liability insurance in an amount greater than \$10,000 be  
417 purchased in conjunction with personal injury protection. Such  
418 insurers shall make benefits and required property damage  
419 liability insurance coverage available through normal marketing  
420 channels. An insurer writing motor vehicle liability insurance  
421 in this state who fails to comply with such availability  
422 requirement as a general business practice violates part IX of  
423 chapter 626, and such violation constitutes an unfair method of  
424 competition or an unfair or deceptive act or practice involving  
425 the business of insurance. An insurer committing such violation

426 | is subject to the penalties provided under that part, as well as  
427 | those provided elsewhere in the insurance code.

428 |       Section 20. Subsection (37) of section 641.31, Florida  
429 | Statutes, is amended to read:

430 |           641.31 Health maintenance contracts.—

431 |           (37) All health maintenance contracts that provide  
432 | coverage for massage must also cover the services of persons  
433 | licensed to practice massage therapy pursuant to chapter 480 if  
434 | the massage is prescribed by a contracted physician licensed  
435 | under chapter 458, chapter 459, chapter 460, or chapter 461 as  
436 | medically necessary and the prescription specifies the number of  
437 | treatments. Such massage services are subject to the same terms,  
438 | conditions, and limitations as those of other covered services.

439 |       Section 21. 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		

1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Goff-Marcil offered the following:

4  
5 **Amendment**

6 Remove lines 47-107 and insert:

7 Section 1. Section 480.033, Florida Statutes, is amended  
8 to read:

9 480.033 Definitions.—As used in this act:

10 (1) "Board" means the Board of Massage Therapy.

11 ~~(2)(9)~~ "Board-approved massage therapy school" means a  
12 facility that meets minimum standards for training and  
13 curriculum as determined by rule of the board and that is  
14 licensed by the Department of Education pursuant to chapter 1005  
15 or the equivalent licensing authority of another state or is  
16 within the public school system of this state or a college or

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17 university that is eligible to participate in the William L.  
18 Boyd, IV, Effective Access to Student Education Grant Program.

19 ~~(3)-(6)~~ "Colon hydrotherapy" "~~Colonic irrigation~~" means a  
20 method of hydrotherapy used to cleanse the colon with the aid of  
21 a mechanical device and water.

22 ~~(4)-(5)~~ "Colon hydrotherapy apprentice" means a person  
23 approved by the board to study colon irrigation ~~massage~~ under  
24 the instruction of a licensed massage therapist practicing  
25 colonic irrigation.

26 ~~(5)-(2)~~ "Department" means the Department of Health.

27 ~~(6)-(11)~~ "Designated establishment manager" means a massage  
28 therapist who holds a clear and active license without  
29 restriction, who is responsible for the operation of a massage  
30 establishment in accordance with the provisions of this chapter,  
31 and who is designated the manager by the rules or practices at  
32 the establishment.

33 (7) "Establishment" or "massage establishment" means a  
34 site or premises, or portion thereof, wherein a massage  
35 therapist practices massage therapy.

36 ~~(8)-(10)~~ "Establishment owner" means a person who has  
37 ownership interest in a massage establishment. The term includes  
38 an individual who holds a massage establishment license, a  
39 general partner of a partnership, an owner or officer of a  
40 corporation, and a member of a limited liability company and its  
41 subsidiaries who holds a massage establishment license.

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Amendment No. 1

42        ~~(9)-(8)~~ "Licensure" means the procedure by which a person,  
43 hereinafter referred to as a "practitioner," applies to the  
44 board for approval to practice massage or to operate an  
45 establishment.

46        ~~(10)-(3)~~ "Massage therapy" means the manipulation of the  
47 soft tissues of the human body with the hand, foot, knee, arm,  
48 or elbow, regardless of whether ~~or not~~ such manipulation is  
49 aided by hydrotherapy, including colonic irrigation, or thermal  
50 therapy; any electrical or mechanical device; or the application  
51 to the human body of a chemical or herbal preparation.

52        ~~(11)-(4)~~ "Massage therapist" means a person licensed as  
53 required by this act, who performs massage therapy, including  
54 massage therapy assessment ~~administers massage~~ for compensation.

55        (12) "Massage therapy assessment" means the determination  
56 of the course of massage therapy treatment.

57        Section 2. Subsections (1), (2), and (4) of section  
58 480.041, Florida Statutes, are amended, and subsection (8) is  
59 added to that section, to read:

60        480.041 Massage therapists; qualifications; licensure;  
61 endorsement.—

62        (1) Any person is qualified for licensure as a massage  
63 therapist under this act who:

64        (a) Is at least 18 years of age or has received a high  
65 school diploma or high school equivalency diploma;

## Amendment No. 1

66 (b) Has completed a course of study at a board-approved  
67 massage therapy school ~~or has completed an apprenticeship~~  
68 ~~program that meets standards adopted by the board;~~ and

69 (c) Has received a passing grade on a national an  
70 examination designated administered by the board department.

71 (2) Every person desiring to be examined for licensure as  
72 a massage therapist must ~~shall~~ apply to the department in  
73 writing upon forms prepared by the board and furnished by the  
74 department. Such applicants are ~~shall be~~ subject to ~~the~~  
75 ~~provisions of s. 480.046(1). Applicants may take an examination~~  
76 ~~administered by the department only upon meeting the~~  
77 ~~requirements of this section as determined by the board.~~

78 (4) Upon an applicant's passing the examination and paying  
79 the initial licensure fee, the department shall issue to the  
80 applicant a license, valid until the next scheduled renewal  
81 date, to practice massage therapy.

82 (8) A person issued a license as a massage apprentice  
83 before July 1, 2020, may continue that apprenticeship and  
84 perform massage therapy as authorized under that license until  
85 it expires. Upon completion of the apprenticeship, which must  
86 occur before July 1, 2023, a massage apprentice may apply to the  
87 board for full licensure and be granted a license if all other  
88 applicable licensure requirements are met.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 1373 Long-Term Care  
**SPONSOR(S):** Health Market Reform Subcommittee, Webb  
**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	Grabowski	Calamas
2) Health & Human Services Committee		Grabowski	Calamas

### SUMMARY ANALYSIS

The Statewide Medicaid Managed Care (SMMC) program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. The SMMC program is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds. Within the SMMC program, the Long-Term Care Managed Care (LTC) program provides services to frail elderly or disabled Medicaid recipients in nursing facilities and in community settings, including an individual's home, an assisted living facility, or an adult family care home.

An individual seeking services under the LTC programs must undergo an initial needs screening by the Department of Elderly Affairs (DOEA) to demonstrate the individual's level of frailty. The screening collects basic information on general health and any assistance the individual needs with activities of daily living. Based on the screening, the individual receives a priority score, which indicates the individual's level of need for services and frailty. Using the priority score, the DOEA then places the individual on a statewide waitlist. Many people on the waitlist have low priority scores, so are not eligible to receive LTC services.

CS/HB 1373 provides additional flexibility to DOEA regarding the composition of the LTC waitlist. The bill requires DOEA to place individuals with high priority scores of on the waitlist, consistent with current practice. DOEA may add individuals with low priority scores, but is not required to do so. The bill requires annual rescreening of individuals with high priority scores, in keeping with current practice, but makes annual rescreening optional for individuals with low priority scores. The bill directs screening staff to inform individuals with low priority scores of alternative community resources that may be available and that the individual may request rescreening at any time if their circumstances change.

The Community Care for the Elderly (CCE) program is a non-Medicaid program that provides community-based services in a continuum of care to help elders with functional impairments to live in the least restrictive and most cost-effective environment suitable to their needs. The program prioritizes applicants based on needs and frailty, and prioritizes individuals referred for services by Adult Protective Services (APS).

The bill also modifies service prioritization procedures under the CCE program. The bill stipulates that a provider of CCE services may dispute an APS referral by requesting that APS negotiate or modify the referral of a vulnerable adult or victim of abuse, neglect, or exploitation.

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

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

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### **Background**

##### Statewide Medicaid Managed Care

The Statewide Medicaid Managed Care (SMMC) program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.<sup>1</sup> The SMMC program is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds.<sup>2</sup> Eligibility for the SMMC program is determined by the Department of Children and Families (DCF).<sup>3</sup>

Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees. The Long-Term Care Managed Care (LTC) Program provides services to frail elderly or disabled Medicaid recipients in nursing facilities and in community settings, including an individual's home, an assisted living facility, or an adult family care home.

##### *Long-Term Care Program*

The LTC Program provides long term care services, including nursing facility and home and community based services, to eligible Medicaid recipients.

Federal law requires state Medicaid programs to provide nursing facility services to individuals, age 21 or older, and in need of nursing facility care.<sup>4</sup> States are prohibited from limiting access to nursing facility services, but the provision of home and community based services is optional.<sup>5</sup> Home and community based services in Florida are delivered through a federal 1915(c), home and community based services waiver.<sup>6</sup> The waiver establishes that home and community based LTC services are available to qualified recipients, but subject to an enrollment cap determined by the availability of funding. As such, the LTC program is managed based on a priority enrollment system and a waitlist.

As of December 31, 2019, there were 116,507 individuals enrolled in the LTC Program, including 65,822 individuals enrolled in the home and community based services portion of the LTC Program, and 50,685 individuals enrolled in the nursing facility services portion of the LTC Program.<sup>7</sup>

Long-term care plans are required to, at a minimum, cover the following:

- Nursing facility care;
- Services provided in assisted living facilities;
- Hospice;
- Adult day care;

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<sup>1</sup> This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.

<sup>2</sup> S. 409.963, F.S.

<sup>3</sup> Id.

<sup>4</sup> 42 C.F.R. §483p(b).

<sup>5</sup> Medicaid.gov, *Nursing Facilities*, available at <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html> (last accessed January 24, 2020).

<sup>6</sup> S. 409.906(13), F.S.

<sup>7</sup> Agency for Health Care Administration, *SMMC LTC Enrollment by County/Plan Report* (as of December 31, 2019), available at [http://ahca.myflorida.com/Medicaid/Finance/data\\_analytics/enrollment\\_report/index.shtml](http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml) (last accessed January 24, 2020).

- Medical equipment and supplies, including incontinence supplies;
- Personal care;
- Home accessibility adaptation;
- Behavior management;
- Home-delivered meals;
- Case Management;
- Occupation therapy;
- Speech therapy;
- Respiratory therapy;
- Physical therapy;
- Intermittent and skilled nursing;
- Medication administration;
- Medication Management;
- Nutritional assessment and risk reduction;
- Caregiver training;
- Respite care;
- Transportation; and
- Personal emergency response systems.<sup>8</sup>

### *LTC Program Eligibility*

To be eligible for the LTC Program, an individual must:

- Be age 65 or older and eligible for Medicaid, or age 18 or older and eligible for Medicaid by reason of a disability;
- Have annual income at or below 222% of the federal poverty level (FPL)<sup>9</sup>; and,
- Be in need of nursing home care, as determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program.<sup>10</sup>

In addition, an individual seeking Medicaid eligibility must demonstrate that he or she meets limits on personal assets. Both federal and state law set parameters for Medicaid LTC eligibility based on personal property, such as a home or vehicle, and on financial assets, such as bank accounts, stocks and bonds, and life insurance policies.<sup>11</sup> Life insurance policies with a cash value greater than \$1,500 may not be retained by individuals seeking Medicaid eligibility. Generally, assets above certain cash thresholds must be divested at least 60 months prior to a period of Medicaid eligibility.<sup>12</sup>

When determining the need for nursing facility care, DOEA considers the nature of the services prescribed, the level of nursing or other health care personnel necessary to provide such services, and the availability of and access to community or alternative resources.<sup>13</sup> Imminent risk of nursing home placement can be evidenced by the need for medical observation throughout a 24-hour period and the need for care performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional. An individual at risk of nursing home care requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation.<sup>14</sup>

<sup>8</sup> S. 409.98, F.S.

<sup>9</sup> This equates to \$28,327 for an individual and \$38,273 for a family of two. U.S. Department of Health and Human Services, *HHS Poverty Guidelines for 2020*, January 8, 2020, available at <https://aspe.hhs.gov/poverty-guidelines> (last accessed January 27, 2020).

<sup>10</sup> S. 409.979(1), F.S.

<sup>11</sup> U.S. Department of Health and Human Services, *Financial Requirements – Assets*, available at <https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets.html> (last accessed January 26, 2020).

<sup>12</sup> 42 U.S.C. §1396p. See also Agency for Health Care Administration, *Medicaid State Plan Attachments – Eligibility Conditions and Requirements*, available at [https://ahca.myflorida.com/medicaid/stateplan\\_attach.shtml](https://ahca.myflorida.com/medicaid/stateplan_attach.shtml) (last accessed January 26, 2020).

<sup>13</sup> S. 409.985(3), F.S.

<sup>14</sup> S. 409.985(3), F.S.

## *LTC Program Enrollment*

The Department of Elder Affairs (DOEA) administers programs and services for elders through 11 Area Agencies on Aging (AAAs), which also operate Aging and Disability Resource Centers (ADRCs). The ADRCs provide information and referral services to individuals seeking long-term care services, and also screen individuals for eligibility for long-term care services.

The LTC Program enrollment process is administered by DOEA, DCF, and AHCA. An individual in need of services or seeking services must contact the appropriate ADRC to request a screening. The screening is intended to provide the ADRC with information describing the individual's level of frailty. During the screening, the ADRC gathers basic information about the individual, including general health information and any assistance the individual needs with activities of daily living. Based on the screening, the individual receives a priority score, which indicates the level of need for services and reflects the level of the individual's frailty. Using the priority score, the individual is then placed on the waitlist. An individual seeking LTC services may request a rescreening any time his or her circumstances change. In addition, ADRC staff are required to rescreen waitlisted individuals on an annual basis.<sup>15</sup>

The prioritization of the waitlist is not described in statute, but rather in administrative rule promulgated by AHCA.<sup>16</sup> The rule sets five frailty-based levels based on the priority score calculation by DOEA. The levels rank the individual's level of need in ascending order, meaning that an individual with a priority score of "1" has very low needs and an individual with a priority score of "5" has very high needs.

When funding becomes available, the frailest individuals are taken off the waitlist first, based upon priority score. The individual must then go through a comprehensive face-to-face assessment conducted by the local CARES staff.<sup>17</sup> After CARES confirms the medical eligibility of the individual, DCF determines the financial eligibility of the individual. If approved for both medical and financial eligibility, AHCA must notify the individual and provide information on selecting a long-term care plan.

It is DOEA's current practice to add any individual who completes the initial needs screening to the wait list, even if he or she has very limited service needs and is unlikely to qualify for services in the future. This approach may be confusing to individuals with low priority scores, giving the impression that they qualify for services, and that services will become available at some point in time. In practice, only individuals with high priority scores will receive services. Current law stipulates an individual may request a rescreening any time his or her circumstances change, which allows individuals with low priority scores the ability to move up the waitlist if need can be demonstrated.

### Community Care for the Elderly

The Community Care for the Elderly (CCE) program is a non-Medicaid program that provides community-based services in a continuum of care to help elders with functional impairments to live in the least restrictive and most cost-effective environment suitable to their needs.<sup>18</sup>

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<sup>15</sup> S. 409.979(3), F.S.

<sup>16</sup> Rule 59G-4.193, F.A.C.

<sup>17</sup> Florida Department of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, available at <http://elderaffairs.state.fl.us/doea/cares.php> (last accessed January 24, 2020). Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants. A registered nurse or assessor performs client assessments. A physician or registered nurse reviews each application to determine the level of care that is most appropriate for the applicant. The assessment identifies long-term care needs, and establishes the appropriate level of care (medical eligibility for nursing facility care), and recommends the least restrictive, most appropriate placement. Federal law also mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through Medicaid waivers.

<sup>18</sup> S. 430.202, F.S.

The CCE program provides a wide range of services to clients, depending on client needs. These services include, but are not limited to, adult day care, chore assistance, counseling, home-delivered meals, home nursing, legal assistance, material aid, medical therapeutic services, personal care, respite, transportation, and other community-based services.<sup>19</sup>

The DOEA administers the program through contracts with AAAs, which subcontract with CCE Lead Agencies. Service delivery is provided by 52 Lead Agencies around the state. The CCE program is funded by a combination of state general revenue and client contributions. Clients are assessed a co-payment based on a sliding scale developed by the DOEA.<sup>20</sup>

To be eligible for the CCE program, an individual must be age 60 or older and functionally impaired<sup>21</sup>, as determined by an initial comprehensive assessment and annual reassessments. Primary consideration for services is given to elders referred by the Department of Children and Families Adult Protective Services (APS) program and determined by APS to be victims of abuse, neglect, or exploitation and in need of immediate services to prevent further harm.<sup>22</sup> Individuals not referred by APS may still receive services, but according to a prioritization which is based upon the potential recipient's frailty level and likelihood of institutional placement. Still, the required prioritization of individuals referred by APS may limit the ability of the CCE program to provide services to other populations using available state funding. The DOEA is also required to consider an applicant's income when prioritizing services – those less able to pay for services must receive higher priority than those with a greater ability to pay for services.<sup>23</sup>

## **Effect of Proposed Changes**

### Medicaid LTC Enrollment

CS/HB 1373 provides additional flexibility to DOEA regarding the composition of the LTC waitlist. The bill requires that DOEA continue to place individuals with high priority scores of on the waitlist in accordance with established policy. However, it authorizes DOEA not to add individuals with low priority scores to the waitlist, at its discretion. The bill requires annual rescreening of individuals with high priority scores, in keeping with current practice, but makes annual rescreening optional for individuals with low priority scores.

The bill requires DOEA to maintain contact information for individuals with low priority scores, should those individuals seek rescreening in the future. The bill also directs ARDC staff to inform individuals with low priority scores of alternative community resources that may be available and that the individual may request rescreening at any time if their circumstances change.

### Community Care for the Elderly

The bill also modifies service prioritization procedures under the CCE program. Current law requires CCE Lead Agencies to prioritize individuals referred for services by APS. The bill stipulates that a provider of CCE service may dispute such a referral by requesting that APS negotiate or modify the referral of a vulnerable adult or victim of abuse, neglect, or exploitation. In cases where the CCE service provider and APS cannot come to an agreement on the disputed referral, the APS recommendation prevails.

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

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<sup>19</sup> Florida Department of Elderly Affairs, *2019 Summary of Programs and Services – Section C: State General Revenue Programs*, January 2019, available at <http://elderaffairs.state.fl.us/doea/sops.php> (last accessed January 28, 2020).

<sup>20</sup> *Id.*

<sup>21</sup> S. 430.203(7), F.S.

<sup>22</sup> S. 430.205(5)(a), F.S.

<sup>23</sup> S. 430.205(5)(b), F.S.



**B. SECTION DIRECTORY:**

- Section 1:** Amends s. 409.979, F.S., relating to eligibility.
- Section 2:** Amends s. 430.205, F.S., relating to community care service system.
- Section 3:** Provides an effective date of July 1, 2020.

**II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT**

**A. FISCAL IMPACT ON STATE GOVERNMENT:**

- 1. Revenues:  
None.
- 2. Expenditures:  
None.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

- 1. Revenues:  
None.
- 2. Expenditures:  
None.

**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 AHCA has adequate rule-making authority to implement the bill.

**C. DRAFTING ISSUES OR OTHER COMMENTS:**

None.

#### **IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

On January 28, 2020, the Health Market Reform Subcommittee adopted a strike-all amendment to the bill. The amendment:

- Eliminates a requirement for the Office of Program Policy Analysis and Government Accountability to conduct a study on the feasibility of modifying state Medicaid eligibility criteria for LTC services;
- Provides flexibility to DOEA regarding the composition of the LTC waitlist;
- Requires DOEA to annually rescreen individuals with high priority scores on the initial needs assessment, while making annual rescreening optional for individuals with low priority scores; and,
- Establishes the ability of service providers to dispute APS referrals to the CCE program.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

1                                   A bill to be entitled  
2           An act relating to long-term care; amending s.  
3           409.979, F.S.; requiring aging resource centers to  
4           annually rescreen certain individuals with high  
5           priority scores for purposes of the statewide wait  
6           list for enrollment for home and community-based  
7           services; authorizing such centers to administer  
8           rescreening for certain individuals with low priority  
9           scores; requiring the Department of Elderly Affairs to  
10          maintain contact information for individuals with low  
11          priority scores for rescreening purposes; requiring  
12          aging resource centers to inform such individuals of  
13          community resources; amending s. 430.205, F.S.;  
14          authorizing community-care-for-the-elderly services  
15          providers to dispute certain referrals; providing that  
16          a referral decision by adult protective service  
17          prevails; providing an effective date.

18  
19   Be It Enacted by the Legislature of the State of Florida:

20  
21           Section 1. Paragraphs (a) and (b) of subsection (3) of  
22           section 409.979, Florida Statutes, are amended to read:

23           409.979 Eligibility.—

24           (3) WAIT LIST, RELEASE, AND OFFER PROCESS.—The Department  
25           of Elderly Affairs shall maintain a statewide wait list for

26 enrollment for home and community-based services through the  
27 long-term care managed care program.

28 (a) The Department of Elderly Affairs shall prioritize  
29 individuals for potential enrollment for home and community-  
30 based services through the long-term care managed care program  
31 using a frailty-based screening tool that results in a priority  
32 score. The priority score is used to set an order for releasing  
33 individuals from the wait list for potential enrollment in the  
34 long-term care managed care program. If capacity is limited for  
35 individuals with identical priority scores, the individual with  
36 the oldest date of placement on the wait list shall receive  
37 priority for release.

38 1. Pursuant to s. 430.2053, aging resource center  
39 personnel certified by the Department of Elderly Affairs shall  
40 perform the screening for each individual requesting enrollment  
41 for home and community-based services through the long-term care  
42 managed care program. The Department of Elderly Affairs shall  
43 request that the individual or the individual's authorized  
44 representative provide alternate contact names and contact  
45 information.

46 2. The individual requesting the long-term care services,  
47 or the individual's authorized representative, must participate  
48 in an initial screening or rescreening for placement on the wait  
49 list. The screening or rescreening must be completed in its  
50 entirety before placement on the wait list.

51 3. Pursuant to s. 430.2053, aging resource center  
52 personnel shall administer rescreening annually or upon  
53 notification of a significant change in an individual's  
54 circumstances for an individual with a high priority score.  
55 Aging resource center personnel may administer rescreening  
56 annually or upon notification of a significant change in an  
57 individual's circumstances for an individual with a low priority  
58 score.

59 4. The Department of Elderly Affairs shall adopt by rule a  
60 screening tool that generates the priority score, and shall make  
61 publicly available on its website the specific methodology used  
62 to calculate an individual's priority score.

63 (b) Upon completion of the screening or rescreening  
64 process, the Department of Elderly Affairs shall notify the  
65 individual or the individual's authorized representative that  
66 the individual has been placed on the wait list, unless the  
67 individual has a low priority score. The Department of Elderly  
68 Affairs must maintain contact information for each individual  
69 with a low priority score for purposes of any future  
70 rescreening. Aging resource center personnel shall inform  
71 individuals with low priority scores of community resources  
72 available to assist them and inform them that they may contact  
73 the aging resource center for a new assessment at any time if  
74 they experience a change in circumstances.

75 Section 2. Paragraph (a) of subsection (5) of section

76 | 430.205, Florida Statutes, is amended to read:

77 |       430.205 Community care service system.—

78 |       (5) Any person who has been classified as a functionally  
79 | impaired elderly person is eligible to receive community-care-  
80 | for-the-elderly core services.

81 |       (a) Those elderly persons who are determined by protective  
82 | investigations to be vulnerable adults in need of services,  
83 | pursuant to s. 415.104(3)(b), or to be victims of abuse,  
84 | neglect, or exploitation who are in need of immediate services  
85 | to prevent further harm and are referred by the adult protective  
86 | services program, shall be given primary consideration for  
87 | receiving community-care-for-the-elderly services. As used in  
88 | this paragraph, "primary consideration" means that an assessment  
89 | and services must commence within 72 hours after referral to the  
90 | department or as established in accordance with department  
91 | contracts by local protocols developed between department  
92 | service providers and the adult protective services program.  
93 | Regardless, a community-care-for-the-elderly services provider  
94 | may dispute a referral under this paragraph by requesting that  
95 | adult protective services negotiate the referral placement of,  
96 | and the services to be provided to, a vulnerable adult or victim  
97 | of abuse, neglect, or exploitation. If an agreement cannot be  
98 | reached with adult protective services for modification of the  
99 | referral decision, the determination by adult protective  
100 | services shall prevail.

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





## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7017      PCB HQS 20-01      Advanced Practice Registered Nurses' Registration Fees  
**SPONSOR(S):** Health Quality Subcommittee, Plasencia  
**TIED BILLS:** CS/HB 607      **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Quality Subcommittee	14 Y, 0 N	Siples	McElroy
1) Health Care Appropriations Subcommittee	11 Y, 0 N	Mielke	Clark
2) Health & Human Services Committee		Siples	Calamas

### SUMMARY ANALYSIS

CS/HB 607 authorizes the Department of Health (DOH) to register advanced practice registered nurses (APRNs), who meet certain criteria, to engage in autonomous practice, enabling the APRN to perform advanced or specialized nursing acts without a supervisory protocol or supervision by a physician. Currently, APRNs may only practice pursuant to a written protocol with a licensed physician.

HB 7017, which is linked to CS/HB 607, authorizes DOH to charge a registration fee not to exceed \$100 for APRNs seeking to engage in autonomous practice. The bill also authorizes a biennial renewal fee not to exceed \$50. These fees are in addition to those for initial licensure and licensure renewal.

The bill will have an indeterminate positive fiscal impact on DOH.

The bill will be effective on the same date that CS/HB 607 or similar legislation takes effect.

**This bill authorizes a new state fee, requiring a two-thirds vote of the membership of the House. See Section III.A.2. of the analysis.**

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### Current Situation

##### Legislation Imposing or Raising State Fees or Taxes

The Florida Constitution provides that no state tax or fee may be imposed, authorized, or raised by the Legislature except through legislation approved by two-thirds of the membership of each house of the Legislature.<sup>1</sup> For purposes of this requirement, a “fee” is any charge or payment required by law, including any fee or charge for services and fees or costs for licenses and to “raise” a fee or tax means to:<sup>2</sup>

- Increase or authorize an increase in the rate of a state tax or fee imposed on a percentage or per mill basis;
- Increase or authorize an increase in the amount of a state tax or fee imposed on a flat or fixed amount basis; or
- Decrease or eliminate a state tax or fee exemption or credit.

A bill that imposes, authorizes, or raises any state fee or tax may only contain the fee or tax provision(s) and may not contain any other subject.<sup>3</sup>

The constitutional provision does not authorize any state tax or fee to be imposed if it is otherwise prohibited by the constitution and does not apply to any tax or fee authorized or imposed by a county, municipality, school board, or special district.<sup>4</sup>

##### Health Practitioner Licensure Fees

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.<sup>5</sup> The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions.<sup>6</sup> Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

Under current law, the costs of regulation of health care practitioners must be borne by the licensees and licensure applicants.<sup>7</sup> Regulatory boards, in consultation with DOH, must set renewal fees by rule that must be:<sup>8</sup>

- Based on revenue projections prepared using generally accepted accounting practices;
- Adequate to cover all expenses relating to that board;

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<sup>1</sup> Fla. Const. art. VII, s. 19(a)-(b). The amendment appeared on the 2018 ballot as Amendment 5.

<sup>2</sup> Fla. Const. art. VII, s. 19(d).

<sup>3</sup> Fla. Const. art. VII, s. 19(e).

<sup>4</sup> Fla. Const. art. VII s. 19(c).

<sup>5</sup> 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.

<sup>6</sup> 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](http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf) (last visited February 20, 2020).

<sup>7</sup> Section 456.025(1), F.S.

<sup>8</sup> *Id.*

- Reasonable, fair, and not serve as a barrier to licensure;
- Be based on potential earnings from working under the scope of the license;
- Similar to fees imposed on similar licensure types; and
- No more than 10 percent greater than the actual cost to regulate that profession for the previous biennium.

### Registration of an Advanced Practice Registered Nurse to Practice Independently

Under current law, advanced practice registered nurses (APRNs) in Florida must practice under a supervising protocol with a physician and only to the extent that a written protocol allows. CS/HB 607 authorizes APRNs who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol.

Currently, APRNs must pay an initial licensure fee of \$110 and a renewal fee of \$50.<sup>9</sup> Current fee collections may be inadequate to cover the additional regulatory requirements for APRNs who opt to practice without physician supervision or a protocol. CS/HB 607 requires such APRNs to register with the Board of Nursing.

### Effect of Proposed Legislation

HB 7017, which is linked to CS/HB 607, authorizes the Board of Nursing to establish a registration fee of up to \$100 and a biennial registration renewal fee of up to \$50 for APRNs who meet the criteria to practice without physician supervision or a protocol. These fees are in addition to those for initial licensure and renewal.

The bill becomes effective on the same date as CS/HB 607 or similar legislation.

#### B. SECTION DIRECTORY:

**Section 1:** Amends s. 464.0123, F.S., relating to advanced practice registered nurses; creating a fee.

**Section 2:** Provides an effective date of the same date that HB 607 or similar legislation takes effect.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

#### A. FISCAL IMPACT ON STATE GOVERNMENT:

##### 1. Revenues:

APRN applicants for registration to practice autonomously must pay an initial registration fee of up to \$100 and a biennial registration renewal fee of up to \$50. The total amount of revenue DOH will receive from such fees is indeterminate because the number of APRNs who will choose to register is not predictable.

##### 2. Expenditures:

DOH and the Board of Nursing will incur costs associated with the regulation of registrants. However, the registration fees authorized by the bill will be sufficient to cover the cost of regulation.

#### B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

##### 1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

APRN applicants for registration to practice without a supervisory protocol will have to pay an application fee and a biennial registration renewal fee. The bill authorizes the Board of Nursing to set the application and biennial renewal fees, but they may not exceed \$100 and \$50, respectively.

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:

Article VII, s. 19 of the Florida Constitution requires the imposition, authorization, or raising of a state tax or fee be contained in a separate bill that contains no other subject and be approved by two-thirds of the membership of each house of the Legislature. As such, the bill appears to implicate Art. VII, s. 19 of the Florida Constitution because the bill authorizes a state fee.

B. RULE-MAKING AUTHORITY:

The Board of Nursing has sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

### IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

HB 7017

2020

1                   A bill to be entitled  
2           An act relating to advanced practice registered  
3           nurses' registration fees; amending s. 464.0123, F.S.;  
4           requiring the Board of Nursing to establish  
5           registration and biennial renewal fees for advanced  
6           practice registered nurses to engage in autonomous  
7           practice; providing a contingent effective date.  
8

9   Be It Enacted by the Legislature of the State of Florida:  
10

11           Section 1. Subsection (9) of section 464.0123, Florida  
12           Statutes, as created by CS/HB 607, 2020 Regular Session, is  
13           renumbered as subsection (10), and a new subsection (9) is added  
14           to that section to read:

15           464.0123 Autonomous practice by an advanced practice  
16           registered nurse.—

17           (9) The board shall establish a registration fee not to  
18           exceed \$100 and a biennial renewal fee not to exceed \$50.

19           Section 2. This act shall take effect on the same date  
20           that CS/HB 607 or similar legislation takes effect, if such  
21           legislation is adopted in the same legislative session or an  
22           extension thereof and becomes a law.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7085      PCB CFS 20-03      Dependency Proceedings and Child Protection Services  
**SPONSOR(S):** Children, Families & Seniors Subcommittee, Roth  
**TIED BILLS:**                      **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	9 Y, 4 N	Woodruff	Brazzell
1) 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. When DCF decides that a child needs to be removed from an unsafe home, a series of dependency court proceedings must occur. The dependency process includes, among other things, 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.

Having both parents involved in the dependency process necessary because they are parties to the case and entitled due process and notice before judicial action may be taken. During the dependency process, it is important for the court to determine the dependent child's father so that person can receive a case plan and work towards its successful completion, or terminate his parental rights so the child can be adopted.

HB 7085 amends various statutes to require the court to establish paternity early in the dependency case, require DCF to file a case plan with the court and serve it to all parties within a specific timeframe, and allows the court to terminate parental rights faster when a parent is a registered sexual predator.

The bill also makes the adoption process more efficient for dependent minors by removing a duplicative administrative review hearing from the adoption process, requires a preliminary homestudy for all prospective parents, and creates a court process for children with deceased parents to be adopted but continue to receive their deceased parents' benefits.

Further, the bill gives statutory responsibility to DCF to adopt rules for the registration of qualified evaluators who assess residential placement for children, rather than the Agency for Health Care Administration. The bill also amends the definition of "Guardian ad Litem" to include the Statewide Guardian ad Litem Office and removes mandated reports that are no longer necessary.

The bill has a significant, positive fiscal impact on state government, and no fiscal impact on local government.

The bill has 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.<sup>1</sup> 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.<sup>2</sup>

##### 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.<sup>3</sup> 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.<sup>4</sup> CBCs contract with a number of subcontractors for case management and direct care services to children and their families.<sup>5</sup> There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.<sup>6</sup>

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<sup>1</sup> S. 39.001, F.S.

<sup>2</sup> S. 39.001(4), F.S.

<sup>3</sup> Florida Department of Children and Families, *Community-Based Care*, <https://www.myflfamilies.com/service-programs/community-based-care/> (last visited Jan. 14, 2020).

<sup>4</sup> S. 409.145(1), F.S.

<sup>5</sup> *Id.*

<sup>6</sup> 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).



## Dependency Case Process

When child welfare necessitates that DCF remove a child from the home, a series of dependency court proceedings must occur to adjudicate the child dependent and placed in out-of-home care. 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 for the parents to address the problems resulting in their child's dependency;
- Placement in out-of-home care, if necessary; and
- Reunification with the child's parent or another option to establish permanency, such as adoption.

### **The Dependency Court Process**

<b>Dependency Proceeding</b>	<b>Description of Process</b>	<b>Controlling Statute</b>
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.

### *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.<sup>7</sup> 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.<sup>8</sup> A child protective investigation begins if the hotline determines the allegations meet the statutory definition of abuse, abandonment or neglect.<sup>9</sup>

Section 39.205(7), F.S., requires a procedure for DCF to determine whether a false hotline report has been made and to submit all identifying information relating to such report to the appropriate law enforcement agency. Any person who knowingly and willingly files a false hotline report, or advises another individual to make such a report, is guilty of a felony of the third degree as provided in ss. 775.082 and 775.083, F.S.

Current law requires DCF to submit an annual report detailing the number of false reports referred to law enforcement for consideration of a criminal investigation. This report has consistently indicated that the vast majority of hotline reports are made in good faith. Since FY 2015-16, DCF has averaged 172,500 child protective investigations per year with only 325 suspected as being initiated as a result of false reporting.<sup>10</sup> Over the past four years, that equates to only one suspected false report per approximately more than 500 investigations.<sup>11</sup> Low rates have repeatedly been reported to the Legislature since 2006.<sup>12</sup>

### *Case Plans*

Section 39.6011, F.S., requires DCF to 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 the child's temporary custodian of the child and the child, if appropriate.

Pursuant to s. 39.6011(2), F.S., 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.
- 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.

Additionally, s. 39.6011(11), F.S., requires the case plan to 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.

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<sup>7</sup> S. 39.201(5), F.S.

<sup>8</sup> S. 39.201(1)(a), F.S.

<sup>9</sup> S. 39.201(2)(a), F.S.

<sup>10</sup> Florida Department of Children and Families, Agency Analysis of 2020 House Bill 7085 (Feb. 11, 2020).

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

- 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.
- The parent's responsibility for financial support of the child.

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.<sup>13</sup>

During FY 2018-19, the court ordered a case plan at disposition for 9,186 children.<sup>14</sup> However, before the court can order parents to comply with the case plan, DCF is required to file the case plan with the court and serve a copy on all the parties. Currently, there is a conflict in law when DCF must perform these tasks.

Section 39.521(1)(a), F.S., governing disposition hearings, requires DCF to file the case plan with the court and serve a copy on the parties:

- Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60<sup>th</sup> day after the date the child was placed in out-of-home care.
- Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60<sup>th</sup> after the date the child was placed in out-of-home care and a case plan has not been submitted, or if the court does not approve the case plan at the disposition hearing. The case plan acceptance hearing must occur within 30 days after the disposition hearing for the court to review and approve the case plan.

However, s. 39.6011(7), F.S., governing case plans, requires DCF to file the case plan with the court and provide copies to all parties not less than three business days before the disposition hearing, regardless of when the disposition hearing is held.

### Paternity

A parent in a dependency action is entitled to due process and notice before judicial action may be taken. Section 39.01(56), F.S., defines "parent" to mean a woman who gives birth to a child and a man whose consent to the adoption of the child would be required. The term "parent" also means legal father.<sup>15</sup> If a child has been legally adopted, the term "parent" means the adoptive mother or father of the child.

The parents are included as parties to a dependency case. As such:

- They must be advised of their right to counsel at each stage of the dependency proceeding.<sup>16</sup>
- DCF must obtain the names of all parents and prospective parents when taking custody of a child.<sup>17</sup>
- They are provided written notice of their right to counsel and right to be heard and present evidence at the shelter hearing.<sup>18</sup>
- They are notified of every proceeding or hearing involving the child.<sup>19</sup>

<sup>13</sup> S. 39.6011(3), F.S.

<sup>14</sup> Florida Department of Children and Families, Agency Bill Analysis for Senate Bill 1548, p. 8 (Jan. 23, 2020).

<sup>15</sup> Section 39.01, F.S., defines "legal father" as a man married to the mother at the time of conception or birth of the child, unless paternity has been otherwise determined by a court of competent jurisdiction. If the mother was not married to a man at the time of birth or conception of the child, the term means a man named on the child's birth certificate, a man determined by a court order to be the father of the child, or a man determined to be the father of the child by the Department of Revenue.

<sup>16</sup> S. 39.013(9), F.S.

<sup>17</sup> S. 39.401(4), F.S.

<sup>18</sup> S. 39.402(5), F.S.

<sup>19</sup> S. 39.502(1), F.S.

- The court makes its own inquiry to discover the parent's identity when a dependency petition is filed and the parent's identity is unknown.<sup>20</sup>
- DCF conducts a diligent search to determine the parent's location when the identity of the parent is known, but his or her whereabouts are unknown.<sup>21</sup>

### *Paternity Inquiry*

When the identity and location of the legal father is unknown, ss. 39.402(8)(c), 39.503(1), and 39.803(1), F.S., require the court to inquire under oath of those present at the shelter, dependency, or termination of parental rights hearing whether they have any of the following information:

- Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.
- Whether the mother was cohabiting with a male at the probable time of conception of the child.
- Whether the mother has received payments or promises of support with respect to the child or in connection with applying for or receiving public assistance.
- Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at the time of or since conception of the child or in which the child has resided or resides.
- Whether a man is named on the birth certificate of the child.
- Whether a man has been determined by a court order to be the father of the child.
- Whether a man has been determined to be the father of the child by the Department of Revenue.

There could be a delay in court proceedings in cases where there is a legally established father because statute requires the court to treat an alleged or prospective father who is identified during the inquiry as a parent even if that person has not yet been located or, if located, fails to execute a sworn affidavit of parenthood. Such delays occur even in cases where it is not contemplated that the legal father will be disestablished and the prospective parent will be established.

Additionally, the law does not specify that the inquiry should stop after an affirmative response to any particular question, and so provides a means for any man identified through the inquiry to become a party to the proceedings and to be treated as a parent.<sup>22</sup> Just like there is no statutory requirement mandating the court to enter an order establishing paternity, there is also no statutory prohibition for the court to act on its own motion to disrupt paternity when no one has sought to disestablish a legal father. As a result, dependency court judges at times make prospective fathers parties to a dependency case even if there is a legal father, resulting in dual paternity for a child and the need to provide services to multiple "fathers" at the same time.

Current law requires DCF and the court to provide notice of hearings where the court's inquiry identifies any person as a parent or a prospective parent and conduct a diligent search if that person's location is unknown. In practice, compliance with statute has resulted in unintended consequences of delay in court proceedings when notice must be provided to a parent whose location is unknown, even after a search was previously conducted, or a diligent search must be conducted to locate a prospective father even where there is a legal father.<sup>23</sup> DCF reports that in FY 2018-19, diligent searches were performed for 2,968 children.<sup>24</sup> On average, it takes a case manager approximately 60 days to perform a diligent search and provide the results of the search to the court and DCF.<sup>25</sup>

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<sup>20</sup> S. 39.503(1), F.S.

<sup>21</sup> S. 39.503(5), F.S.

<sup>22</sup> Ss. 39.503(8) and 39.803(3), F.S.

<sup>23</sup> *Supra* note 10.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

## *Paternity Establishment*

If there is no legal father, then a diligent search for a prospective parent is appropriate to establish paternity and potentially increase the pool of relative placements for the child. Section 39.503(8), F.S., requires a prospective parent to be given an opportunity to become a party to a dependency proceeding if the inquiry and diligent search identified that person as a prospective parent. A prospective parent who files a sworn affidavit of parenthood before an adjudicatory hearing for termination of parental rights is considered a parent unless the other parent contests the determination of parenthood.

Chapter 742, F.S., concerns determination of parentage. Section 742.011, F.S., permits any woman who is pregnant or has a child, any man who has reason to believe that he is the father of a child, or any child to bring proceedings in court to determine the paternity of the child when paternity has not been established by law or otherwise. Section 742.031, F.S., requires the court to conduct a hearing on the complaint and establish paternity if the court finds the alleged father is the father of the child. Additionally, s. 742.18, F.S., allows a man to disestablish paternity or terminate a child support obligation when the male is not the biological father of the child.

Current law does not provide guidance to the court if a prospective parent files a sworn affidavit of parenthood in a dependency case or files an action under Ch. 742, F.S., after the legal father's rights have been terminated. Instead, courts get their guidance on resolving a Ch. 742, F.S., disestablishment of paternity claim from case law.

The Florida Supreme Court established the test to determine whether a biological father has standing to bring a paternity action when a child is born in an intact marriage.<sup>26</sup> The Court found that if a biological father manifests a substantial and continuing concern for the welfare of his child, he will not be precluded from bringing a paternity action even if the mother was married at the time of conception or birth.<sup>27</sup> Thereafter, the biological father must show there is a clear and compelling reason based primarily on the child's best interest to disestablish paternity of the legal father.<sup>28</sup>

## Guardianship Assistance Program

DCF's Guardianship Assistance Program (GAP) is a federally-supported program for relatives and fictive kin who care for dependent children in out-of-home care. The federal government gives states the option of using federal funds to support kinship guardianship payments for children living in the home of relative caregivers who become legal guardians.<sup>29</sup> The program became effective in Florida on July 1, 2019.

A requirement for a guardian to receive a GAP payment is the identification of a successor guardian in the event the current guardian can no longer take care of the child.<sup>30</sup> To be deemed a successor guardian, an individual must be selected by the child's initial guardian and complete background screening. Successor guardians are intended to maintain a relationship with the child while the child is placed with the initial guardian, thus giving them a relationship to the child. For a successor guardian to receive a GAP payment, the individual must complete background checks and have the child placed in the custody of the caregiver for six months. This requires the child to be placed back in the custody of DCF for six months before permanent placement with the successor guardian.

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<sup>26</sup> *Simmonds v. Perkins*, 247 So. 3d 397 (Fla. 2018)

<sup>27</sup> *Id.*

<sup>28</sup> *Dep't of Health & Rehab. Servs. v. Privette*, 617 So. 2d 305, 308 (Fla. 1993).

<sup>29</sup> Mark F. Testa and Leslie Cohen, *Pursuing Permanence for Children in Foster Care: Issues and Options for Establishing a Federal Guardianship Assistance Program in New York State*, School of Social Work, The University of North Carolina at Chapel Hill, (June 2010), <http://ocfs.ny.gov/main/report/Pursuing%20Permanence%20for%20Children%20in%20Foster%20Care%20June%202010.pdf> (last visited Feb. 2, 2010).

<sup>30</sup> 42 U.S.C. § 673(b)(1)(d)

## Suitability Assessments for Children in Residential Care

Section 39.407, F.S., provides a process for assessing a child in DCF's custody for suitability for residential mental health treatment. This assessment must be conducted by a qualified evaluator who evaluates whether:

- The child appears to have an emotional disturbance serious enough to require treatment.
- The child has had the treatment explained to him or her.
- There are no less restrictive placements available.

Current law requires the Agency for Health Care Administration (AHCA) to appoint qualified evaluators. In 2016, the Legislature required AHCA to assign all rights, obligations, and other interest under the contract pertaining to qualified evaluator to DCF.<sup>31</sup> However, the Legislature did not amend s. 39.407(6)(b), F.S., to reflect this change, and thus the statute still requires AHCA to appoint the qualified evaluators. AHCA continues to have statutory authority to adopt rules for the registration of and fee schedule for qualified evaluators.

## Termination of Parental Rights and Requirements for Reasonable Efforts

Beginning with the Adoption Assistance and Child Welfare Act of 1980,<sup>32</sup> federal law has required states to show they have made "reasonable efforts" to provide assistance and services to prevent a child's removal or to reunify a child with his or her family prior to terminating parental rights. The Adoption and Safe Families Act of 1997 stated, however, that the child's health and safety are the primary concern when assessing the degree for a state to strive in making reasonable efforts.<sup>33</sup> Additionally, the Adoption and Safe Families Act does not require states to make reasonable efforts when a court has determined that the parent has subjected the child to aggravated circumstances as defined in state law, which includes but is not limited to abandonment, torture, chronic abuse, and sexual abuse.<sup>34</sup>

Section 39.806, F.S., regarding grounds for termination of parental rights, addresses DCF's reasonable efforts. DCF's failure to make reasonable efforts to reunify the parent and child may excuse the parent's noncompliance with a case plan, leading to invalidate such noncompliance as grounds for a termination of his or her rights. However, a court may exempt DCF from having to make reasonable efforts to preserve and reunify families if the parents have engaged in certain conduct, such as subjecting the child to aggravated child abuse or murdering the child's sibling; or if the court has taken certain actions, such as involuntarily terminating the parent's rights to the child's sibling. Reasonable efforts are also not required if the court determines that abandonment of a child has occurred.<sup>35</sup> Abandonment of a child, or when the identity of location of the parent or parents is unknown and cannot be ascertained by diligent search within 60 days, is also grounds for termination of parental rights.

When DCF does not have to make reasonable efforts before terminating parental rights it is known as an expedited termination of parent rights. In these situations, DCF does not need to obtain an adjudication of dependency and offer the parents a case plan for reunification before seeking termination of the parent's rights.

Current law does include registration as a sexual predator in the grounds to expedite the termination of a parent's rights. Therefore, DCF must provide a parent who is a registered sexual predator a case plan for reunification and provide services to that parent prior to seeking termination of that parent's rights.

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<sup>31</sup> Ch. No. 2016-80, L.O.F.

<sup>32</sup> Adoption Assistance and Child Welfare Act of 1980, Public L. No. 96-272, H.R. 3434, 96th Cong. (1980).

<sup>33</sup> CHILD WELFARE INFORMATION GATEWAY, CHILDREN'S BUREAU, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Reasonable Efforts to Preserve or Reunify Families and Achieve Permanency for Children*, <https://www.childwelfare.gov/pubPDFs/reunify.pdf> (last visited Jan. 31, 2020).

<sup>34</sup> 42 U.S.C. § 671(a)(15)(D)(i).

<sup>35</sup> S. 39.806(2), F.S.

## Child Welfare Adoptions

Adoption is a method of achieving permanency for children who have suffered abuse, abandonment, or neglect and are unable to be reunified with their parents. To become a licensed adoptive parent, an individual or couple must complete a licensing study class and complete a homestudy.<sup>36</sup> Adoption proceedings are governed by Ch. 63, F.S., regardless of whether the child is being adopted from the child welfare system or through private adoption.

For a child in the custody of DCF, current law allows a parent to execute a consent for placement of a minor with an adoption entity<sup>37</sup> or qualified adoptive parents when parental rights have not yet been terminated. The adoption consent is valid, binding, and enforceable by the court. After the parent executes the consent to adopt, the adoption entity may intervene in the dependency case to place the child with a prospective adoptive parent. The adoption entity is required to provide the court with a copy of the preliminary home study of the prospective adoptive parents and any other evidence showing the placement would be stable for the child.

Although s. 63.082(6), F.S., does not allow exceptions for the completion of a preliminary home study before the court may transfer custody of the child to the prospective adoptive parents, parties have been able to intervene and accomplish a modification of placement without presenting the court with a home study by relying on s. 63.092(3), F.S. This section does not require a preliminary homestudy in a if the petitioner for adoption is a stepparent or relative<sup>38</sup>.

As a result, relatives who do not pass DCF homestudies because of safety concerns or disqualifying background offenses are permitted to intervene in a dependency action to obtain placement of a child. DCF reports one recent case where a relative failed five DCF home studies, yet the trial court held that she did not need to complete a home study to intervene in a dependency proceeding.<sup>39</sup>

### *Selection of Adoptive Placement*

DCF's ability to place a child in its custody for adoption and the court's review of the placement is controlled by s. 39.812, F.S. DCF may place a child in its custody in a home and DCF's consent alone is sufficient for the placement. The dependency court retains jurisdiction over any child in DCF's custody until the child is adopted. After custody of a child has been given to DCF for subsequent adoption, the court has jurisdiction for the purpose of reviewing the status of the child and the progress being made toward permanent adoptive placement. As part of this continuing jurisdiction, s. 39.811(9), F.S., allows the court to review the appropriateness of the adoptive placement of the child after the child's Guardian ad Litem shows good cause.

When a child is available for adoption, DCF, through its contractors, will receive applications to adopt the child. Some applicants are not selected because their adoption homestudy is denied. When there are two or more families with approved homestudies, DCF routes these conflicting applications through the adoption applicant review committee (AARC) for resolution. The decision of the AARC is then reviewed by DCF which issues its consent for adoption to one applicant while communicating its denial to the other applicant through a certified letter. These final letters are considered final agency action which gives an unsuccessful applicant a point of entry to seek review of DCF's decision through an administrative review hearing process under Ch. 120, F.S.

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<sup>36</sup> Florida Department of Children and Families, *How Do I Become a Foster Parent?*, <https://www.myflfamilies.com/service-programs/foster-care/how-do-i.shtml> (last visited Jan. 31, 2019).

<sup>37</sup> Section 63.032(3) defines adoption entity as DCF, a child caring-agency registered under s. 409.176, an intermediary, a Florida child-placing agency licensed under s. 63.202, or a child-placing agency licensed in another state which is licensed by DCF to place children in the State of Florida.

<sup>38</sup> Relative is defined as a person related by blood to the person being adopted within the third degree.

<sup>39</sup> *Supra* note 10.

Additionally, Florida law permits individuals whom DCF declines consent for adoption of a child to initiate a new Ch. 63, F.S., legal proceeding by filing a petition for adoption. Upon filing the petition, the petitioner must demonstrate DCF unreasonably withheld its consent to adopt a child. Because Ch. 63, F.S., permits anyone who meets statutory requirements to adopt a child and any petition may argue DCF's unreasonable withheld its consent for the adoption, multiple parties may file a petition to adopt the same child. Therefore, there can possibly be three separate legal proceedings simultaneously addressing the adoption of a child:

- A Ch. 39, F.S., dependency proceeding.
- A Ch. 63, F.S., adoption proceeding filed by the family who has DCF's consent.
- A Ch. 63, F.S., adoption proceeding filed by the applicant who asserts DCF unreasonably withheld its consent.

Multiple competing adoption petitions require additional court hearings to resolve the conflict and may lead to a delay of the child's adoption. These court proceedings often occur concurrently with the administrative hearing process, which can lead to disparate results.

Chapter 120 administrative review hearings are heard by designated hearing officers within DCF. Assignment of adoption disputes to the Ch. 120, F.S., process arose due to the opinion in *Department of Children & Family Services v. I.B. and D.B.*, 891 So. 2d 1168 (Fla. 1<sup>st</sup> DCA 2005). These hearings require agency resources to conduct.

Administrative appeals can delay permanency. From a sample of 25 Ch. 120 contested adoption matters between 2018 and 2019, the average length of time between the receipt of a hearing request and entry of a final order was 213 days.<sup>40</sup> This does not include any additional delays caused by appeal to the appropriate District Court, which adds, on average, an additional 120 days.

### *Adoptions of Orphaned Children*

Section 39.01(15), F.S., defines a "child who is found to be dependent" to mean a child who, pursuant to Ch. 39, F.S., is found by the court to:

- Have been abandoned, abused, or neglected by the child's parent or parents or legal custodian.
- Have been surrendered to DCF or a licensed child-placing agency for purpose of adoption.
- Have been voluntarily placed with a licensed child-caring agency, a licensed child-placing agency, an adult relative, or DCF, after which placement, under the requirements of Ch. 39, F.S., a case plan has expired and the parent or parents or legal custodians have failed to substantially comply with the requirements of the plan.
- Have been voluntarily placed with a licensed child-placing agency for the purposes of subsequent adoption, and a parent or parents have signed a consent for adoption.
- Have no parent or legal custodians capable of providing supervision and care.
- Be at substantial risk of imminent abuse, abandonment, or neglect by the parent or parents or legal custodians.
- Have been sexually exploited and to have no parent, legal custodian, or reasonable adult relative currently known and capable of providing the necessary and appropriate supervision and care.

Currently, DCF can adjudicate a child dependent if both parents are deceased; however, there are no legal mechanisms to permanently commit that child to DCF for subsequent adoption. Florida's Fourth District Court of Appeal has held that when parents or guardians have died, they have not abandoned the child because the definition of "abandonment" contemplates the failure to provide minor child with support and supervision while being able, and the deceased parents are no longer able to do so. Instead, the court held that an orphaned child without a legal custodian can be properly adjudicated dependent based upon finding that the child has no parent or legal custodian capable of providing supervision and care.

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<sup>40</sup> *Supra* note 10.



Section 39.811(2), F.S., permits a court to commit a child to the custody of DCF for the purpose of adoption if the court finds that the grounds for termination of parental rights have been established by clear and convincing evidence. All the current grounds to terminate a parent's rights for a child to be subsequently adopted require that the parent engage in some kind of behavior that puts a child at risk.<sup>41</sup> Because a deceased parent can no longer engage in any behavior, DCF cannot seek the termination of a deceased parent's parental rights. Moreover, even if there was a legal ground to seek termination of a deceased parent's parental rights, the child may be receiving benefits such as social security benefits or an inheritance because of the parent's death that DCF would not want to halt by seeking a termination of the deceased parent's rights.

Because DCF cannot seek termination of parental rights when both parents are deceased, courts are permanently committing children to DCF's custody. Florida statutes do not currently have a mechanism that permits an orphaned child to be permanently committed to DCF for subsequent adoption without terminating the deceased parent's rights to allow the child to continue receiving death benefits.

### Independent Living Services Reporting

The Florida Legislature created the Independent Living Services Advisory Council (ILSAC) with the "purpose of reviewing and making recommendations concerning the implementation and operation of independent living transition services."<sup>42</sup> It was formed in 2005 to improve interagency policy and services coordination to support older foster youth aging out of foster care.<sup>43</sup> Section 409.1451, F.S., specifies an array of services for older foster youth to help them become independent self-supporting young adults, including Aftercare Services, Extended Foster Care, and Post-Secondary Education Services and Support. The ILSAC keeps DCF informed of problems with independent living services, barriers to effective and efficient integration of services across systems of care, and successes that system of services has achieved.<sup>44</sup> The ILSAC must submit a report by December 31 of each year to the Senate President and Speaker of the House that includes a summary of the factors reported on by the council and provide DCF's response to its recommendations.

In addition to the ILSAC annual report, s. 409.1451(6), F.S., requires DCF to prepare a report on the outcome measures and DCF's oversight activities regarding independent living services no later than January 31 of each year. DCF submits the report to the Senate President and Speaker of the House and to the committees with jurisdiction over issues relating to children and families.

The report must include:

- (a) An analysis of performance on the outcome measures developed under the section reported for each community-based care lead agency (CBC) and compared with the performance of the Department on the same measures.
- (b) A description of the Department's oversight of the program, including, by CBC, any programmatic or fiscal deficiencies found, corrective actions required and status of compliance.
- (c) Any rules adopted or proposed under the section since the last report.

DCF is required to provide the Children's Bureau, an Office of the Administration for Children and Families, an Annual Progress and Services Report (APSR). A section of the federal APSR is dedicated to sharing outcome and oversight information regarding the Department's independent living services programs and services provided under s. 409.1451, F.S., that are linked to federal funding. The APSR is also provided to the Legislature each year for review.

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<sup>41</sup> S. 39.806(1), F.S.,

<sup>42</sup> S. 409.1451(5), F.S.

<sup>43</sup> Florida Department of Children and Families, Independent Living Service Advisory Council, 2019 Annual Report, <https://www.myflfamilies.com/service-programs/child-welfare/docs/2019LMRs/ILSAC%20Annual%20Report%202019.pdf> (last visited Feb. 2, 2020).

<sup>44</sup> S. 409.1451(7)(b), F.S.

In addition, DCF is required to develop a legislatively mandated Results Oriented Accountability - CBC Performance Report. The report monitors and measures the use of resources, the quality and amount of services provided, and the child and family outcomes. While this report does not currently capture specific outcomes related to independent living program, the content could be expanded to include this population if some level of duplication is needed for document context.

Through the course of legislative changes affecting independent living services throughout the years, s. 409.1451(7), F.S., regarding the ILSAC's charge has remained unchanged except for incorporating extended foster care. The law still requires DCF's Secretary to appoint members to ILSAC for reviewing and making recommendations concerning the implementation and operation of independent living program services.

## **Effect of Proposed Changes**

### Paternity

The bill amends statute throughout Ch. 39, F.S., to require the court to establish paternity earlier in the dependency case. Specifically, the bill:

- Removes an alleged or prospective parent from the definition of "parent" to ensure a legal parent's rights are not modified. This will also eliminate the need to provide rights to prospective parents who have not yet established their paternity when there is currently a legal father. The prospective parent may still execute an affidavit of parenthood at the dependency hearing to establish rights to notice and participation.
- Removes the requirement of notice when a prospective parent's identity or location is unknown and there is an identified legal father.
- Requires the court to establish paternity at the dependency hearing if the inquiry identifies a legal father.
- Relieves the court from being required to do further search or give notice when a legal father has been identified or an inquiry does not identify a parent or prospective parent.
- Requires notice of all hearings if an inquiry and diligent search identifies and locates a parent during the dependency or termination of parental rights hearing.
- Gives an identified prospective parent the opportunity to become a party by completing an affidavit of parenthood when there is no legal father.
- Requires the court to give notice for termination of parental rights only on a prospective parent who has been identified and located.
- Requires the court to establish paternity at a termination of parental rights hearing if a legal father is identified.
- Relieves the court from conducting an inquiry to identify or locate a parent at termination of parental rights hearing if the inquiry was previously performed at the dependency hearing.

The bill also creates a new section to provide the court guidance on establishing paternity in cases involving dependent children. The new section allows a paternity proceeding concerning a dependent child to either be part of the dependency case or a separate action. The new section concerns a dependent child who already has a legal father and a different man has filed a complaint to establish paternity. Under the new section, before the court may proceed on his complaint, the alleged father must prove he has acted with diligence in seeking the establishment of paternity and manifested a substantial and continuing concern for the child's welfare. The father must then prove by clear and convincing evidence that there is a clear and compelling reason, based primarily on the dependent child's best interest, to establish his paternity and disestablish the legal father's paternity. However, the bill establishes a rebuttable presumption that it is not in the child's best interest to disestablish the legal father's paternity if the alleged father files his complaint 12 months or more after the child became dependent or the alleged father cannot pass a home study for placement of the child.

Establishing paternity early in the dependency case will make the process more efficient and may eliminate unnecessary delays in the dependency process. Eliminating these unnecessary delays may speed up permanency for children.

## Adoptions

### *Selection of Adoptive Placements*

The bill amends statute to eliminate the opportunity for a hearing under Ch. 120 when an applicant is denied the ability to adopt a child. This will reduce the number of simultaneous adoption actions that can be filed by multiple parties to adopt the same child. The bill requires a denied applicant seeking court review of DCF's determination to appeal the decision to the applicable district court of appeals under Ch. 63, F.S. Therefore, review of the decision would only be reviewable by the appellate courts.

Given the other avenue for appeal under Ch. 63, F.S., the Ch. 120 administrative review hearing is unnecessary, resource-intensive, and delays permanency for children. By barring a Ch. 120 administrative process, adoption selection appeals would only be heard in circuit court by the same judge already assigned to the child's case.

### *Orphaned Children*

The bill creates a new process for the permanent commitment of a child to DCF's custody for the purpose of adoption when both parents are deceased without terminating the deceased parent's parental rights. This will allow the child to continue to receive death benefits.

New s. 39.8025, F.S., allows a person to file a petition for adjudication and permanent commitment to DCF's custody of a child whose parents have died and there is no legal custodian through probate or guardianship proceedings. The new section also addresses situations where a child has already been adjudicated dependent and that child's parent dies to allow DCF's attorney or another person who has knowledge of the facts to file a petition for permanent commitment of the child to DCF's custody for adoption. The petition for either of these situations must be in writing, identify the deceased parents, and allege the facts that establish both parents are deceased and the child does not have a legal custodian through a probate or guardianship proceeding. The petition must be signed by the petitioner under oath stating the petitioner's good faith in filing the petition.

Creating a process for DCF to take a child whose parents have died into custody for adoption without a process that legally cuts off needed benefits for the child reinforces the goal of getting children to permanency faster while maintaining resources for the child.

### *Home Studies in Ch. 63, F.S., Intervention Proceedings*

The bill amends statute to require a preliminary home study for all prospective parents, regardless of whether that individual is a stepparent or relative. This change will ensure that individuals who have failed a home study to be a placement under Ch. 39, F.S., cannot use Ch. 63, F.S., to become a placement for the child. This change promotes placements that are in the child's best interest.

## Termination of Parental Rights

The bill allows DCF to expedite termination of parental rights without having to try to reunify the child with his or her parent when the parent is a registered sexual predator. Therefore, DCF will not have to give the parent who is a registered sexual predator a case plan before terminating parental rights. This will speed up permanency for children while ensuring their safety from a dangerous parent.

## Qualified Evaluators

The bill moves the statutory responsibility to adopt rules for the registration of qualified evaluators who assess residential placements for the children from AHCA to DCF. This conforms to DCF's current statutory responsibility for the qualified evaluators.

## Case Plans

The bill amends statute to ensure that case plans are filed not less than 72 hours before the disposition hearing. This change resolves a conflict in law and ensures there is consistency statewide when case plans are filed to the court and provided to all parties.

## Guardian ad Litem Program

The bill amends the definition of "Guardian ad Litem" to include the Statewide Guardian ad Litem Office. This change reflects that the circuit Guardian ad Litem programs are under the single statewide entity. This change will allow the statewide Guardian ad Litem office electronic access to needed records.

## Statutorily Mandated Reports

The bill removes statutory requirements for two reports that must be submitted to the Legislature and the Governor on false reporting of child abuse, abandonment and neglect and on the Independent Living program. This change eliminates unnecessary duplication of information to the Legislature.

Finally, the bill provides an effective date of July 1, 2020.

## B. SECTION DIRECTORY:

- Section 1:** Amending s. 39.01, F.S., relating to definitions.
- Section 2:** Amending s. 39.205, F.S., relating to penalties relating to reporting of child abuse, abandonment, or neglect.
- Section 3:** Amending s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.
- Section 4:** Amending s. 39.503, F.S., relating to identity or location of parent unknown; special procedures.
- Section 5:** Creating s. 39.5035, F.S., relating to deceased parents; special procedures.
- Section 6:** Amending s. 39.6011, F.S., relating to case plan development.
- Section 7:** Amending s. 39.6221, F.S., relating to permanent guardianship of a dependent child.
- Section 8:** Amending s. 39.801, F.S., relating to procedures and jurisdiction; notice; service of process.
- Section 9:** Amending s. 39.803, F.S., relating to identity or location of parent unknown after filing of termination of parental rights petition; special procedures.
- Section 10:** Amending s. 39.806, F.S., relating to grounds for termination of parental rights.
- Section 11:** Amending s. 39.8011, F.S., relating to powers of disposition; order of disposition.
- Section 12:** Amending s. 39.812, F.S., relating to postdisposition relief; petition for adoption.
- Section 13:** Amending s. 39.820, F.S., relating to definitions.
- Section 14:** Amending s. 63.062, F.S., relating to persons required to consent to adoption; affidavit of nonpaternity; waiver of venue.
- Section 15:** Amending s. 63.082, F.S., relating to execution of consent to adoption or affidavit of nonpaternity; family social and medical history; revocation of consent.
- Section 16:** Amending s. 409.1451, F.S., relating to the road-to-independence program.
- Section 17:** Creating s. 742.0211, F.S., relating to proceedings applicable to dependent children.
- Section 18:** Providing an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DCF estimates a cost avoidance of \$1,169,231.88 if the changes related to the adoption selection process are implemented based on a review of cases from 2019.<sup>45</sup> In addition, eliminating requiring a case plan for parents who have to register has a sexual predator and the reduction of supervision of the guardian successor by three months will result in a cost avoidance of judicial case supervision by DCF's attorneys.<sup>46</sup>

### B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

### C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Community-based care lead agencies may have a positive fiscal impact if the changes in the bill speed up permanency for children in their care.

### 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:

DCF has sufficient rulemaking authority to implement the bill's provisions.

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<sup>45</sup> *Supra* note 10.

<sup>46</sup> *Id.*

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

**IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES**

1 A bill to be entitled

2 An act relating to dependency proceedings and child  
3 protection services; amending s. 39.01, F.S.; revising  
4 the definition of "parent"; amending s. 39.205, F.S.;  
5 removing a reporting requirement to the Legislature;  
6 amending s. 39.407, F.S.; transferring certain duties  
7 to the department rather than the Agency for Health  
8 Care Administration; amending ss. 39.503 and 39.803,  
9 F.S.; revising procedures and requirements relating to  
10 the unknown identity or location of a parent of a  
11 dependent child; removing standing to file a sworn  
12 affidavit to establish parenthood after the entry of a  
13 certain judgment; creating s. 39.5035, F.S.; providing  
14 procedures and requirements relating to deceased  
15 parents of a dependent child; amending s. 39.6011,  
16 F.S.; providing timeframes in which case plans must be  
17 filed with the court and provided to specified  
18 parties; amending s. 39.6221, F.S.; revising the  
19 conditions under which a court determines permanent  
20 guardian placement for a child; amending s. 39.801,  
21 F.S.; conforming provisions to changes made by the  
22 act; amending s. 39.806, F.S.; providing that efforts  
23 to preserve or reunify a family are not required under  
24 specified circumstances; conforming cross-references;  
25 amending s. 39.811, F.S.; providing that the court

26 retains jurisdiction under certain circumstances;  
27 providing when certain decisions relating to adoption  
28 are reviewable; amending s. 39.812, F.S.; authorizing  
29 certain actions without a court order; providing that  
30 certain persons may file a petition to adopt a child  
31 without the department's consent; providing standing;  
32 providing a standard of proof; providing  
33 responsibilities of the court in such cases; amending  
34 s. 39.820, F.S.; revising the definition of the term  
35 "guardian ad litem;" amending s. 63.062, F.S.;  
36 requiring the department to consent to certain  
37 adoptions; providing exceptions; amending s. 63.082,  
38 F.S.; requiring a home study of a stepparent or  
39 relative under certain circumstances; amending s.  
40 409.1451, F.S.; removing a reporting requirement of  
41 the department and the Independent Living Services  
42 Advisory Council; creating s. 742.0211, F.S.; defining  
43 the term "dependent child"; providing requirements for  
44 the determination of paternity when a child is  
45 dependent; requiring a hearing and written order  
46 within a specified time; providing the burden of proof  
47 for certain paternity complaints; providing  
48 applicability; providing an effective date.

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



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Section 1. Subsection (56) of section 39.01, Florida Statutes, is amended to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(56) "Parent" means a woman who gives birth to a child and a man whose consent to the adoption of the child would be required under s. 63.062(1). The term "parent" also means legal father as defined in this section. If a child has been legally adopted, the term "parent" means the adoptive mother or father of the child. For purposes of this chapter only, when the phrase "parent or legal custodian" is used, it refers to rights or responsibilities of the parent and, only if there is no living parent with intact parental rights, to the rights or responsibilities of the legal custodian who has assumed the role of the parent. The term does not include an individual whose parental relationship to the child has been legally terminated, or an alleged or prospective parent, unless:

~~(a) The parental status falls within the terms of s. 39.503(1) or s. 63.062(1); or~~

~~(b) parental status is applied for the purpose of determining whether the child has been abandoned.~~

Section 2. Subsection (7) of section 39.205, Florida Statutes, is amended to read:

39.205 Penalties relating to reporting of child abuse,

76 abandonment, or neglect.—

77 (7) The department shall establish procedures for  
 78 determining whether a false report of child abuse, abandonment,  
 79 or neglect has been made and for submitting all identifying  
 80 information relating to such a report to the appropriate law  
 81 enforcement agency ~~and shall report annually to the Legislature~~  
 82 ~~the number of reports referred.~~

83 Section 3. Subsection (6) of section 39.407, Florida  
 84 Statutes, is amended to read:

85 39.407 Medical, psychiatric, and psychological examination  
 86 and treatment of child; physical, mental, or substance abuse  
 87 examination of person with or requesting child custody.—

88 (6) Children who are in the legal custody of the  
 89 department may be placed by the department, without prior  
 90 approval of the court, in a residential treatment center  
 91 licensed under s. 394.875 or a hospital licensed under chapter  
 92 395 for residential mental health treatment only as provided in  
 93 ~~pursuant to~~ this section or may be placed by the court in  
 94 accordance with an order of involuntary examination or  
 95 involuntary placement entered under ~~pursuant to~~ s. 394.463 or s.  
 96 394.467. All children placed in a residential treatment program  
 97 under this subsection must have a guardian ad litem appointed.

98 (a) As used in this subsection, the term:

99 1. "Residential treatment" means placement for  
 100 observation, diagnosis, or treatment of an emotional disturbance

101 in a residential treatment center licensed under s. 394.875 or a  
102 hospital licensed under chapter 395.

103 2. "Least restrictive alternative" means the treatment and  
104 conditions of treatment that, separately and in combination, are  
105 no more intrusive or restrictive of freedom than reasonably  
106 necessary to achieve a substantial therapeutic benefit or to  
107 protect the child or adolescent or others from physical injury.

108 3. "Suitable for residential treatment" or "suitability"  
109 means a determination concerning a child or adolescent with an  
110 emotional disturbance as defined in s. 394.492(5) or a serious  
111 emotional disturbance as defined in s. 394.492(6) that each of  
112 the following criteria is met:

113 a. The child requires residential treatment.

114 b. The child is in need of a residential treatment program  
115 and is expected to benefit from mental health treatment.

116 c. An appropriate, less restrictive alternative to  
117 residential treatment is unavailable.

118 (b) Whenever the department believes that a child in its  
119 legal custody is emotionally disturbed and may need residential  
120 treatment, an examination and suitability assessment must be  
121 conducted by a qualified evaluator who is appointed by the  
122 department ~~Agency for Health Care Administration~~. This  
123 suitability assessment must be completed before the placement of  
124 the child in a residential treatment center for emotionally  
125 disturbed children and adolescents or a hospital. The qualified

126 evaluator must be a psychiatrist or a psychologist licensed in  
127 Florida who has at least 3 years of experience in the diagnosis  
128 and treatment of serious emotional disturbances in children and  
129 adolescents and who has no actual or perceived conflict of  
130 interest with any inpatient facility or residential treatment  
131 center or program.

132 (c) Before a child is admitted under this subsection, the  
133 child shall be assessed for suitability for residential  
134 treatment by a qualified evaluator who has conducted a personal  
135 examination and assessment of the child and has made written  
136 findings that:

137 1. The child appears to have an emotional disturbance  
138 serious enough to require residential treatment and is  
139 reasonably likely to benefit from the treatment.

140 2. The child has been provided with a clinically  
141 appropriate explanation of the nature and purpose of the  
142 treatment.

143 3. All available modalities of treatment less restrictive  
144 than residential treatment have been considered, and a less  
145 restrictive alternative that would offer comparable benefits to  
146 the child is unavailable.

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148 A copy of the written findings of the evaluation and suitability  
149 assessment must be provided to the department, to the guardian  
150 ad litem, and, if the child is a member of a Medicaid managed

151 care plan, to the plan that is financially responsible for the  
152 child's care in residential treatment, all of whom must be  
153 provided with the opportunity to discuss the findings with the  
154 evaluator.

155 (d) Immediately upon placing a child in a residential  
156 treatment program under this section, the department must notify  
157 the guardian ad litem and the court having jurisdiction over the  
158 child and must provide the guardian ad litem and the court with  
159 a copy of the assessment by the qualified evaluator.

160 (e) Within 10 days after the admission of a child to a  
161 residential treatment program, the director of the residential  
162 treatment program or the director's designee must ensure that an  
163 individualized plan of treatment has been prepared by the  
164 program and has been explained to the child, to the department,  
165 and to the guardian ad litem, and submitted to the department.  
166 The child must be involved in the preparation of the plan to the  
167 maximum feasible extent consistent with his or her ability to  
168 understand and participate, and the guardian ad litem and the  
169 child's foster parents must be involved to the maximum extent  
170 consistent with the child's treatment needs. The plan must  
171 include a preliminary plan for residential treatment and  
172 aftercare upon completion of residential treatment. The plan  
173 must include specific behavioral and emotional goals against  
174 which the success of the residential treatment may be measured.  
175 A copy of the plan must be provided to the child, to the

176 guardian ad litem, and to the department.

177 (f) Within 30 days after admission, the residential  
178 treatment program must review the appropriateness and  
179 suitability of the child's placement in the program. The  
180 residential treatment program must determine whether the child  
181 is receiving benefit toward the treatment goals and whether the  
182 child could be treated in a less restrictive treatment program.  
183 The residential treatment program shall prepare a written report  
184 of its findings and submit the report to the guardian ad litem  
185 and to the department. The department must submit the report to  
186 the court. The report must include a discharge plan for the  
187 child. The residential treatment program must continue to  
188 evaluate the child's treatment progress every 30 days thereafter  
189 and must include its findings in a written report submitted to  
190 the department. The department may not reimburse a facility  
191 until the facility has submitted every written report that is  
192 due.

193 (g)1. The department must submit, at the beginning of each  
194 month, to the court having jurisdiction over the child, a  
195 written report regarding the child's progress toward achieving  
196 the goals specified in the individualized plan of treatment.

197 2. The court must conduct a hearing to review the status  
198 of the child's residential treatment plan no later than 60 days  
199 after the child's admission to the residential treatment  
200 program. An independent review of the child's progress toward

201 achieving the goals and objectives of the treatment plan must be  
202 completed by a qualified evaluator and submitted to the court  
203 before its 60-day review.

204 3. For any child in residential treatment at the time a  
205 judicial review is held under ~~pursuant to~~ s. 39.701, the child's  
206 continued placement in residential treatment must be a subject  
207 of the judicial review.

208 4. If at any time the court determines that the child is  
209 not suitable for continued residential treatment, the court  
210 shall order the department to place the child in the least  
211 restrictive setting that is best suited to meet his or her  
212 needs.

213 (h) After the initial 60-day review, the court must  
214 conduct a review of the child's residential treatment plan every  
215 90 days.

216 (i) The department must adopt rules for:

217 1. Implementing timeframes for the completion of  
218 suitability assessments by qualified evaluators. ~~and~~

219 2. A procedure that includes timeframes for completing the  
220 60-day independent review by the qualified evaluators of the  
221 child's progress toward achieving the goals and objectives of  
222 the treatment plan which review must be submitted to the court.

223 3. ~~The Agency for Health Care Administration must adopt~~  
224 ~~rules for~~ The registration of qualified evaluators, the  
225 procedure for selecting the evaluators to conduct the reviews

226 required under this section, and a reasonable, cost-efficient  
227 fee schedule for qualified evaluators.

228 Section 4. Section 39.503, Florida Statutes, is amended to  
229 read:

230 39.503 Identity or location of parent unknown; special  
231 procedures.—

232 (1) If the identity or location of a parent is unknown and  
233 a petition for dependency ~~or shelter~~ is filed, the court shall  
234 conduct under oath an ~~the following~~ inquiry of the parent or  
235 legal custodian who is available, or, if no parent or legal  
236 custodian is available, of any relative or custodian of the  
237 child who is present at the hearing and likely to have any of  
238 the following information:

239 (a) Whether the mother of the child was married at the  
240 probable time of conception of the child or at the time of birth  
241 of the child.

242 (b) Whether the mother was cohabiting with a male at the  
243 probable time of conception of the child.

244 (c) Whether the mother has received payments or promises  
245 of support with respect to the child or because of her pregnancy  
246 from a man who claims to be the father.

247 (d) Whether the mother has named any man as the father on  
248 the birth certificate of the child or in connection with  
249 applying for or receiving public assistance.

250 (e) Whether any man has acknowledged or claimed paternity



251 of the child in a jurisdiction in which the mother resided at  
252 the time of or since conception of the child, or in which the  
253 child has resided or resides.

254 (f) Whether a man is named on the birth certificate of the  
255 child under ~~pursuant to~~ s. 382.013(2).

256 (g) Whether a man has been determined by a court order to  
257 be the father of the child.

258 (h) Whether a man has been determined to be the father of  
259 the child by the Department of Revenue as provided in s.  
260 409.256.

261 (2) The information required in subsection (1) may be  
262 supplied to the court or the department in the form of a sworn  
263 affidavit by a person having personal knowledge of the facts.

264 (3) If the inquiry under subsection (1) identifies any  
265 person as a parent or prospective parent and that person's  
266 location is known, the court shall require notice of the hearing  
267 to be provided to that person. However, notice is not required  
268 to be provided to a prospective parent if there is an identified  
269 legal father, as defined in s. 39.01, of the child.

270 (4) If the inquiry under subsection (1) identifies a  
271 person as a legal father, as defined in s. 39.01, the court  
272 shall enter an order establishing the paternity of the father.  
273 Once an order establishing paternity has been entered, the court  
274 may not take any action to disestablish this paternity in the  
275 absence of an action filed under chapter 742. An action filed

276 under chapter 742 concerning a child who is the subject in a  
277 dependency proceeding must comply with s. 742.0211.

278 (5)-(4) If the inquiry under subsection (1) fails to  
279 identify any person as a parent or prospective parent, the court  
280 shall so find and may proceed without further notice and the  
281 petitioner is relieved of performing any further search.

282 (6)-(5) If the inquiry under subsection (1) identifies a  
283 parent or prospective parent, and that person's location is  
284 unknown, the court shall direct the petitioner to conduct a  
285 diligent search for that person before scheduling a disposition  
286 hearing regarding the dependency of the child unless the court  
287 finds that the best interest of the child requires proceeding  
288 without notice to the person whose location is unknown. However,  
289 a diligent search is not required to be conducted for a  
290 prospective parent if there is an identified legal father, as  
291 defined in s. 39.01, of the child.

292 (7)-(6) The diligent search required by subsection (6)-(5)  
293 must include, at a minimum, inquiries of all relatives of the  
294 parent or prospective parent made known to the petitioner,  
295 inquiries of all offices of program areas of the department  
296 likely to have information about the parent or prospective  
297 parent, inquiries of other state and federal agencies likely to  
298 have information about the parent or prospective parent,  
299 inquiries of appropriate utility and postal providers, a  
300 thorough search of at least one electronic database specifically

301 designed for locating persons, a search of the Florida Putative  
302 Father Registry, and inquiries of appropriate law enforcement  
303 agencies. Pursuant to s. 453 of the Social Security Act, 42  
304 U.S.C. s. 653(c)(4), the department, as the state agency  
305 administering Titles IV-B and IV-E of the act, shall be provided  
306 access to the federal and state parent locator service for  
307 diligent search activities.

308 (8)~~(7)~~ Any agency contacted by a petitioner with a request  
309 for information under ~~pursuant to~~ subsection (7)~~(6)~~ must ~~shall~~  
310 release the requested information to the petitioner without the  
311 necessity of a subpoena or court order.

312 (9) If the inquiry and diligent search identifies and  
313 locates a parent, that person is considered a parent for all  
314 purposes under this chapter and must be provided notice of all  
315 hearings.

316 (10)~~(8)~~ If the inquiry and diligent search identifies and  
317 locates a prospective parent and there is no legal father, that  
318 person must be given the opportunity to become a party to the  
319 proceedings by completing a sworn affidavit of parenthood and  
320 filing it with the court or the department. A prospective parent  
321 who files a sworn affidavit of parenthood while the child is a  
322 dependent child but no later than at the time of or before the  
323 adjudicatory hearing in any termination of parental rights  
324 proceeding for the child shall be considered a parent for all  
325 purposes under this chapter ~~section~~ unless the other parent

326 | contests the determination of parenthood. A person does not have  
 327 | standing to file a sworn affidavit of parenthood or otherwise  
 328 | establish parenthood, except through adoption, after entry of a  
 329 | judgment terminating the parental rights of the legal father for  
 330 | a child. If the known parent contests the recognition of the  
 331 | prospective parent as a parent, the court having jurisdiction  
 332 | over the dependency matter shall conduct a determination of  
 333 | parentage under chapter 742. The prospective parent may not be  
 334 | recognized as a parent until proceedings to determine maternity  
 335 | or paternity ~~under chapter 742~~ have been concluded. However, the  
 336 | prospective parent shall continue to receive notice of hearings  
 337 | as a participant pending results of the ~~chapter 742~~ proceedings  
 338 | to determine maternity or paternity.

339 |       ~~(11)(9)~~ If the diligent search under subsection ~~(6)(5)~~  
 340 | fails to ~~identify and~~ locate a parent or prospective parent who  
 341 | was identified during the inquiry under subsection (1), the  
 342 | court shall so find and may proceed without further notice and  
 343 | the petitioner is relieved from performing any further search.

344 |       Section 5. Section 39.5035, Florida Statutes, is created  
 345 | to read:

346 |       39.5035 Deceased parents; special procedures.-

347 |       (1) (a) 1. If both parents of a child are deceased and a  
 348 | legal custodian has not been appointed for the child through a  
 349 | probate or guardianship proceeding, then the attorney for any  
 350 | person who has knowledge of the facts alleged or is informed of

351 the alleged facts, and believes them to be true, may initiate a  
352 proceeding by filing a petition for adjudication and permanent  
353 commitment.

354 2. If a child has been placed in shelter status by order  
355 of the court but has not yet been adjudicated, a petition for  
356 adjudication and permanent commitment must be filed within 21  
357 days after the shelter hearing. In all other cases, the petition  
358 must be filed within a reasonable time after the date the child  
359 was referred to protective investigation or after the petitioner  
360 first becomes aware of the facts that support the petition for  
361 adjudication and permanent commitment.

362 (b) If both parents die or the last living parent dies  
363 after a child has already been adjudicated dependent, any person  
364 who has knowledge of the facts alleged or is informed of the  
365 alleged facts, and believes them to be true, may file a petition  
366 for permanent commitment.

367 (2) The petition:

368 (a) Must be in writing, identify the alleged deceased  
369 parents, and provide facts that establish that both parents of  
370 the child are deceased and that a legal custodian has not been  
371 appointed for the child through a probate or guardianship  
372 proceeding.

373 (b) Must be signed by the petitioner under oath stating  
374 the petitioner's good faith in filing the petition.

375 (3) When a petition for adjudication and permanent

376 commitment or a petition for permanent commitment has been  
377 filed, the clerk of court shall set the case before the court  
378 for an adjudicatory hearing. The adjudicatory hearing must be  
379 held as soon as practicable after the petition is filed, but no  
380 later than 30 days after the filing date.

381 (4) Notice of the date, time, and place of the  
382 adjudicatory hearing and a copy of the petition must be served  
383 on the following persons:

384 (a) Any person who has physical custody of the child.

385 (b) A living relative of each parent of the child, unless  
386 a living relative cannot be found after a diligent search and  
387 inquiry.

388 (c) The guardian ad litem for the child or the  
389 representative of the guardian ad litem program, if the program  
390 has been appointed.

391 (5) The court shall conduct adjudicatory hearings without  
392 a jury and apply the rules of evidence in use in civil cases.  
393 The court must determine whether the petitioner has established  
394 by clear and convincing evidence that both parents of the child  
395 are deceased and that a legal custodian has not been appointed  
396 for the child through a probate or guardianship proceeding. A  
397 certified copy of the death certificate for each parent is  
398 sufficient evidence of the parents' deaths.

399 (6) Within 30 days after an adjudicatory hearing on a  
400 petition for adjudication and permanent commitment:

401        (a) If the court finds that the petitioner has met the  
402 clear and convincing standard, the court shall enter a written  
403 order adjudicating the child dependent and permanently  
404 committing the child to the custody of the department for the  
405 purpose of adoption. A disposition hearing shall be scheduled no  
406 later than 30 days after the entry of the order, in which the  
407 department shall provide a case plan that identifies the  
408 permanency goal for the child to the court. Reasonable efforts  
409 must be made to place the child in a timely manner in accordance  
410 with the permanency plan and to complete all steps necessary to  
411 finalize the permanent placement of the child. Thereafter, until  
412 the adoption of the child is finalized or the child reaches the  
413 age of 18 years, whichever occurs first, the court shall hold  
414 hearings every 6 months to review the progress being made toward  
415 permanency for the child as provided in s. 39.701.

416        (b) If the court finds that clear and convincing evidence  
417 does not establish that both parents of a child are deceased and  
418 that a legal custodian has not been appointed for the child  
419 through a probate or guardianship proceeding, but that a  
420 preponderance of the evidence establishes that the child does  
421 not have a parent or legal custodian capable of providing  
422 supervision or care, the court shall enter a written order  
423 adjudicating the child dependent. A disposition hearing shall be  
424 scheduled no later than 30 days after the entry of the order as  
425 provided in s. 39.521.

426        (c) If the court finds that clear and convincing evidence  
427 does not establish that both parents of a child are deceased and  
428 that a legal custodian has not been appointed for the child  
429 through a probate or guardianship proceeding and that a  
430 preponderance of the evidence does not establish that the child  
431 does not have a parent or legal custodian capable of providing  
432 supervision or care, the court shall enter a written order so  
433 finding and dismiss the petition.

434        (7) Within 30 days after an adjudicatory hearing on a  
435 petition for permanent commitment:

436        (a) If the court finds that the petitioner has met the  
437 clear and convincing standard, the court shall enter a written  
438 order permanently committing the child to the custody of the  
439 department for purposes of adoption. A disposition hearing shall  
440 be scheduled no later than 30 days after the entry of the order,  
441 in which the department shall provide an amended case plan that  
442 identifies the permanency goal for the child to the court.  
443 Reasonable efforts must be made to place the child in a timely  
444 manner in accordance with the permanency plan and to complete  
445 all steps necessary to finalize the permanent placement of the  
446 child. Thereafter, until the adoption of the child is finalized  
447 or the child reaches the age of 18 years, whichever occurs  
448 first, the court shall hold hearings every 6 months to review  
449 the progress being made toward permanency for the child.

450        (b) If the court finds that clear and convincing evidence



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451 does not establish that both parents of a child are deceased and  
452 that a legal custodian has not been appointed for the child  
453 through a probate or guardianship proceeding, the court shall  
454 enter a written order denying the petition. The order has no  
455 effect on the child's prior adjudication. The order does not bar  
456 the petitioner from filing a subsequent petition for permanent  
457 commitment based on newly-discovered evidence that establishes  
458 that both parents of a child are deceased and that a legal  
459 custodian has not been appointed for the child through a probate  
460 or guardianship proceeding.

461 Section 6. Subsection (8) of section 39.6011, Florida  
462 Statutes, is amended to read:

463 39.6011 Case plan development.—

464 (8) The case plan must be filed with the court and copies  
465 provided to all parties, including the child if appropriate;7  
466 ~~not less than 3 business days before the disposition hearing.~~

467 (a) Not less than 72 hours before the disposition hearing,  
468 if the disposition hearing occurs on or after the 60th day after  
469 the date the child was placed in out-of-home care; or

470 (b) Not less than 72 hours before the case plan acceptance  
471 hearing, if the disposition hearing occurs before the 60th day  
472 after the date the child was placed in out-of-home care and a  
473 case plan has not been submitted under this subsection, or if  
474 the court does not approve the case plan at the disposition  
475 hearing.

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476 Section 7. Paragraph (a) of subsection (1) of section  
477 39.6221, Florida Statutes, is amended to read:

478 39.6221 Permanent guardianship of a dependent child.—

479 (1) If a court determines that reunification or adoption  
480 is not in the best interest of the child, the court may place  
481 the child in a permanent guardianship with a relative or other  
482 adult approved by the court if all of the following conditions  
483 are met:

484 (a) The child has been in the placement for not less than  
485 the preceding 6 months, or the preceding 3 months if the  
486 caregiver has been named as the successor guardian on the  
487 child's Guardianship Assistance Agreement.

488 Section 8. Paragraph (a) of subsection (3) of section  
489 39.801, Florida Statutes, is amended to read:

490 39.801 Procedures and jurisdiction; notice; service of  
491 process.—

492 (3) Before the court may terminate parental rights, in  
493 addition to the other requirements set forth in this part, the  
494 following requirements must be met:

495 (a) Notice of the date, time, and place of the advisory  
496 hearing for the petition to terminate parental rights and a copy  
497 of the petition must be personally served upon the following  
498 persons, specifically notifying them that a petition has been  
499 filed:

500 1. The parents of the child.

- 501           2. The legal custodians of the child.
- 502           3. If the parents who would be entitled to notice are dead  
503 or unknown, a living relative of the child, unless upon diligent  
504 search and inquiry no such relative can be found.
- 505           4. Any person who has physical custody of the child.
- 506           5. Any grandparent entitled to priority for adoption under  
507 s. 63.0425.
- 508           6. Any prospective parent who has been identified and  
509 located under s. 39.503 or s. 39.803, unless a court order has  
510 been entered under s. 39.503(5) or (11) or s. 39.803(5) or (11)  
511 ~~pursuant to s. 39.503(4) or (9) or s. 39.803(4) or (9)~~ which  
512 indicates no further notice is required. Except as otherwise  
513 provided in this section, if there is not a legal father, notice  
514 of the petition for termination of parental rights must be  
515 provided to any known prospective father who is identified under  
516 oath before the court or who is identified and located by a  
517 diligent search of the Florida Putative Father Registry. Service  
518 of the notice of the petition for termination of parental rights  
519 is not required if the prospective father executes an affidavit  
520 of nonpaternity or a consent to termination of his parental  
521 rights which is accepted by the court after notice and  
522 opportunity to be heard by all parties to address the best  
523 interests of the child in accepting such affidavit.
- 524           7. The guardian ad litem for the child or the  
525 representative of the guardian ad litem program, if the program

526 | has been appointed.

527 |

528 | The document containing the notice to respond or appear must  
 529 | contain, in type at least as large as the type in the balance of  
 530 | the document, the following or substantially similar language:

531 | "FAILURE TO PERSONALLY APPEAR AT THIS ADVISORY HEARING  
 532 | CONSTITUTES CONSENT TO THE TERMINATION OF PARENTAL RIGHTS OF  
 533 | THIS CHILD (OR CHILDREN). IF YOU FAIL TO APPEAR ON THE DATE AND  
 534 | TIME SPECIFIED, YOU MAY LOSE ALL LEGAL RIGHTS AS A PARENT TO THE  
 535 | CHILD OR CHILDREN NAMED IN THE PETITION ATTACHED TO THIS  
 536 | NOTICE."

537 | Section 9. Section 39.803, Florida Statutes, is amended to  
 538 | read:

539 | 39.803 Identity or location of parent unknown after filing  
 540 | of termination of parental rights petition; special procedures.-

541 | (1) If the identity or location of a parent is unknown,  
 542 | ~~and~~ a petition for termination of parental rights is filed, and  
 543 | the court has not previously conducted an inquiry or entered an  
 544 | order relieving the petitioner of further search or notice under  
 545 | s. 39.503, the court shall conduct under oath the following  
 546 | inquiry of the parent who is available, or, if no parent is  
 547 | available, of any relative, caregiver, or legal custodian of the  
 548 | child who is present at the hearing and likely to have the  
 549 | information:

550 | (a) Whether the mother of the child was married at the

551 | probable time of conception of the child or at the time of birth  
552 | of the child.

553 |       (b) Whether the mother was cohabiting with a male at the  
554 | probable time of conception of the child.

555 |       (c) Whether the mother has received payments or promises  
556 | of support with respect to the child or because of her pregnancy  
557 | from a man who claims to be the father.

558 |       (d) Whether the mother has named any man as the father on  
559 | the birth certificate of the child or in connection with  
560 | applying for or receiving public assistance.

561 |       (e) Whether any man has acknowledged or claimed paternity  
562 | of the child in a jurisdiction in which the mother resided at  
563 | the time of or since conception of the child, or in which the  
564 | child has resided or resides.

565 |       (f) Whether a man is named on the birth certificate of the  
566 | child under ~~pursuant to~~ s. 382.013(2).

567 |       (g) Whether a man has been determined by a court order to  
568 | be the father of the child.

569 |       (h) Whether a man has been determined to be the father of  
570 | the child by the Department of Revenue as provided in s.  
571 | 409.256.

572 |       (2) The information required in subsection (1) may be  
573 | supplied to the court or the department in the form of a sworn  
574 | affidavit by a person having personal knowledge of the facts.

575 |       (3) If the inquiry under subsection (1) identifies any

576 | person as a parent or prospective parent and that person's  
577 | location is known, the court shall require notice of the hearing  
578 | to be provided to that person. However, notice is not required  
579 | to be provided to a prospective parent if there is an identified  
580 | legal father, as defined in s. 39.01, of the child.

581 |       (4) If the inquiry under subsection (1) identifies a  
582 | person as a legal father, as defined in s. 39.01, the court  
583 | shall enter an order establishing the paternity of the father.  
584 | Once an order establishing paternity has been entered, the court  
585 | may not take any action to disestablish this paternity in the  
586 | absence of an action filed under chapter 742. An action filed  
587 | under chapter 742 concerning a child who is the subject in a  
588 | dependency proceeding must comply with s. 742.0211.

589 |       ~~(5)~~~~(4)~~ If the inquiry under subsection (1) fails to  
590 | identify any person as a parent or prospective parent, the court  
591 | shall so find and may proceed without further notice and the  
592 | petitioner is relieved of performing any further search.

593 |       ~~(6)~~~~(5)~~ If the inquiry under subsection (1) identifies a  
594 | parent or prospective parent, and that person's location is  
595 | unknown, the court shall direct the petitioner to conduct a  
596 | diligent search for that person before scheduling an  
597 | adjudicatory hearing regarding the petition for termination of  
598 | parental rights to the child unless the court finds that the  
599 | best interest of the child requires proceeding without actual  
600 | notice to the person whose location is unknown. However, a

601 diligent search is not required to be conducted for a  
602 prospective parent if there is an identified legal father, as  
603 defined in s. 39.01, of the child.

604 ~~(7)(6)~~ The diligent search required by subsection ~~(6)(5)~~  
605 must include, at a minimum, inquiries of all known relatives of  
606 the parent or prospective parent, inquiries of all offices of  
607 program areas of the department likely to have information about  
608 the parent or prospective parent, inquiries of other state and  
609 federal agencies likely to have information about the parent or  
610 prospective parent, inquiries of appropriate utility and postal  
611 providers, a thorough search of at least one electronic database  
612 specifically designed for locating persons, a search of the  
613 Florida Putative Father Registry, and inquiries of appropriate  
614 law enforcement agencies. Pursuant to s. 453 of the Social  
615 Security Act, 42 U.S.C. s. 653(c)(4), the department, as the  
616 state agency administering Titles IV-B and IV-E of the act,  
617 shall be provided access to the federal and state parent locator  
618 service for diligent search activities.

619 ~~(8)(7)~~ Any agency contacted by petitioner with a request  
620 for information under ~~pursuant to~~ subsection ~~(7)(6)~~ shall  
621 release the requested information to the petitioner without the  
622 necessity of a subpoena or court order.

623 (9) If the inquiry and diligent search identifies and  
624 locates a parent, that person is considered a parent for all  
625 purposes under this chapter and must be provided notice of all

626 hearings.

627 (10)-(8) If the inquiry and diligent search identifies and  
628 locates a prospective parent and there is no legal father, that  
629 person must be given the opportunity to become a party to the  
630 proceedings by completing a sworn affidavit of parenthood and  
631 filing it with the court or the department. A prospective parent  
632 who files a sworn affidavit of parenthood while the child is a  
633 dependent child but no later than at the time of or before the  
634 adjudicatory hearing in the termination of parental rights  
635 proceeding for the child shall be considered a parent for all  
636 purposes under this chapter section. A person does not have  
637 standing to file a sworn affidavit of parenthood or otherwise  
638 establish parenthood, except through adoption, after the entry  
639 of a judgment terminating the parental rights of the legal  
640 father for a child. If the known parent contests the recognition  
641 of the prospective parent as a parent, the court having  
642 jurisdiction over the dependency matter shall conduct a  
643 determination of parentage proceeding under chapter 742. The  
644 prospective parent may not be recognized as a parent until  
645 proceedings to determine maternity or paternity have been  
646 concluded. However, the prospective parent shall continue to  
647 receive notice of hearings as a participant pending results of  
648 the proceedings to determine maternity or paternity.

649 (11)-(9) If the diligent search under subsection (6)-(5)  
650 fails to identify and locate a parent or prospective parent who



651 was identified during the inquiry under subsection (1), the  
 652 court shall so find and may proceed without further notice and  
 653 the petitioner is relieved from performing any further search.

654 Section 10. Paragraph (e) of subsection (1) and subsection  
 655 (2) of section 39.806, Florida Statutes, are amended to read:

656 39.806 Grounds for termination of parental rights.—

657 (1) Grounds for the termination of parental rights may be  
 658 established under any of the following circumstances:

659 (e) When a child has been adjudicated dependent, a case  
 660 plan has been filed with the court, and:

661 1. The child continues to be abused, neglected, or  
 662 abandoned by the parent or parents. The failure of the parent or  
 663 parents to substantially comply with the case plan for a period  
 664 of 12 months after an adjudication of the child as a dependent  
 665 child or the child's placement into shelter care, whichever  
 666 occurs first, constitutes evidence of continuing abuse, neglect,  
 667 or abandonment unless the failure to substantially comply with  
 668 the case plan was due to the parent's lack of financial  
 669 resources or to the failure of the department to make reasonable  
 670 efforts to reunify the parent and child. The 12-month period  
 671 begins to run only after the child's placement into shelter care  
 672 or the entry of a disposition order placing the custody of the  
 673 child with the department or a person other than the parent and  
 674 the court's approval of a case plan having the goal of  
 675 reunification with the parent, whichever occurs first; ~~or~~

676           2. The parent or parents have materially breached the case  
677 plan by their action or inaction. Time is of the essence for  
678 permanency of children in the dependency system. In order to  
679 prove the parent or parents have materially breached the case  
680 plan, the court must find by clear and convincing evidence that  
681 the parent or parents are unlikely or unable to substantially  
682 comply with the case plan before time to comply with the case  
683 plan expires; or.

684           3. The child has been in care for any 12 of the last 22  
685 months and the parents have not substantially complied with the  
686 case plan so as to permit reunification under s. 39.522(3) ~~s.~~  
687 ~~39.522(2)~~ unless the failure to substantially comply with the  
688 case plan was due to the parent's lack of financial resources or  
689 to the failure of the department to make reasonable efforts to  
690 reunify the parent and child.

691           (2) Reasonable efforts to preserve and reunify families  
692 are not required if a court of competent jurisdiction has  
693 determined that any of the events described in paragraphs  
694 (1) (b) - (d) or paragraphs (1) (f) - (n) ~~(1) (f) - (m)~~ have occurred.

695           Section 11. Subsection (9) of section 39.811, Florida  
696 Statutes, is amended to read:

697           39.811 Powers of disposition; order of disposition.—

698           (9) After termination of parental rights or a written  
699 order of permanent commitment entered under s. 39.5035, the  
700 court shall retain jurisdiction over any child for whom custody

701 is given to a social service agency until the child is adopted.  
702 The court shall review the status of the child's placement and  
703 the progress being made toward permanent adoptive placement. As  
704 part of this continuing jurisdiction, for good cause shown by  
705 the guardian ad litem for the child, the court may review the  
706 appropriateness of the adoptive placement of the child. The  
707 department's decision to deny an application to adopt a child  
708 who is under the court's jurisdiction is reviewable only through  
709 a motion to file a chapter 63 petition as provided in s.  
710 39.812(4), and is not subject to chapter 120.

711 Section 12. Subsections (1), (4), and (5) of section  
712 39.812, Florida Statutes, are amended to read:

713 39.812 Postdisposition relief; petition for adoption.—

714 (1) If the department is given custody of a child for  
715 subsequent adoption in accordance with this chapter, the  
716 department may place the child with an agency as defined in s.  
717 63.032, with a child-caring agency registered under s. 409.176,  
718 or in a family home for prospective subsequent adoption without  
719 the need for a court order unless otherwise required under this  
720 section. The department may allow prospective adoptive parents  
721 to visit with a child in the department's custody without a  
722 court order to determine whether the adoptive placement would be  
723 appropriate. The department may thereafter become a party to any  
724 proceeding for the legal adoption of the child and appear in any  
725 court where the adoption proceeding is pending and consent to

726 the adoption, and that consent alone shall in all cases be  
727 sufficient.

728 (4) The court shall retain jurisdiction over any child  
729 placed in the custody of the department until the child is  
730 adopted. After custody of a child for subsequent adoption has  
731 been given to the department, the court has jurisdiction for the  
732 purpose of reviewing the status of the child and the progress  
733 being made toward permanent adoptive placement. As part of this  
734 continuing jurisdiction, for good cause shown by the guardian ad  
735 litem for the child, the court may review the appropriateness of  
736 the adoptive placement of the child.

737 (a) If the department has denied a person's application to  
738 adopt a child, the denied applicant may file a motion with the  
739 court within 30 days after the issuance of the written  
740 notification of denial. This motion allows the denied applicant  
741 to file a chapter 63 petition to adopt a child without the  
742 department's consent. The denied applicant must allege in its  
743 motion that the department unreasonably withheld its consent to  
744 the adoption. The court, as part of its continuing jurisdiction,  
745 may review and rule on the motion.

746 1. The denied applicant only has standing in the chapter  
747 39 proceeding to file the motion in paragraph (a) and to present  
748 evidence in support of the motion at a hearing, which must be  
749 held within 30 days after the filing of the motion.

750 2. At the hearing on the motion, the court may only

751 consider whether the department's review of the application was  
752 consistent with its policies and made in an expeditious manner.  
753 The standard of review by the court is whether the department's  
754 denial of the application is an abuse of discretion. The court  
755 may not compare the denied applicant against another applicant  
756 to determine which placement is in the best interests of the  
757 child.

758 3. If the denied applicant establishes by a preponderance  
759 of the evidence that the department unreasonably withheld its  
760 consent, the court shall enter an order authorizing the denied  
761 applicant to file a petition to adopt the child under chapter 63  
762 without the department's consent.

763 4. If the denied applicant does not prove by a  
764 preponderance of the evidence that the department unreasonably  
765 withheld its consent, the court shall enter an order so finding  
766 and dismiss the motion.

767 5. The standing of the denied applicant in a proceeding  
768 under this chapter is terminated upon entry of the court's  
769 order.

770 (b) When a licensed foster parent or court-ordered  
771 custodian has applied to adopt a child who has resided with the  
772 foster parent or custodian for at least 6 months and who has  
773 previously been permanently committed to the legal custody of  
774 the department and the department does not grant the application  
775 to adopt, the department may not, in the absence of a prior

776 court order authorizing it to do so, remove the child from the  
777 foster home or custodian, except when:

778 1.~~(a)~~ There is probable cause to believe that the child is  
779 at imminent risk of abuse or neglect;

780 2.~~(b)~~ Thirty days have expired following written notice to  
781 the foster parent or custodian of the denial of the application  
782 to adopt, within which period no formal challenge of the  
783 department's decision has been filed; ~~or~~

784 3.~~(c)~~ The foster parent or custodian agrees to the child's  
785 removal; or.

786 4. The department has selected another prospective  
787 adoptive parent to adopt the child and either the foster parent  
788 or custodian has not filed a motion with the court to allow him  
789 or her to file a chapter 63 petition to adopt a child without  
790 the department's consent, as provided under paragraph (a), or  
791 the court has denied such a motion.

792 (5) The petition for adoption must be filed in the  
793 division of the circuit court which entered the judgment  
794 terminating parental rights, unless a motion for change of venue  
795 is granted under ~~pursuant to~~ s. 47.122. A copy of the consent  
796 executed by the department must be attached to the petition,  
797 unless such consent is waived under subsection (4) ~~pursuant to~~  
798 ~~s. 63.062(7)~~. The petition must be accompanied by a statement,  
799 signed by the prospective adoptive parents, acknowledging  
800 receipt of all information required to be disclosed under s.

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801 63.085 and a form provided by the department which details the  
802 social and medical history of the child and each parent and  
803 includes the social security number and date of birth for each  
804 parent, if such information is available or readily obtainable.  
805 The prospective adoptive parents may not file a petition for  
806 adoption until the judgment terminating parental rights becomes  
807 final. An adoption proceeding under this subsection is governed  
808 by chapter 63.

809 Section 13. Subsection (1) of section 39.820, Florida  
810 Statutes, is amended to read:

811 39.820 Definitions.—As used in this chapter part, the  
812 term:

813 (1) "Guardian ad litem" as referred to in any civil or  
814 criminal proceeding includes the following: the Statewide  
815 Guardian ad Litem Office, which includes circuit a certified  
816 guardian ad litem programs; program, a duly certified volunteer,  
817 a staff member, a staff attorney, a contract attorney, or a  
818 ~~certified~~ pro bono attorney working on behalf of a guardian ad  
819 litem ~~or the program; staff members of a program office;~~ a  
820 court-appointed attorney; or a responsible adult who is  
821 appointed by the court to represent the best interests of a  
822 child in a proceeding as provided for by law, including, but not  
823 limited to, this chapter, who is a party to any judicial  
824 proceeding as a representative of the child, and who serves  
825 until discharged by the court.

826 Section 14. Subsection (7) of section 63.062, Florida  
 827 Statutes, is amended to read:

828 63.062 Persons required to consent to adoption; affidavit  
 829 of nonpaternity; waiver of venue.—

830 (7) If parental rights to the minor have previously been  
 831 terminated, the adoption entity with which the minor has been  
 832 placed for subsequent adoption may provide consent to the  
 833 adoption. In such case, no other consent is required. If the  
 834 minor has been permanently committed to the department for  
 835 subsequent adoption, the department must consent to the adoption  
 836 or, in the alternative, the court order entered under s.  
 837 39.812(4) finding that the department ~~The consent of the~~  
 838 ~~department shall be waived upon a determination by the court~~  
 839 ~~that such consent is being~~ unreasonably withheld its consent  
 840 must be attached to the petition to adopt and ~~if~~ the petitioner  
 841 must file ~~has filed with the court~~ a favorable preliminary  
 842 adoptive home study as required under s. 63.092.

843 Section 15. Paragraph (b) of subsection (6) of section  
 844 63.082, Florida Statutes, is amended to read:

845 63.082 Execution of consent to adoption or affidavit of  
 846 nonpaternity; family social and medical history; revocation of  
 847 consent.—

848 (6)

849 (b) Upon execution of the consent of the parent, the  
 850 adoption entity is ~~shall be~~ permitted to intervene in the



851 dependency case as a party in interest and must provide the  
852 court that acquired jurisdiction over the minor, pursuant to the  
853 shelter order or dependency petition filed by the department, a  
854 copy of the preliminary home study of the prospective adoptive  
855 parents and any other evidence of the suitability of the  
856 placement. The preliminary home study must be maintained with  
857 strictest confidentiality within the dependency court file and  
858 the department's file. A preliminary home study must be provided  
859 to the court in all cases in which an adoption entity has  
860 intervened under ~~pursuant to~~ this section. The exemption in s.  
861 63.092(3) from the home study for a stepparent or relative does  
862 not apply if a minor is under the supervision of the department  
863 or is otherwise subject to the jurisdiction of the dependency  
864 court as a result of the filing of a shelter petition,  
865 dependency petition, or termination of parental rights petition  
866 under chapter 39. Unless the court has concerns regarding the  
867 qualifications of the home study provider, or concerns that the  
868 home study may not be adequate to determine the best interests  
869 of the child, the home study provided by the adoption entity is  
870 ~~shall be deemed to be~~ sufficient and no additional home study  
871 needs to be performed by the department.

872 Section 16. Subsection (6) and paragraphs (b) and (e) of  
873 subsection (7) of section 409.1451, Florida Statutes, are  
874 amended to read:

875 409.1451 The Road-to-Independence Program.—

876 (6) ACCOUNTABILITY.—The department shall develop outcome  
877 measures for the program and other performance measures ~~in order~~  
878 to maintain oversight of the program. ~~No later than January 31~~  
879 ~~of each year, the department shall prepare a report on the~~  
880 ~~outcome measures and the department's oversight activities and~~  
881 ~~submit the report to the President of the Senate, the Speaker of~~  
882 ~~the House of Representatives, and the committees with~~  
883 ~~jurisdiction over issues relating to children and families in~~  
884 ~~the Senate and the House of Representatives. The report must~~  
885 ~~include:~~

886 (a) ~~An analysis of performance on the outcome measures~~  
887 ~~developed under this section reported for each community-based~~  
888 ~~care lead agency and compared with the performance of the~~  
889 ~~department on the same measures.~~

890 (b) ~~A description of the department's oversight of the~~  
891 ~~program, including, by lead agency, any programmatic or fiscal~~  
892 ~~deficiencies found, corrective actions required, and current~~  
893 ~~status of compliance.~~

894 (c) ~~Any rules adopted or proposed under this section since~~  
895 ~~the last report. For the purposes of the first report, any rules~~  
896 ~~adopted or proposed under this section must be included.~~

897 (7) INDEPENDENT LIVING SERVICES ADVISORY COUNCIL.—The  
898 secretary shall establish the Independent Living Services  
899 Advisory Council for the purpose of reviewing and making  
900 recommendations concerning the implementation and operation of

901 the provisions of s. 39.6251 and the Road-to-Independence  
902 Program. The advisory council shall function as specified in  
903 this subsection until the Legislature determines that the  
904 advisory council can no longer provide a valuable contribution  
905 to the department's efforts to achieve the goals of the services  
906 designed to enable a young adult to live independently.

907 ~~(b) The advisory council shall report to the secretary on~~  
908 ~~the status of the implementation of the Road-to-Independence~~  
909 ~~Program, efforts to publicize the availability of the Road-to-~~  
910 ~~Independence Program, the success of the services, problems~~  
911 ~~identified, recommendations for department or legislative~~  
912 ~~action, and the department's implementation of the~~  
913 ~~recommendations contained in the Independent Living Services~~  
914 ~~Integration Workgroup Report submitted to the appropriate~~  
915 ~~substantive committees of the Legislature by December 31, 2013.~~  
916 ~~The department shall submit a report by December 31 of each year~~  
917 ~~to the Governor, the President of the Senate, and the Speaker of~~  
918 ~~the House of Representatives which includes a summary of the~~  
919 ~~factors reported on by the council and identifies the~~  
920 ~~recommendations of the advisory council and either describes the~~  
921 ~~department's actions to implement the recommendations or~~  
922 ~~provides the department's rationale for not implementing the~~  
923 ~~recommendations.~~

924 ~~(c) The advisory council report required under paragraph~~  
925 ~~(b) must include an analysis of the system of independent living~~

926 ~~transition services for young adults who reach 18 years of age~~  
927 ~~while in foster care before completing high school or its~~  
928 ~~equivalent and recommendations for department or legislative~~  
929 ~~action. The council shall assess and report on the most~~  
930 ~~effective method of assisting these young adults to complete~~  
931 ~~high school or its equivalent by examining the practices of~~  
932 ~~other states.~~

933 Section 17. Section 742.0211, Florida Statutes, is created  
934 to read:

935 742.0211 Proceedings applicable to dependent children.—

936 (1) As used in this section, the term "dependent child"  
937 means a child who is the subject of any proceeding under chapter  
938 39.

939 (2) In addition to the other requirements of this chapter,  
940 any paternity proceeding filed under this chapter that concerns  
941 a dependent child must also comply with the requirements of this  
942 section.

943 (3) Notwithstanding s. 742.021(1), a paternity proceeding  
944 filed under this chapter that concerns a dependent child may be  
945 filed in the circuit court of the county that is exercising  
946 jurisdiction over the chapter 39 proceeding, even if the  
947 plaintiff or defendant does not reside in that county.

948 (4) The court having jurisdiction over the dependency  
949 matter may conduct any paternity proceeding filed under this  
950 chapter either as part of the chapter 39 proceeding or as a

951 separate action under this chapter.

952 (5) A person does not have standing to file a complaint  
953 under this chapter after the entry of a judgment terminating the  
954 parental rights of the legal father, as defined in s. 39.01, for  
955 the dependent child in the chapter 39 proceeding.

956 (6) The court must hold a hearing on the complaint  
957 concerning a dependent child as required under s. 742.031 within  
958 30 days after the complaint is filed.

959 (7) (a) If the dependent child has a legal father, as  
960 defined in s. 39.01, and a different man, who has reason to  
961 believe that he is the father of the dependent child, has filed  
962 a complaint to establish paternity under this chapter and  
963 disestablish the paternity of the legal father, the alleged  
964 father must prove at the hearing held under s. 742.031 that:

965 1. He has acted with diligence in seeking the  
966 establishment of paternity.

967 2. He is the father of the dependent child.

968 3. He has manifested a substantial and continuing concern  
969 for the welfare of the dependent child.

970 (b) If the alleged father establishes the facts under  
971 paragraph (a), he must then prove by clear and convincing  
972 evidence that there is a clear and compelling reason to  
973 disestablish the legal father's paternity and instead establish  
974 paternity with him by considering the best interest of the  
975 dependent child.

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976 (c) There is a rebuttable presumption that it is not in  
977 the dependent child's best interest to disestablish the legal  
978 father's paternity if:

979 1. The dependent child has been the subject of a chapter  
980 39 proceeding for 12 months or more before the alleged father  
981 files a complaint under this chapter.

982 2. The alleged father does not pass a preliminary home  
983 study as required under s. 63.092 to be a placement for the  
984 dependent child.

985 (8) The court must enter a written order on the paternity  
986 complaint within 30 days after the conclusion of the hearing.

987 (9) If the court enters an order disestablishing the  
988 paternity of the legal father and establishing the paternity of  
989 the alleged father, then the newly established father shall be  
990 considered a parent, as defined in s. 39.01, for all purposes of  
991 the chapter 39 proceeding.

992 Section 18. This act shall take effect October 1, 2020.



## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCS for CS/HB 7053 Direct Care  
**SPONSOR(S):** Health & Human Services Committee  
**TIED BILLS:** **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee		Siples	Calamas

### SUMMARY ANALYSIS

Access to health care is an ongoing issue in this state. Florida, which has experienced a significant growth in its general population and its aging population, faces shortages of health care providers and direct care staff.

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. Employers find it difficult to retain individuals in these positions due to a lack of full-time employment and upward mobility.

PCS for 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, including 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, applying and reapplying bandages for minor cuts and abrasions, and nebulizer treatments.

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.

To increase access to health care for the general population, the bill authorizes advanced practice registered nurses (APRNs) who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol and authorizes physician assistants (PAs) to practice primary care without physician supervision. Under current law, APRNs must practice under a supervising protocol with a physician and only to the extent that a written protocol allows. Similarly, physician assistants (PAs) must practice under a supervising physician and may only perform those tasks delegated by the physician.

The bill revises the composition of the Council on PAs (Council) so that it has a PA majority. The bill requires the Boards of Medicine and Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council. The bill also expands the scope of practice for all PAs by authorizing them to certify involuntary examination under the Baker Act, file death certificates, certify causes of death, and participate in guardianship plans.

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 and authorizes 3.5 FTE, with associated salary rate of 183,195, and appropriates \$219,089 in recurring and \$17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to Department of Health (DOH) to implement the requirements of the bill. The bill has no fiscal impact on local governments.

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

**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

**STORAGE NAME:** pcs7053b.HHS

**DATE:** 2/25/2020



# FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

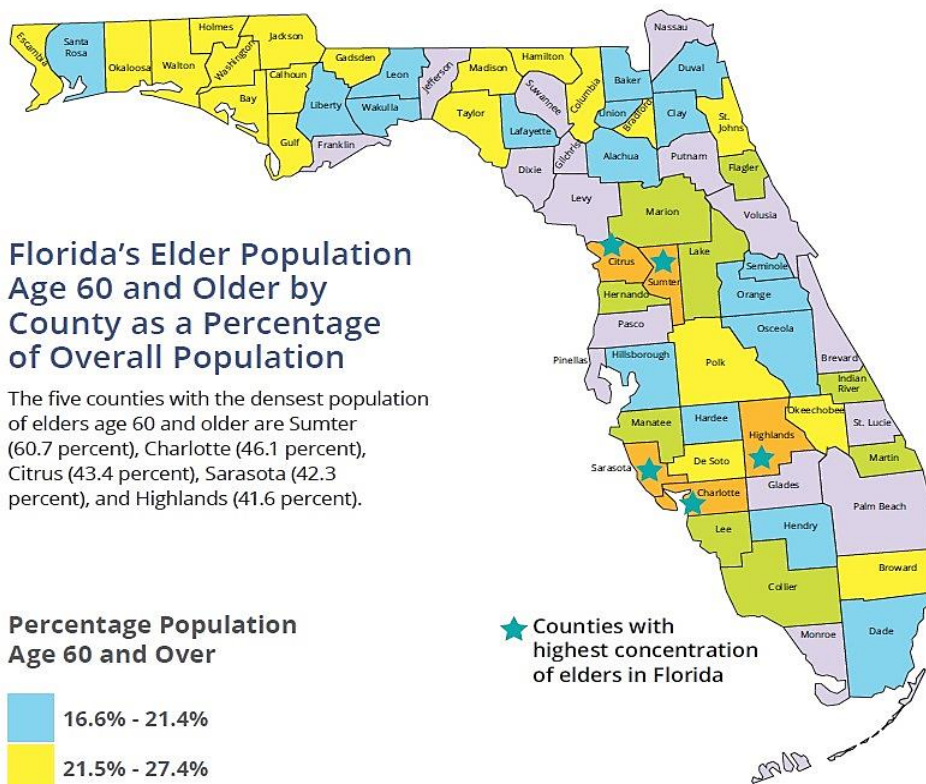
### A. EFFECT OF PROPOSED CHANGES:

#### Current 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.<sup>1</sup>

Florida ranks first in the nation in the percentage of residents who are age 65 or older.<sup>2</sup> It is estimated that 20.5 percent of the state's population is over the age of 65.<sup>3</sup> Florida ranks fourth in the nation in the percentage of residents who are 60 and older,<sup>4</sup> and there are 21 counties in which residents aged 60 and older comprise at least 25 percent of the population.<sup>5</sup>



Source: Department of Elder Affairs 2017 Final Profiles are based on Florida Legislature, Office of Economic and Demographic Research 2017 estimates, provided February 2018

<sup>1</sup> Paul Osterman, WHO WILL CARE FOR US: LONG-TERM CARE AND THE LONG-TERM CARE WORKFORCE 3 (2017).

<sup>2</sup> Department of Elder Affairs, 2019 Summary of Programs and Services, (Jan. 2019), available at [http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/SOPS\\_A.pdf](http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/SOPS_A.pdf) (last visited January 10, 2020).

<sup>3</sup> 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.

<sup>4</sup> *Supra* note 1 at p. 8.

<sup>5</sup> *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.<sup>6</sup> 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.<sup>7</sup> They work in many different settings, such as private homes, group homes, residential care facilities, assisted living facilities, skilled nursing facilities, and hospitals.<sup>8</sup> 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.<sup>9</sup>

### 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.<sup>10</sup> 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.<sup>11</sup> A CNA must biennially complete 24 hours of inservice training to maintain certification.<sup>12</sup>

The Board of Nursing establishes the general scope of practice for CNAs. A CNA performs services under the general supervision<sup>13</sup> of a registered nurse or licensed practical nurse.<sup>14</sup> A CNA may perform the following services:<sup>15</sup>

- 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;

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<sup>6</sup> 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).

<sup>7</sup> Paraprofessional Healthcare Institute, *Understanding the Direct Care Workforce*, available at <https://phinational.org/policy-research/key-facts-faq/> (last visited November 8, 2019).

<sup>8</sup> 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).

<sup>9</sup> *Id.*  
<sup>10</sup> 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).

<sup>11</sup> 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.

<sup>12</sup> Section 464.203(7), F.S.

<sup>13</sup> 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

<sup>14</sup> Rule 64B9-15.002, F.A.C.

<sup>15</sup> *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.<sup>16</sup>

### *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.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup>

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:<sup>20</sup>

- 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.<sup>21</sup>

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<sup>16</sup> *Supra* note 14.

<sup>17</sup> *Supra* note 10. If the only service the home health agency provides, is physical, speech, or occupational therapy, in addition to the home health aide or CNA services, the licensed therapist may provide supervision.

<sup>18</sup> 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](https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/Home_health_aides.shtml) (last visited January 20, 2020).

<sup>19</sup> Rules 59A-8.0095(5)

<sup>20</sup> *Id.*, and 64B9-15.002, F.A.C.

<sup>21</sup> Rule 59A-8.0095(5)(p), F.A.C.

## *Personal Care Assistants*

Personal care assistants (PCAs) work in either private or group homes.<sup>22</sup> They have many titles, including personal care attendant, home care worker, homemaker/companion, and direct support professional.<sup>23</sup> (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.<sup>24</sup> 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.<sup>25</sup> Florida Medicaid authorizes the following personal care services:<sup>26</sup>

- 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.<sup>27</sup> 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.<sup>28</sup> Many other states authorize HHAs or CNAs who complete additional training to administer medication.<sup>29</sup> For example, Texas authorizes home health medication aides.<sup>30</sup> Arizona, Georgia, Illinois, Minnesota, and North Arizona authorize CNAs to administer medication upon completion of specialized training.<sup>31</sup> Connecticut has a stand-alone medication administration technician profession.<sup>32</sup>

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<sup>22</sup> *Supra* note 10.

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> Agency for Health Care Administration, Florida Medicaid, *Personal Care Services Coverage Policy*, (Nov. 2016), adopted in r. 59G-4.215, F.A.C.

<sup>26</sup> *Id.*

<sup>27</sup> Section 465.003, F.S.

<sup>28</sup> Section 393.506, F.S.

<sup>29</sup> Some states specifically certify or license medication aides.

<sup>30</sup> See TEX. HEALTH & SAFETY CODE 242 and 26 TEX. ADMIN. CODE 557.128.

<sup>31</sup> 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.

<sup>32</sup> 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.<sup>33</sup> 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.<sup>34</sup> This 2-hour training may be included in the initial 75-hour or 40-hour HHA training.

Assistance with self-administration of medication includes:<sup>35</sup>

- 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:<sup>36</sup>

- 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.

### Direct Care Workforce Challenges

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.<sup>37</sup> The demand for home

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<sup>33</sup> *Supra* note 19.

<sup>34</sup> *Id.*

<sup>35</sup> Section 400.488(3), F.S.

<sup>36</sup> Section 400.488(4), F.S.

<sup>37</sup> 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*,  
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health aides and nursing assistants is expected to increase by 34 percent by 2025.<sup>38</sup> However, the turnover rate in long term care is estimated to be between 45 to 66 percent.<sup>39</sup>

Many factors contribute to the high turnover rate, including compensation, lack of full-employment, and low job satisfaction.<sup>40</sup> 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.<sup>41</sup>

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.<sup>42</sup> Indirect costs to employers include lost productivity, lost revenue, and reduced service quality.<sup>43</sup> 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.<sup>44</sup> 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.<sup>45</sup>

Approximately two-thirds of HHAs and PCAs work part time.<sup>46</sup> 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.<sup>47</sup> 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.<sup>48</sup>

Low job satisfaction, which in turn leads to higher turnover, results from inadequate training and lack of opportunities for advancement.<sup>49</sup> 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.<sup>50</sup> 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.<sup>51</sup> In fact, one in four CNAs and one in five HHAs report that they are actively seeking another job.<sup>52</sup>

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(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).

<sup>38</sup> Id.

<sup>39</sup> 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).

<sup>40</sup> *Supra* note 1, at pp. 27-37.

<sup>41</sup> 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](https://www.ahcancal.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf) (last visited January 20, 2020).

<sup>42</sup> 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](https://www.ncbi.nlm.nih.gov/books/NBK215401/pdf/Bookshelf_NBK215401.pdf) (last visited January 14, 2020).

<sup>43</sup> 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).

<sup>44</sup> *Supra* note 42.

<sup>45</sup> Id.

<sup>46</sup> 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](https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf) (last visited January 14, 2020).

<sup>47</sup> 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).

<sup>48</sup> 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).

<sup>49</sup> *Supra* note 41.

<sup>50</sup> *Supra* note 41, at p. 48.

<sup>51</sup> *Supra* note 42.

<sup>52</sup> Id.

Direct care workers are also at an increased risk of work-related injuries.<sup>53</sup> Direct care workers have an injury rate of 144 injuries per 10,000 workers among PCAs, 116 among HHAs, and 337 among CNAs.<sup>54</sup> By contrast, the injury rate across all occupations is 100 per 10,000 workers.<sup>55</sup>

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.<sup>56</sup>

### 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.<sup>57</sup> 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.<sup>58</sup>

CMS proposed that states collect a minimum data set of information on direct care workers, including the:

- Number 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:<sup>59</sup>

- 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.<sup>60</sup>

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<sup>61</sup> and some may be employed by individuals through government-funded programs, such as Medicaid.<sup>62</sup> However, since these individuals are directly employed by patients, it is difficult to quantify the size of this market.

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<sup>53</sup> *Supra* note 41.

<sup>54</sup> 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).

<sup>55</sup> *Id.*

<sup>56</sup> *Supra* note 46, at p. 8.

<sup>57</sup> 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).

<sup>58</sup> *Id.*

<sup>59</sup> *Id.* at p. 8.

<sup>60</sup> *Id.*

<sup>61</sup> *Supra* note 1 at 18.

<sup>62</sup> 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<sup>63</sup> 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.<sup>64</sup> 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.<sup>65</sup> Additionally, non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing requirements.<sup>66</sup>

### *Paid Feeding Assistants*

Under federal regulations, nursing home facilities may employ trained feeding assistants to help residents who have no complicated feeding problems but need some assistance in eating or drinking.<sup>67</sup>

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<sup>63</sup> A week is defined as Sunday through Saturday.

<sup>64</sup> 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.

<sup>65</sup> 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.

<sup>66</sup> Sections 400.23(3)(b), F.S.

<sup>67</sup> 42 C.F.R. s. 483.60(h). Complicated feeding problems include, but is not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.



Such feeding assistants must complete a state-approved training course, which must, at minimum, be eight hours and provide training on:<sup>68</sup>

- Feeding techniques;
- Assistance with feeding and hydration;
- Communication and interpersonal skills;
- Appropriate responses to resident behavior;
- Safety and emergency procedures, including the Heimlich maneuver;
- Infection control;
- Residents rights; and
- Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

Paid feeding assistants must work under the supervision of a registered nurse or licensed practical nurse. Facilities must maintain a record of all individuals that have successfully complete the training course and it uses as paid feeding assistants. Currently, paid feeding assistants are not allowed in Florida as there are no state-approved training courses. AHCA

### Background Screening

Certain licensees, including CNAs, and certain individuals who provide services to vulnerable populations<sup>69</sup> must pass a background screening to be approved for certification or employment. Chapter 435, F.S., outlines the screening requirements.

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.<sup>70</sup> 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,<sup>71</sup> 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.<sup>72</sup>

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.<sup>73</sup> The FDLE notifies the employer or agency whether a screening has revealed any disqualifying information.<sup>74</sup>

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.<sup>75</sup> The Clearinghouse allows the background screening results to be shared among these agencies, so that the employee or licensee

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<sup>68</sup> 42 C.F.R. s. 483.160.

<sup>69</sup> "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.

<sup>70</sup> Section 435.05(1)(a), F.S.

<sup>71</sup> 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).

<sup>72</sup> Section 435.04, F.S.

<sup>73</sup> Section 435.05(1)(b)-(c), F.S.

<sup>74</sup> Section 435.05(1)(c), F.S.

<sup>75</sup> Section 435.12, F.S.

does not have to undergo multiple background screenings when changing employers.<sup>76</sup> Employers register with the Clearinghouse and maintain the employment status of its employees listed in the Clearinghouse by timely reporting changes in employment.<sup>77</sup>

## Health Care Workforce

### Health Care Professional Shortage

The U.S. has a current health care provider shortage.<sup>78</sup> As of December 31, 2019, the U.S. Department of Health and Human Services has designated 7,655 Primary Medical Health Professional Shortage Areas (HPSAs) (requiring 14,392 additional primary care physicians to eliminate the shortage), 6,520 Dental HPSAs (requiring 10,258 additional dentists to eliminate the shortage), and 6,117 Mental Health HPSAs (requiring 6,335 additional psychiatrists to eliminate the shortage).<sup>79</sup>

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population<sup>80</sup> and ongoing efforts to expand access.<sup>81</sup> Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.<sup>82</sup> Additionally, as more individuals qualify for health care benefits, there will necessarily be greater demand for more health care professionals to provide these services.

Florida is not immune to this national problem and also has a health care provider shortage itself. Florida has 735 HPSAs just for primary care, dental care, and mental health.<sup>83</sup> It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.<sup>84</sup>

### Health Care Workforce Data

#### *Physician Workforce*

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 46,900 and 121,900 across all specialties by 2032.<sup>85</sup> In 2018, there were 277.8 physicians<sup>86</sup> actively practicing per 100,000 population in the U.S., ranging from a high of 449.5 in Massachusetts to a low of 191.3 in Mississippi.<sup>87</sup> The states with the highest number of

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<sup>76</sup> Section 435.12(1), F.S.

<sup>77</sup> Section 435.12(20), F.S.

<sup>78</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Dec. 31, 2019), available at <https://data.hrsa.gov/topics/health-workforce/shortage-areas> (last visited February 20, 2020). Click on "Designated HPSA Quarterly Summary" to access the report.

<sup>79</sup> *Id.*

<sup>80</sup> There will be an increase in the U.S. population, estimated to grow from just over 323 million in 2016 to approximately 355 million in 2030, eventually reaching just under 405 million in 2060. See U.S. Census Bureau, *2017 National Populations Projections Tables* available at <https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html> (last visited February 20, 2020). Click on "Table 1. Projected population size and births, deaths, and migration."

<sup>81</sup> Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, (April 2019), available at [https://www.aamc.org/system/files/c/2/31-2019\\_update\\_-\\_the\\_complexities\\_of\\_physician\\_supply\\_and\\_demand\\_-\\_projections\\_from\\_2017-2032.pdf](https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf) (last visited February 20, 2020).

<sup>82</sup> *Id.*

<sup>83</sup> *Supra* note 78.

<sup>84</sup> *Id.*

<sup>85</sup> *Supra* note 81.

<sup>86</sup> These totals include allopathic and osteopathic physicians.

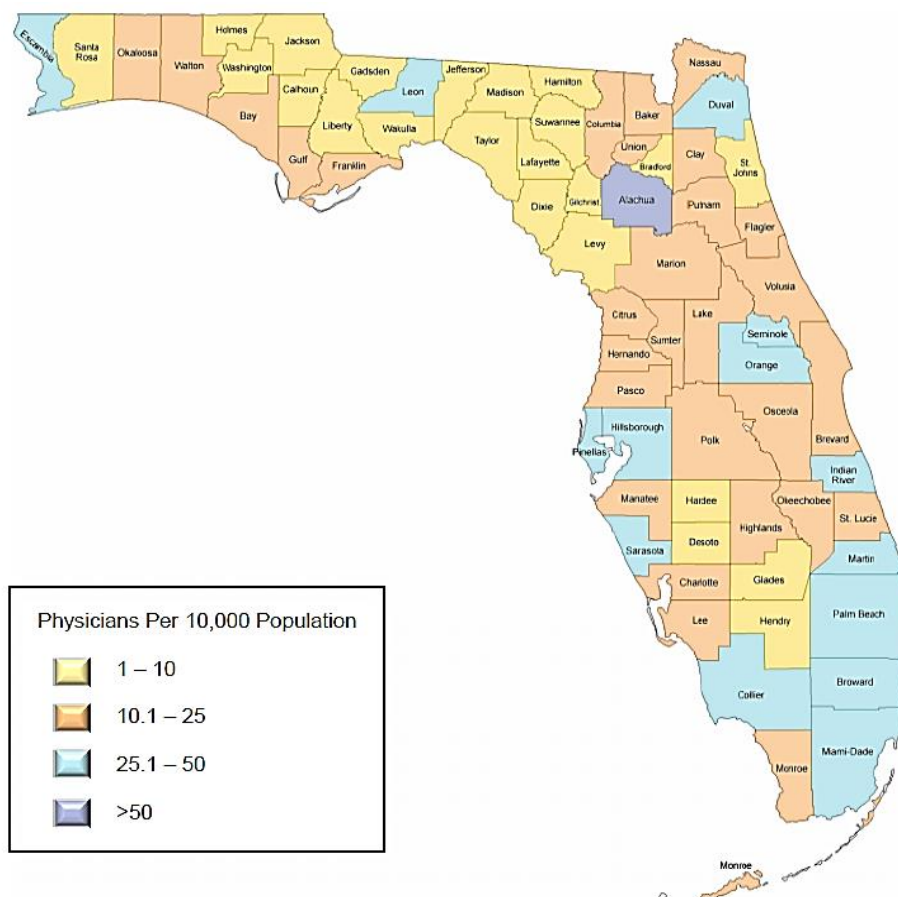
<sup>87</sup> Association of American Medical Colleges, *2019 State Physician Workforce Data Book*, November 2019, pg. 5, available at <https://store.aamc.org/2019-state-physician-workforce-data-report.html> (last visited on February 21, 2020). The book must be downloaded to view its contents.

physicians per 100,000 population are concentrated in the northeastern states. Regarding primary care physicians, there were 92.5 per 100,000 population.<sup>88</sup>

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.<sup>89</sup> Although Florida is the third most populous state in the nation,<sup>90</sup> it ranks as having the 23rd highest physician to population ratio.<sup>91</sup> In 2018, Florida had a ratio of 86.8 primary care physicians providing direct patient care per 100,000 population, ranking Florida 31st compared to other states.<sup>92</sup>

In its 2019 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 12.5 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.<sup>93</sup> Additionally, 35 percent of practicing physicians are age 60 and older.<sup>94</sup>

The following map illustrates that not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.<sup>95</sup>



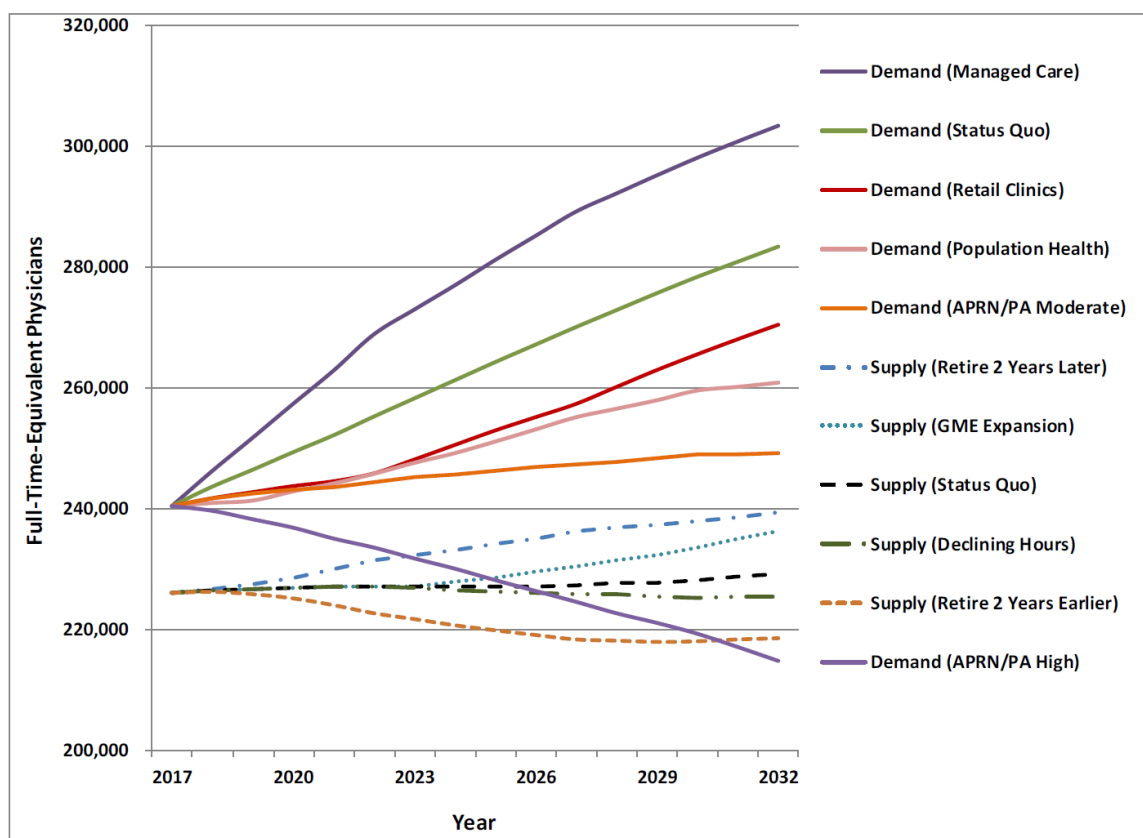
<sup>88</sup> Id.  
<sup>89</sup> *Supra* note 87, at pp. 7-8  
<sup>90</sup> As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 21,299,325 residents, behind California (39,557,045) and Texas (28,701,845). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates*, available at: [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP\\_2014\\_PEPANNRES&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table) (last visited on February 21, 2020).  
<sup>91</sup> *Supra* note 87, at pp. 7-8.  
<sup>92</sup> *Supra* note 87, at pp. 12-13.  
<sup>93</sup> Florida Department of Health, "2019 Physician Workforce Annual Report," (Nov. 2019), available at: <http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2019DOHPhysicianWorkforceReport-10-30-19.pdf> (last visited on February 21, 2020).  
<sup>94</sup> Id. at p. 9.  
<sup>95</sup> Id. at p. 42.

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The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.<sup>96</sup> Currently, primary care physicians make up 28 percent of the physician workforce.<sup>97</sup> In 2018, 26 percent of new medical school graduates entered the workforce as primary care providers, and this rate will maintain the status quo of the supply of primary care physicians.<sup>98</sup> However, in almost any scenario, the projected supply and demand for primary care physicians demonstrate that demand will exceed supply except the scenario that reflects the highest use of APRNs and PAs.<sup>99</sup>

The table below compares the effects of a moderate increase in the use of APRNs and PAs, greater use of alternate settings such as retail clinics, delayed physician retirement, expansion in graduate medical education, and changes in payment and delivery system, on the supply and demand for primary care physicians.<sup>100</sup>

**Exhibit 3: Projected Supply and Demand for Primary Care Physicians, 2017-2032**



In Florida, more than a third of the practicing physicians are primary care physicians (34.9 percent).<sup>101</sup> Of these, 14.2 percent of family medicine physicians and 11.0 percent of general internal medicine physicians have expressed an intention to retire in the next five years and approximately 4.5 percent and 4.4 percent, respectively, have expressed an intention to relocate out of the state in the next five years.<sup>102</sup>

<sup>96</sup> *Supra* note 81. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.

<sup>97</sup> *Id.* at p. 45.

<sup>98</sup> *Id.* at p. 46.

<sup>99</sup> *Id.* at p. 18.

<sup>100</sup> *Id.*

<sup>101</sup> *Supra* note 93 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.

<sup>102</sup> *Id.* at p. 25.

## Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNP), 45,000 certified registered nurse anesthetists (CRNAs), 6,500 certified nurse midwives (CNMs), and 3,059,800 registered nurses (RNs) employed in the U.S.<sup>103</sup> There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.<sup>104</sup>

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.<sup>105</sup> There are also 309,761 actively licensed registered nurses. Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 156 APRNs and 1,469 RNs.<sup>106</sup> The Florida Center for Nursing Center) estimates that in 2016 and 2017, the number of APRNs who are actually working is 22,795,<sup>107</sup> and the number of RNs who are actually working is 208,870.<sup>108</sup> Using these numbers the figures are: 108 APRNs and 990 RNs per 100,000 population.

The Center also reports that approximately 45 percent of Florida's RNs<sup>109</sup> and 39 percent of the state's APRNs<sup>110</sup> are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.<sup>111</sup>

## Physician Assistant Workforce

In Florida, there are approximately 9,784 actively licensed physician assistants (PAs),<sup>112</sup> which means there are approximately 46 PAs per 100,000 Florida population. Approximately 21 percent of certified PAs in Florida are practicing in primary care, which includes family medicine, general internal medicine, and general pediatrics.<sup>113</sup> On average, a full-time PA sees 83 patients a week.<sup>114</sup>

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<sup>103</sup> U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," available at: <http://data.bls.gov/projections/occupationProj> (last visited on February 21, 2020).

<sup>104</sup> These ratios were calculated using the U.S. Census Bureau's total population estimate for 2018, which was 327,167,434, which is available at:

[http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP\\_2014\\_PEPANNRES&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table) (last visited on February 21, 2020) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.

<sup>105</sup> 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 21, 2020).

<sup>106</sup> These ratios were calculated using population estimates as of April 1, 2019 provided by the Florida Office of Economic & Demographic Research, which is 21,091,609, and available at: [http://edr.state.fl.us/Content/population-demographics/data/2019\\_Pop\\_Estimates.pdf](http://edr.state.fl.us/Content/population-demographics/data/2019_Pop_Estimates.pdf) (last visited February 21, 2020).

<sup>107</sup> Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Advanced Registered Nurse Practitioners*, (June 2018), available at

[https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core\\_Download&EntryId=1611&PortalId=0&TabId=151](https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1611&PortalId=0&TabId=151) (last visited on February 21, 2020).

<sup>108</sup> Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Registered Nurses*, (June 2018), available at

[https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core\\_Download&EntryId=1608&PortalId=0&TabId=151](https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1608&PortalId=0&TabId=151) (last visited on February 21, 2020).

<sup>109</sup> *Supra* note 108. Of working RNs in this state, 25.4 percent are 51 to 60 years old and 20.1 percent are 61 or older.

<sup>110</sup> *Supra* note 107. Of working APRNs in this state, 22.6 percent are 51 to 60 years old and 16.7 percent are 61 or older.

<sup>111</sup> Florida Center for Nursing, Presentation on Florida's Nurse Workforce, January 23, 2019, available at

[https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting\\_Packets&FileName=hqs\\_1-23-19.pdf](https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting_Packets&FileName=hqs_1-23-19.pdf) (last visited on November 20, 2019).

<sup>112</sup> *Supra* note 105.

<sup>113</sup> National Commission on Certification of Physician Assistants, *2018 Statistical Profile of Certified Physician Assistants by State: An Annual Report of the National Commission on Certification of Physician Assistants*, (Jan. 2019), available at <https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPhysicianAssistants.pdf> (last visited March 12, 2019). Please note that PAs must pass the initial certification examination to qualify for licensure in Florida; however, certification is not an ongoing requirement for licensure.

<sup>114</sup> Id at p. 47.

## Advanced Practice Nurses

### Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)<sup>115</sup> is licensed in one of four roles: a certified nurse practitioner (CNP), certified nurse midwife (CNM), clinical nurse specialist (CNS), or certified registered nurse anesthetist (CRNA).<sup>116</sup> As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.<sup>117</sup>

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (Board), established under s. 464.004, F.S., provides by rule the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices. Additionally, the Board is responsible for administratively disciplining an APRN who commits an act prohibited under ss. 464.018 or 456.072, F.S.

Section 464.003(2), F.S., defines the term “advanced or specialized nursing practice” to include, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician’s protocol.<sup>118</sup> In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician’s protocol.<sup>119</sup>

To be eligible to be licensed as an APRN, an applicant must be licensed as a registered nurse, have a master’s degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.<sup>120</sup> A nursing specialty board must:<sup>121</sup>

- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

Pursuant to s. 456.048, F.S., all APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility within sixty days of licensure and prior to each biennial licensure renewal. The APRN must have professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000 or an unexpired irrevocable letter of credit in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000 and which is payable to the APRN as beneficiary.<sup>122</sup> By comparison, physicians must establish some method of financial

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<sup>115</sup> Section 464.003(3), F.S.

<sup>116</sup> Section 464.012(4), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from “Advanced Registered Nurse Practitioner (APRN)” to “Advanced Practice Registered Nurse (APRN),” and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (see ch. 2018-106, Laws of Fla.). DOH is still in the process of effectuating this transition.

<sup>117</sup> Email correspondence from DOH dated November 25, 2019, on file with committee staff.

<sup>118</sup> Section 464.012(3)-(4), F.S.

<sup>119</sup> Section 464.003, F.S., and s. 464.012, F.S.

<sup>120</sup> Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.

<sup>121</sup> Rule 64B9-4.002(3), F.A.C.

<sup>122</sup> Rule 64B9-4.002, F.A.C. DOH Form DH-MQA 1186, 01/09, “Financial Responsibility,” is incorporated into the rule by reference. Certain licensees, such as those who practice exclusively for federal or state governments, only practice in conjunction with a teaching position, or can demonstrate no malpractice exposure in this state are exempt from the financial responsibility requirements.

responsibility with the same coverage amounts and can choose one of three options for doing so: malpractice insurance, an escrow account, or a letter of credit. However, physicians who agree to pay adverse judgments, up to certain statutory limits, are exempt from this requirement but must notify patients that they have chosen not to carry malpractice insurance.<sup>123</sup>

Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, HB 423 eliminated the joint committee and instead, authorized physicians and APRNs to determine the medical acts the APRN could perform within the supervisory protocol.<sup>124</sup>

### APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:<sup>125</sup>

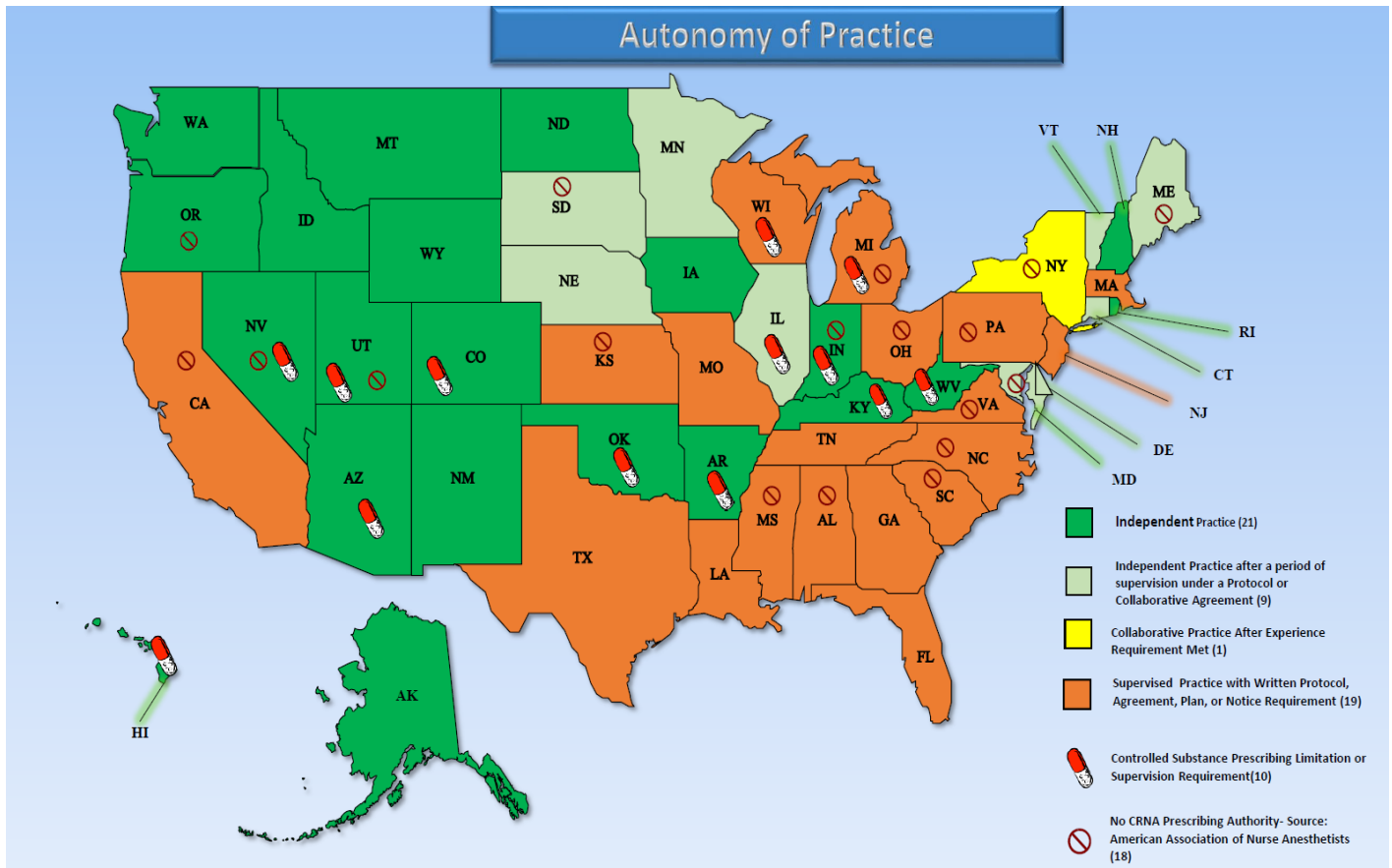
1. Independent nursing practice;
2. Transitory period in which an APRN is supervised by a physician or independent APRN prior to authority to engage in independent nursing practice;
3. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement; or
4. Supervised nursing practice or prescribing that requires physician supervision with a written agreement, protocol, notice, or plan signed by the physician, who has discretion as to what practices are authorized, including controlled substance prescribing.

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<sup>123</sup> If allopathic and osteopathic physicians meet certain eligibility criteria and post signage at their medical office disclosing to the public that they do not carry medical malpractice insurance, they are exempt from medical malpractice or proof of financial responsibility requirements provided in ss. 458.320 and 459.0085, F.S., respectively.

<sup>124</sup> Chapter 2016-224, Laws of Fla.

<sup>125</sup> Findings based on research conducted by professional staff of the Health and Human Services Committee.



### APRN Autonomy in Veterans Health Administration Facilities

The U.S. Department of Veterans Affairs (VA) adopted a rule in December 2016, which permits APRN full practice authority.<sup>126</sup> Under the rule, an APRN working within the scope of his or her VA employment is authorized to perform specified services within the scope of his or her training, education, and certification without the clinical oversight of a physician, regardless of state law restrictions. However, the rule expressly provides that the full practice of an APRN is subject to state law with regard to the prescribing or administration of controlled substances. The rule is limited to CNPs, CNMs, and CNSs, and does not apply to CRNAs. In Florida, 59 VA medical centers and health care clinics are affected by this policy change.<sup>127</sup>

### APRN Autonomy in Florida

Florida is a supervisory state. Under s. 464.012(3), F.S., APRNs may perform only those nursing and medical practices delineated in a written physician protocol. A physician providing primary health care services may supervise APRNs in up to four medical offices,<sup>128</sup> in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices in addition to the physician's primary practice location may be supervised.<sup>129</sup> Furthermore, a special

<sup>126</sup> U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Grants Full Practice Authority to Advanced Practice Registered Nurses," (December 14, 2016), available at <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847> (last visited February 21, 2020). The final rule can be found at <https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf> (last visited on February 21, 2020).

<sup>127</sup> U.S. Department of Veterans Affairs, Veterans Health Administration, "Locations: Florida," available at: <http://www.va.gov/directory/guide/state.asp?STATE=FL&dnum=1> (last visited February 21, 2020).

<sup>128</sup> The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.

<sup>129</sup> Sections 458.348, and 459.025, F.S.



limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.<sup>130</sup>

### APRN Scope of Practice

State laws vary as to the scope within which an APRN may practice, which is often determined by whether the APRN is a CNP, CNM, CNS, or CRNA, and often relates to the authority to prescribe drugs and sign documents.

Twenty of the 30 independent practice states authorize an APRN to prescribe controlled substances to a patient without physician supervision. Several independent practice states, such as Arkansas, Kentucky, Michigan, Oklahoma, and Wisconsin, require APRNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.<sup>131</sup> In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017.<sup>132</sup> The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,<sup>133</sup> as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.<sup>134</sup> The map on p. 7 illustrates the varying controlled substance prescribing requirements throughout the U.S.

Thirty-nine states, including Florida, recognize APRNs as "primary care providers" in policy.<sup>135</sup> Recognizing APRNs as primary care providers assists them with being able to directly bill public or private payers for services provided, order certain tests, and establish independent primary care practices.<sup>136</sup> Insurers may be unwilling to contract directly with a provider who is supervised by another provider.

### *APRN Scope of Practice in Florida*

Within the framework of the written protocol, an APRN may:

- Prescribe, dispense, administer, or order any drug;<sup>137</sup>
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy; and
- Perform certain acts within his or her specialty.<sup>138</sup>

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<sup>130</sup> *Id.*

<sup>131</sup> *Supra* note 125. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.

<sup>132</sup> Chapter 2016-224, Laws of Fla.

<sup>133</sup> Pursuant to s. 893.03(2), a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.

<sup>134</sup> *Supra* note 125.

<sup>135</sup> Scope of Practice Policy, *Nurse Practitioners: Nurse Practitioner as Primary Care Provider*, available at <http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/> (last visited February 21, 2020). APRNs may practice as a primary care provider in states that do not specifically recognize them as such.

<sup>136</sup> Tine Hansen-Turton, BA, MGA, et. al., "Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change," *POLICY, POLITICS & NURSING PRACTICE*, 7:3 (Aug. 2006), pp. 216-226.

<sup>137</sup> Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.

<sup>138</sup> Sections 464.012(3),(4), and 464.003, F.S.

APRNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APRNs are not authorized to sign a certificate to initiate the involuntary examination of a person under the Baker Act, to sign for the release of persons in receiving facilities under the Baker Act, or to sign death certificates.<sup>139</sup>

## Reports and Studies Related to Advanced Practice Nurses

### *Patient Health Care Outcomes*

Despite concerns that APRNs provide a different quality of care than physicians,<sup>140</sup> a multitude of reports and studies suggest treatment by an APRN is just as safe as treatment by a physician. In 2018, the Cochrane Collaboration updated a review of the findings of 25 articles comparing physician and APRN patient outcomes, which was first published in 2009. The review found that, in general, compared to primary care physicians, APRNs:<sup>141</sup>

- Probably provide equal or possibly even better quality of care compared to primary care physicians;
- Probably achieve equal or better health outcomes for patients;
- Probably achieve higher levels of patient satisfaction;
- Had longer consultation lengths and higher return visits; and
- Had comparable resource utilization outcomes.

The study was unable to ascertain the effects of nurse-led care on the costs of care.

Similar to the Cochrane review, the National Governors Association performed a review of various studies to determine whether there were differences in the quality of care provided by CNPs compared to physicians. The studies measured quality of care components such as patient satisfaction, time spent with patients, and prescribing accuracy. The review of those studies found that CNPs provided at least equal quality of care to patients as compared to physicians and, in fact, CNPs were found to have equal or higher patient satisfaction rates and tended to spend more time with patients during clinical visits.<sup>142</sup>

A recently published study of medically complex patients within the VA health care system found that patients of primary care APRNs and PAs incurred less outpatient, pharmacy, and total expenditures than patients of physicians.<sup>143</sup> This same study found that patients of APRNs and PAs also sought care at in an emergency department of a hospital less frequently than patients of physicians. A 2013 study, found that allowing CNPs to practice and prescribe drugs without physician oversight leads to increased primary health care utilization and improvements in health outcomes.<sup>144</sup>

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<sup>139</sup> Sections 394.463(2) and 382.008, F.S.

<sup>140</sup> When 972 clinicians, including 467 nurse practitioners and 505 physicians, were surveyed in a study as to whether physicians provide a higher quality of examination and consultation, the respondents were diametrically opposed. Approximately 66.1% of physicians agreed with the statement and 75.3% of nurse practitioners disagreed with the statement. Donelan, K., Sc.D., DesRoches, C., Dr. P.H., Dittus, R., M.D., M.P.H., and Buerhaus, P., R.N., Ph.D., "Perspectives of Physicians and Nurse Practitioners on Primary Care Practice," N. ENGL. J. MED. 2013, 368:1898-1906, available at <http://www.nejm.org/doi/full/10.1056/NEJMsa1212938> (last visited on February 21, 2020).

<sup>141</sup> Laurant, M., et al., The Cochrane Collaboration, "Nurses as Substitute for Doctors in Primary Care," July 16, 2018, available at <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001271.pub3/full> (last visited on February 21, 2020).

<sup>142</sup> National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, available at <http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf> (last visited on February 21, 2020).

<sup>143</sup> Perri A. Morgan, et. al. "Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients," HEALTH AFFAIRS, 38:6 (2019), available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00014> (last visited February 21, 2020).

<sup>144</sup> Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," May 4, 2014, available at [http://www2.hawaii.edu/~jtraczyn/paperdraft\\_050414\\_ASHE.pdf](http://www2.hawaii.edu/~jtraczyn/paperdraft_050414_ASHE.pdf) (last visited on February 21, 2020).

## Cost Savings

The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. These rising costs will only be intensified by the increasing number of persons with health care coverage and the shortage of health care workers.<sup>145</sup>

A 2012 Texas analysis of APRN practice concluded that more efficient use of APRNs in the provision of patient care, especially primary care, would improve patient outcomes, reduce overall health care costs, and increase access to health care.<sup>146</sup> The report estimated savings of \$16.1 billion in total expenditures and \$8 billion in output (gross product) each year.<sup>147</sup> Additionally, it was estimated that 97,205 permanent jobs would be added to Texas' workforce. Finally, the report estimated that Texas would receive additional tax receipts of up to \$483.9 million to the state and \$233.2 million to local government entities each year.<sup>148</sup>

Another study found that states that allow APRNs to practice and prescribe without physician supervision experience 16-35% increases in health care utilization, increases in care quality, and reductions in inappropriate emergency room use.<sup>149</sup> The researchers concluded these advances were primarily due to elimination of supervision time (10%) and lower indirect costs (such as better appointment availability and lower patient travel costs).<sup>150</sup>

Finally, a study found that individuals treated by primary care APRNs who were dually-eligible for Medicaid and Medicare had a lower risk of preventable hospitalizations and emergency department use than those cared for by primary care physicians.<sup>151</sup> The study also found that primary care APRNs treating those with chronic illnesses received the same health care services consistent with established guidelines as those treated by primary care physicians.<sup>152</sup>

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.<sup>153</sup> The FTC finds scope of practice restrictions anti-competitive, reduce competitive market pressures, increase out-of-pocket prices, limit service hours, and reduce the distribution of services.<sup>154</sup> The FTC poses that if such constraints were eliminated, not only would access to services be increased, but also there would be benefits to price competition that would help contain health care costs.<sup>155</sup>

## Physician Assistants

PAs are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S.

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<sup>145</sup> The Perryman Group, "The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas," May 2012, available at <https://cdn.ymaws.com/www.texasnp.org/resource/resmgr/Advocacy/Perryman%20APRN%20Utilization%20Economic%20Impact%20Report%20May%202012.pdf> (last visited on February 21, 2020).

<sup>146</sup> Id.

<sup>147</sup> Id.

<sup>148</sup> Id.

<sup>149</sup> *Supra* note 144.

<sup>150</sup> Id.

<sup>151</sup> Peter Buerhaus, American Enterprise Institute, *Nurse Practitioners: A Solution to America's Primary Care Crisis*, (Sept. 2018), available at <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/> (last visited February 21, 2020).

<sup>152</sup> Id.

<sup>153</sup> Federal Trade Commission, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, (Mar. 2014), available at <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicy.pdf> (last visited February).

<sup>154</sup> Id.

<sup>155</sup> Id.

## Council on Physician Assistants

The Council consists of five members including three physicians who are members of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and one licensed PA appointed by the Surgeon General.<sup>156</sup> Two of the physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:<sup>157</sup>

- Making recommendations to DOH regarding the licensure of PAs;
- Developing rules for the regulation of PAs for consideration for adoption by the boards;
- Making recommendations to the boards regarding all matters relating to PAs;
- Addressing concerns and problems of practicing PAs to ensure patient safety; and
- Denying, restricting, or placing conditions on the license of PA who fails to meet the licensing requirements.

## Licensure and Regulation of PAs

An applicant for a PA license must apply to DOH, and DOH must issue a license to a person certified by the Council as having met all of the following requirements:<sup>158</sup>

- Completed an approved PA training program;
- Obtained a passing score on the National Commission on Certification of Physician Assistants exam;
- Acknowledged any prior felony convictions;
- Submitted to a background screening and have no disqualifying offenses;<sup>159</sup>
- Acknowledged any previous revocation or denial of licensure in any state; and
- Provided a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.<sup>160</sup> To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially and must take a re-certification examination every 10 years.<sup>161</sup>

## PA Education

PA education programs are typically three years and award master's degrees.<sup>162</sup> Many programs require students to have health care experience as a condition for admission.<sup>163</sup> PA students receive classroom training in:<sup>164</sup>

- Anatomy;

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<sup>156</sup> Sections 458.347(9) and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. See ss. 458.307 and 459.004, F.S., respectively.

<sup>157</sup> Id.

<sup>158</sup> Sections 458.347(7) and 459.022(7), F.S.

<sup>159</sup> Section 456.0135, F.S.

<sup>160</sup> Sections 458.347(7)(c) and 459.022(7)(c), F.S.

<sup>161</sup> National Commission on Certification of Physician Assistants, *Maintaining Certification*, available at <https://www.nccpa.net/CertificationProcess> (last visited February 21, 2020).

<sup>162</sup> American Academy of PAs, *Become a PA*, available at <https://www.aapa.org/career-central/become-a-pa/> (last visited February 21, 2020).

<sup>163</sup> Id.

<sup>164</sup> Id.

- Physiology;
- Biochemistry;
- Pharmacology;
- Physical diagnosis;
- Pathophysiology;
- Microbiology;
- Clinical laboratory science;
- Behavioral science; and
- Medical Ethics.

A PA student must also complete approximately 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices, and acute or long-term care facilities.<sup>165</sup> A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.<sup>166</sup>

### PA Scope of Practice

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.<sup>167</sup> A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.<sup>168</sup> The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.<sup>169</sup>

The Boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate, is dependent upon the:

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.<sup>170</sup>

A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.<sup>171</sup> A supervising physician may delegate the authority for a PA to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the formulary established by the Council;<sup>172</sup>

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<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> Sections 458.347(2)(f) and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.

<sup>168</sup> Rules 64B8-30.012 and 64B15-6.010, F.A.C.

<sup>169</sup> Sections 458.347(15) and 459.022(15), F.S.

<sup>170</sup> Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.

<sup>171</sup> "Direct supervision" refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. "Indirect supervision" refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication. *Supra* note 170.

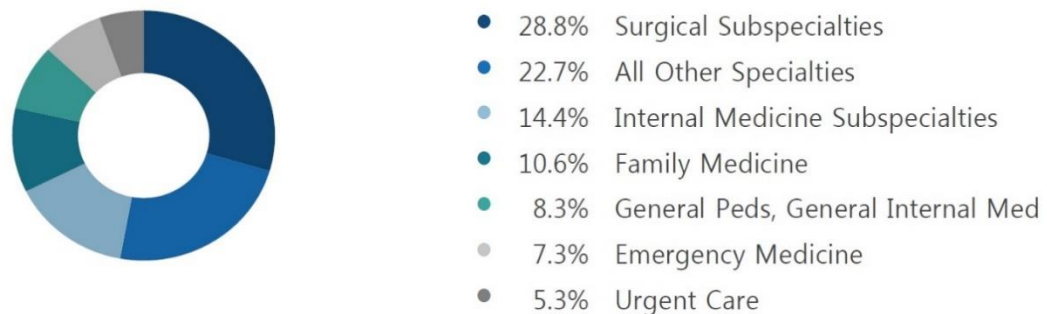
<sup>172</sup> Sections 458.347(4)(f), F.S., and 459.022(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C., prohibits PAs from prescribing; general, spinal or epidural anesthetics; radiographic contrast materials; and psychiatric mental health controlled substances for children younger

- Order any medication for administration to the supervising physician’s patient in a hospital or other facility licensed under chapter 395, F.S., or a nursing homes licensed under part II of chapter 400, F.S.;<sup>173</sup> and
- Perform any other service that are is not expressly prohibited in ch. 458, F.S., ch. 459, F.S., or the rules adopted thereunder.<sup>174</sup>

### PA Practice Characteristics

In the United States, approximately 26 percent of PAs work in primary care, which includes family medicine, general internal medicine, and general pediatrics.<sup>175</sup> Approximately 19 percent of Florida-licensed PAs practice primary care, but may also practice in other disciplines of medical practice:<sup>176</sup>

Percent of PAs by Specialty in Florida



### PA Adverse Incident Reporting

A PA must report to DOH, any adverse incident occurring in an office practice setting within 15 days after the occurrence of the adverse incident.<sup>177</sup> DOH must review each report to determine if discipline against the PA’s license is warranted.<sup>178</sup>

An adverse incident in an office setting is defined as an event over which the PA could exercise control and which is associated with a medical intervention and results in one of the following patient injuries:<sup>179</sup>

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- If the procedure results in death; brain or spinal damage; permanent disfigurement; the fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory functions; or any condition that required the transfer of a patient, the performance of:
  - A wrong-site surgical procedure;
  - A wrong surgical procedure; or

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than 18 years of age. It also restricts the prescribing of Schedule II controlled substances to a 7-day supply. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in hospitals and other facilities licensed under ch. 395, F.S.

<sup>173</sup> Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.

<sup>174</sup> Sections 458.347(4) and 459.022(e), F.S.

<sup>175</sup> *Supra* note 113.

<sup>176</sup> American Academy of PAs, *Florida Practice Profile*, available at [https://www.aapa.org/wp-content/uploads/2016/12/PAs\\_In\\_Florida.pdf](https://www.aapa.org/wp-content/uploads/2016/12/PAs_In_Florida.pdf) (last visited March 14, 2019).

<sup>177</sup> Sections 458.351 and 459.026, F.S.

<sup>178</sup> Sections 458.351(5) and 459.026(5), F.S.

<sup>179</sup> Sections 458.351(4) and 459.026(4), F.S.

- A surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process;
- A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
- Any condition that required the transfer of a patient to a hospital from an ambulatory surgical center or any facility or any office maintained by a physician for the practice of medicine which is not licensed under ch. 395, F.S.

### Reports and Studies Related to Physician Assistants

Several studies have shown that PAs provide care that is comparable to physicians. One study examined more than 23,000 patient visits to more than 1,100 practitioners to determine the quality of care provided by APRNs, PAs, and physicians.<sup>180</sup> The study found that there was no statistically significant differences in the care provided by APRNs and PAs and that provided by primary care physicians.<sup>181</sup> Additionally, the study noted that PAs provided more health education services than primary care physicians.<sup>182</sup>

Another study assessed the care PAs, APRNs, and primary care physicians provided to diabetic patients within the VA health care system. This study suggests that there are similar chronic illness outcomes for physicians, APRNs, and PAs.<sup>183</sup>

Finally, a study assessed the care received by medically complex patients within the VA health care system and found that the patients of primary care APRNs and PAs incurred less outpatient, pharmacy, and total expenditures than patients of physicians.<sup>184</sup>

### Effect of Proposed Changes

#### **Direct Care Workers**

##### Nurse Delegation in Home Health Agencies

PCS for HB 7053 authorizes a registered nurse to delegate any task, including medication administration, to a home health aide (HHA)<sup>185</sup> who do not work in a nursing home facility, as long as the registered nurse determines that the 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.

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<sup>180</sup> Kurtzman, Ellen T. PhD, MPH, RN, FAAN and Barnow, Burt S. PhD., "A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers," 55 MEDICAL CARE 6: 615 (June 2017), *abstract* available at [https://journals.lww.com/ww-medicalcare/Abstract/2017/06000/A\\_Comparison\\_of\\_Nurse\\_Practitioners\\_Physician.11.aspx](https://journals.lww.com/ww-medicalcare/Abstract/2017/06000/A_Comparison_of_Nurse_Practitioners_Physician.11.aspx) (last visited February 21, 2020).

<sup>181</sup> *Id.*

<sup>182</sup> *Id.*

<sup>183</sup> Jackson, G., et al., "Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study," ANNALS OF INTERNAL MEDICINE 169:825–835 (Nov. 2018), *abstract*, available at <https://annals.org/aim/article-abstract/2716077/intermediate-diabetes-outcomes-patients-managed-physicians-nurse-practitioners-physician-assistants> (last visited February 21, 2020).

<sup>184</sup> *Supra* note 143.

<sup>185</sup> Home health aide includes those CNAs who work in positions that work as home health aides or equivalent positions.

## *Medication Administration*

Currently, HHAs can only assist a patient with medication but not actually provide it to the patient. The bill authorizes a registered nurse to delegate administration of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a HHA. Once delegated the authority, the 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 HHA if the 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 HHA can competently administer medication, and annually validate such competency. A 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 HHAs must currently complete. The bill places an affirmative duty on a nursing facility or home health agency to ensure that 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 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 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 Workforce 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 registered nurses, licensed practical nurses, and direct care workers employed or contracted by the licensee;
- Turnover and vacancy rates of registered nurses, licensed practical nurses, and direct care workers and contributing factors, as applicable;
- Average wage for registered nurses, licensed practical nurses, and each category of direct care worker for employees and contractors of the licensee;
- Employment benefits for registered nurses, licensed practical nurses, and direct care workers and average cost to the employer and employee or contractor; and
- Type and availability of training for registered nurses, licensed practical nurses, and direct care workers.



The bill authorizes AHCA to establish a schedule for the survey in rule but prohibits AHCA from issuing 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,<sup>186</sup> 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,<sup>187</sup> and a full face, passport-type color photograph of the home care worker;
- Preferred contact information for the home care worker or contact information for the employing home care services provider;<sup>188</sup>
- 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

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<sup>186</sup> 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.

<sup>187</sup> The bill expressly prohibits AHCA from displaying the social security number on its website.

<sup>188</sup> The bill defines "home care services provider" as a home health agency or nurse registry.

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;
- 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 or denial 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 applying and replacing bandages for minor cuts and abrasions. The bill also authorizes a CNA or HHA to assist with 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.

#### Paid Feeding Assistants

The bill authorizes nursing home facilities to use paid feeding assistants who successfully complete a 12-hour training course that meets federal nursing home regulations and is approved by AHCA. The bill prohibits paid feeding assistants from counting towards minimum staffing requirements.

#### **Regulation of APRNs and PAs**

##### General APRN Provisions

The bill requires APRNs to apply to the Board for licensure, rather than DOH, to reflect current practice. Currently, applicants for licensure as APRNs submit documentation that they meet certification and financial responsibility requirements directly to the Board, rather than DOH. The bill also authorizes

APRNs to sign, certify, stamp, verify, or endorse any document that requires the signature, certification, stamp, verification, or endorsement of a physician.

### General PA Provisions

The bill revises the composition of the Council so that it has a PA majority. Under the bill, the Council is composed of one physician who is a member of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and three licensed PAs appointed by the Surgeon General. The physician members must supervise PAs in their practices.

The bill requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill removes a requirement that a PA notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill expands the scope of practice for PAs to authorize them to:

- Certify a person for involuntary examination under the Baker Act;
- File death certificates and certify a cause of death; and
- Examine and provide a report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

### **Autonomous Practice for APRNs and PAs**

#### Registration Requirements

The bill authorizes an APRN who meets certain eligibility criteria to register with the Board of Nursing to engage in autonomous practice and perform acts of advanced or specialized nursing practice without a supervisory protocol or supervision by a physician. The bill also authorizes a PA who meets certain eligibility to register with the Board of Medicine or the Board of Osteopathic Medicine to practice primary care as an autonomous PA without supervision by a physician.

To register to engage in autonomous practice, an APRN or PA must hold an active and unencumbered Florida license and must have:

- Completed, in any U.S. jurisdiction, at least 2,000 clinical instructional hours or clinical practice hours supervised by an actively licensed physician within the 5-year period for APRNs or 3-year period for PAs immediately preceding the registration request;
- Not been subject to any disciplinary action during the five years immediately preceding the application;
- Completed a graduate level course in pharmacology; and
- Any other appropriate requirement adopted by rule by the respective boards.

The bill also requires APRNs and PAs (jointly referred to as practitioners) who practice autonomously to obtain and maintain liability coverage at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000. However, this requirement does not apply to practitioners who:

- Practices exclusively as an officer, employee, or agent of the federal government or of the state or its agencies or subdivisions;
- Is not practicing in this state and whose license is inactive;
- Practices only in conjunction with teaching duties at an accredited school or its main teaching hospitals; and

- Not practicing in this state but holds an active license to practice. Such practitioners must notify DOH if they initiate or resume autonomous practice in this state.

The registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN or PA license. To maintain registration, an APRN must complete at least 10 hours of continuing education approved by the Board in pharmacology for each biennial renewal.<sup>189</sup> An autonomous PA does not have to complete any additional continuing medical education hours above the 100 hours required for PA licensure renewal.

The bill directs DOH to create practitioner profiles for autonomous PAs, which conspicuously informs the public of the autonomous PA's registration. The bill also requires that DOH conspicuously distinguishes the practitioner profiles of APRNs registered to engage in autonomous practice.

### Scope of Practice

Pursuant to the bill, an APRN registered to engage in autonomous practice is authorized to perform any advanced or specialized nursing act currently authorized for an APRN, without the supervision of a physician or a written protocol. In addition to those acts, the registered APRN may autonomously and without supervision or a written protocol perform the following acts:

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility, as authorized under federal law or rule.
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.
- Certify causes of death and sign, correct, and file death certificates.
- Act as a patient's primary care provider.
- Execute a certificate to subject a person to involuntary examination under the Baker Act.
- Examine, and approve the release of, a person admitted into a receiving facility under the Baker Act, if the APRN holds a national certification as a psychiatric-mental health advanced practice nurse.
- Perform certain physical examinations currently reserved to physicians and physician assistants by Florida law, such as examinations of pilots, law enforcement officers, and suspected child abuse victims.
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

The bill reestablishes the advisory committee that was abolished in 2016, to make evidence-based recommendations about medical acts an APRN who is practicing autonomously may perform. The 7-member joint committee is to be composed of four APRNs appointed by the Board of Nursing, two physicians recommended by the Board of Medicine, and the State Surgeon General or his or her designee. The bill requires the Board of Nursing to act on any recommendation of the committee within 90 days of submission. The Board may choose to adopt a recommendation, reject a recommendation, or otherwise act on it as the Board deems appropriate. Under current law, APRNs may only perform medical acts as authorized within the framework of a physician protocol. The advisory committee recommendations may provide autonomous APRNs the authority to perform certain medical acts that they are currently performing under protocols.

The bill authorizes an autonomous PA to:

- Only render primary care services as defined by the applicable board rule;
- Render services consistent with the scope of his or her education and experience and provided in accordance with rules adopted by the applicable board;

<sup>189</sup> The bill provides an exception to the 10 hours of continuing education in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.

- Prescribe, dispense, administer, or order any medicinal drug to the extent authorized under a formulary adopted by the Council;
- Order any medication for administration to a patient in a facility licensed under ch. 395, F.S., or part II of ch. 400, F.S.;<sup>190</sup>
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court; and
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.

The bill requires the Council to develop rules defining the primary specialties in which an autonomous PA may practice. Such specialties may include internal medicine, general pediatrics, family medicine, geriatrics, and general obstetrics and gynecology.

The bill also authorizes autonomous PAs to participate in the Public School Volunteer Health Care Practitioner Program. This program allows any participating health care practitioner who agrees to provide his or her services, without compensation, in a public school for at least 80 hours a year for each school year during the biennial licensure period to be eligible for waiver of the biennial license renewal fee for an active license and fulfillment of a maximum of 25 percent of the continuing education hours required for license renewal under s. 456.013(9), F.S.

The bill also requires autonomous PAs to comply with the Florida Patient's Bill of Rights and Responsibilities Act.

### Accountability

The bill imposes safeguards to ensure APRNs registered to engage in autonomous practice do so safely, similar to those for physicians.<sup>191</sup> The bill defines an adverse incident as an event over which the APRN could exercise control and which is associated with a medical or nursing intervention, including the prescribing of controlled substances, rather than a condition for which such intervention occurred, which results in at least one of the following:

- A condition that requires the transfer to a hospital;
- Permanent physical injury to the patient; or
- Death of the patient.

If such an event occurs, the APRN must report the adverse incident to DOH, in writing, within 15 days of its occurrence or discovery of its occurrence, consistent with the requirements for doctors. DOH must review the adverse incident to determine if the APRN committed any act that would make the APRN subject to disciplinary action.

PAs are subject to the existing adverse incident requirements for physicians.

In addition, the bill requires several other accountability measures for APRNs registered to engage in autonomous practice. The bill authorizes the Board to administratively discipline an APRN for several delineated prohibited acts related to relationships with patients, business practices, and nursing practices:

- Paying or receiving any commission, bonus, kickback, rebate, or engaging in a split-fee arrangement with a health care practitioner, organization, agency, or person for patient referrals;
- Exercising influence over a patient for the purpose of engaging in sexual activity;

<sup>190</sup> This includes ambulatory surgical centers, hospitals, and nursing homes.

<sup>191</sup> See ss. 458.351 and 459.026, F.S.

- Making deceptive, untrue, or fraudulent representation related to advanced or specialized nursing practice;
- Soliciting patients, personally or through an agent, using fraud, intimidation, undue influence, or overreaching or vexatious conduct;
- Failing to keep legible medical records;
- Performing professional services that have not been authorized by the patient or his or her representative except as provided by the Medical Consent Law<sup>192</sup> and the Good Samaritan Act;<sup>193</sup>
- Performing any procedure or prescribing any medicinal drug that would constitute experimentation on a human subject, without full, informed, and written consent of the patient;
- Delegating professional responsibilities to an unqualified or unlicensed person;
- Conspiring with another person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;
- Advertising or holding oneself out as having a certification in a specialty that the APRN has not received;
- Failing to inform patients about patient rights and how to file a patient complaint; and
- Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.

PAs are subject to the same discipline as physicians as it relates to relationships with patients, business practices, and medical practices.

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

#### B. SECTION DIRECTORY:

- Section 1:** Amends s. 400.141, F.S., relating to administration and management of nursing home facilities.
- Section 2:** Amends s. 400.23, F.S., relating to rules; evaluation and deficiencies; licensure status.
- Section 3:** Amends s. 400.462, F.S., relating to definitions.
- Section 4:** Amends s. 400.464, F.S., relating to home health agencies to be licensed; expiration of license; unlawful acts; penalties.
- Section 5:** Amends s. 400.488, F.S., relating to assistance with self-administration of medication.
- Section 6:** Creates s. 400.489, F.S., relating to administration of medication by a home health aide; staff training requirements.
- Section 7:** Creates s. 400.490, F.S., relating to nurse delegated tasks.
- Section 8:** Creates s. 400.52, F.S., relating to Excellence in Home Health program.
- Section 9:** Creates s. 408.064, F.S., relating to Home Care Services Registry.
- Section 10:** Creates s. 408.822, F.S., relating to direct care workforce survey.
- Section 11:** Creates s. 464.0156, F.S., relating to delegation of duties.
- Section 12:** Amends s. 464.018, F.S., relating to disciplinary actions.
- Section 13:** Creates s. 464.2035, F.S., relating to administration of medication.
- Section 14:** Amends s. 456.0391, F.S., relating to advanced practice registered nurses and autonomous physician assistants; information required for licensure or registration.
- Section 15:** Amends s. 456.041, F.S., relating to practitioner profile; creation.
- Section 16:** Amends s. 458.347, F.S., relating to physician assistants.
- Section 17:** Amends s. 459.022, F.S., relating to physician assistants.
- Section 18:** Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
- Section 19:** Creates s. 464.0123, F.S., autonomous practice by an advanced practice registered nurse.

<sup>192</sup> Section 766.103, F.S.

<sup>193</sup> Section 768.13, F.S.

- Section 20:** Creates s. 464.0155, F.S., relating to reports of adverse incidents by advanced practice registered nurses.
- Section 21:** Amends s. 464.018, F.S., relating to disciplinary actions.
- Section 22:** Amends s. 39.01, F.S., relating to definitions.
- Section 23:** Amends s. 39.303, F.S., relating to child protection teams and sexual abuse treatment programs; services; eligible cases.
- Section 24:** Amends s. 39.304, F.S., relating to photographs, medical examinations, X rays, and medical treatment of abused, abandoned, or neglected child.
- Section 25:** Amends s. 110.12315, F.S., relating to the prescription drug program.
- Section 26:** Amends s. 252.515, F.S., relating to the Postdisaster Relief Assistance Act; immunity from civil liability.
- Section 27:** Amends s. 310.071, F.S., relating to deputy pilot certification.
- Section 28:** Amends s. 310.073, F.S., relating to state pilot licensing.
- Section 29:** Amends s. 310.081, F.S., relating to department to examine and license state pilots and certificate deputy pilots; vacancies.
- Section 30:** Amends s. 320.0848, F.S., relating to persons who have disabilities; issuance of disabled parking permits; temporary permits; permits for certain providers of transportation services to persons who have disabilities.
- Section 31:** Amends s. 381.00315, F.S., relating to public health advisories; public health emergencies; isolation and quarantines.
- Section 32:** Amends s. 381.00593, F.S., relating to public school volunteer health care practitioner program.
- Section 33:** Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
- Section 34:** Amends s. 382.008, F.S., relating to death, fetal death, and nonviable birth registration.
- Section 35:** Amends s. 382.011, F.S., relating to medical examiner determination of cause of death.
- Section 36:** Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
- Section 37:** Amends s. 390.0111, F.S., relating to termination of pregnancies.
- Section 38:** Amends s. 390.012, F.S., relating to powers of agency; rules; and disposal of fetal remains.
- Section 39:** Amends s. 394.463, F.S., relating to involuntary examination.
- Section 40:** Amends s. 395.0191, F.S., relating to staff membership and clinical privileges.
- Section 41:** Amends s. 395.602, F.S., relating to rural hospitals.
- Section 42:** Amends s. 397.501, F.S., relating to rights of individuals.
- Section 43:** Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
- Section 44:** Amends s. 397.6793, F.S., relating to professional's certificate for emergency admission.
- Section 45:** Amends s. 400.021, F.S., relating to definitions.
- Section 46:** Amends s. 400.172, F.S., relating to respite care provided in nursing home facilities.
- Section 47:** Amends s. 400.487, F.S., relating to Home health service agreements; physician's, physician assistant's, autonomous physician assistant's, and advanced practice registered nurse's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.
- Section 48:** Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; and penalties.
- Section 49:** Amends s. 400.9973, F.S., relating to client admission, transfer, and discharge.
- Section 50:** Amends s. 400.9974, F.S., relating to client comprehensive treatment plans; client services.
- Section 51:** Amends s. 400.9976, F.S., relating to administration of medication.
- Section 52:** Amends s. 400.9979, F.S., relating to restraint and seclusion; client safety.
- Section 53:** Amends s. 401.445, F.S., relating to emergency examination and treatment of incapacitated persons.
- Section 54:** Amends s. 409.906, F.S., relating to optional Medicaid services.
- Section 55:** Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
- Section 56:** Amends s. 409.973, F.S., relating to benefits.

- Section 57:** Amends s. 429.26, F.S., relating to appropriateness of placements; and examinations of residents.
- Section 58:** Amends s. 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center.
- Section 59:** Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
- Section 60:** Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
- Section 61:** Amends s. 456.072, F.S., relating to grounds for discipline; penalties; and enforcement.
- Section 62:** Amends s. 456.44, F.S., relating to controlled substance prescribing.
- Section 63:** Amends s. 458.3265, F.S., relating to pain-management clinics.
- Section 64:** Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
- Section 65:** Amends s. 459.0137, F.S., relating to pain-management clinics.
- Section 66:** Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
- Section 67:** Amends s. 464.003, F.S., relating to definitions.
- Section 68:** Amends s. 464.0205, relating to retired volunteer nurse certificate.
- Section 69:** Amends s. 480.0475, F.S., relating to massage establishments and prohibited practices.
- Section 70:** Amends s. 493.6108, F.S., relating to investigation of applicants by Department of Agriculture and Consumer Services.
- Section 71:** Amends s. 626.9707, F.S., relating to disability insurance; discrimination on basis of sickle-cell trait prohibited.
- Section 72:** Amends s. 627.357, F.S., relating to medical malpractice self-insurance.
- Section 73:** Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; and claims.
- Section 74:** Amends s. 633.412, F.S., relating to firefighters and qualifications for certification.
- Section 75:** Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
- Section 76:** Amends s. 744.2006, F.S., relating to Office of Public and Professional Guardians; appointment, notification.
- Section 77:** Amends s. 744.331, F.S., relating to procedures to determine incapacity.
- Section 78:** Amends s. 744.3675, F.S., relating to the annual guardianship plan.
- Section 79:** Amends s. 766.103, F.S., relating to Florida Medical Consent Law.
- Section 80:** Amends s. 766.105, F.S., relating to Florida Patient's Compensation Fund.
- Section 81:** Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
- Section 82:** Amends s. 766.1116, F.S., relating to health care practitioner; waiver of license renewal fees and continuing education requirements.
- Section 83:** Amends s. 766.118, F.S., relating to determination of noneconomic damages.
- Section 84:** Amends s. 768.135, F.S., relating to volunteer team physicians; immunity.
- Section 85:** Amends s. 794.08, F.S., relating to female genital mutilation.
- Section 86:** Amends s. 893.02, F.S., relating to definitions.
- Section 87:** Amends s. 943.13, F.S., relating to officers' minimum qualifications for employment or appointment.
- Section 88:** Amends s. 945.603, F.S., relating to powers and duties of authority.
- Section 89:** Amends s. 948.03, F.S., relating to terms and conditions of probation.
- Section 90:** Amends s. 984.03, F.S., relating to definitions.
- Section 91:** Amends s. 985.03, F.S., relating to definitions.
- Section 92:** Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
- Section 93:** Amends s. 1002.42, F.S., relating to private schools.
- Section 94:** Amends s. 1006.062, F.S., relating to administration of medication and provision of medical services by district school board personnel.
- Section 95:** Amends s. 1006.20, F.S., relating to athletics in public K-12 schools.
- Section 96:** Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.



**Section 97:** Provides an appropriation.

**Section 98:** Provides an appropriation.

**Section 99:** Provides an effective date of July 1, 2020.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

HB 7017 authorizes an initial registration fee of \$100 for APRNs who choose to practice autonomously, and a biennial renewal fee of \$50 to maintain such registration. The total revenue DOH will receive from such fees is indeterminate because the number of APRNs who will choose to register to engage in autonomous practice is not predictable.

#### 2. Expenditures:

PCS for 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 the direct care worker registry, direct care workforce survey, and the Excellence in Home Health award program.

The bill also authorizes 3.5 full-time equivalent positions, with association salary rate of 183,895, and appropriates \$219,089 in recurring funds, and \$17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to DOH for the regulation of autonomous APRNs.

### 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.

APRNs who register to practice independently must pay a registration fee, as well as a fee to renew their registration. HB 7017 authorizes the Board of Nursing to set the application and biennial renewal fees, up to \$100 and \$50, respectively. Such APRNs will also have to pay for the additional continuing education hours required by the bill.

APRNs and PAs who have paid physicians for supervision will achieve cost-savings if they register to practice autonomously since supervision will no longer be needed.

### D. FISCAL COMMENTS:

None.

### III. COMMENTS

#### A. CONSTITUTIONAL ISSUES:

##### 1. Applicability of Municipality/County Mandates Provision:

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

##### 2. Other:

None.

#### B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the bill.

The Boards of Medicine, Osteopathic Medicine, and Nursing have sufficient rule-making authority to implement the bill.

#### C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

### IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1                   A bill to be entitled  
2           An act relating to direct care; amending s. 400.141,  
3           F.S.; authorizing a nursing home facility to use paid  
4           feeding assistants in accordance with federal law  
5           under certain circumstances; amending s. 400.23, F.S.;  
6           prohibiting paid feeding assistants from counting  
7           toward compliance with minimum staffing standards;  
8           amending s. 400.462, F.S.; revising the definition of  
9           "home health aide"; amending s. 400.464, F.S.;  
10          requiring a licensed home health agency that  
11          authorizes a registered nurse to delegate tasks to a  
12          certified nursing assistant to ensure that certain  
13          requirements are met; amending s. 400.488, F.S.;  
14          authorizing an unlicensed person to assist with self-  
15          administration of certain treatments; revising the  
16          requirements for such assistance; creating s. 400.489,  
17          F.S.; authorizing a home health aide to administer  
18          certain prescription medications under certain  
19          conditions; requiring the home health aide to meet  
20          certain training and competency requirements;  
21          requiring that the training, determination of  
22          competency, and annual validations be performed by a  
23          registered nurse or a physician; requiring a home  
24          health aide to complete annual inservice training in  
25          medication administration and medication error  
26          prevention in addition to existing annual inservice

27 training requirements; requiring the Agency for Health  
 28 Care Administration, in consultation with the Board of  
 29 Nursing, to adopt rules for medication administration;  
 30 creating s. 400.490, F.S.; authorizing a certified  
 31 nursing assistant or home health aide to perform tasks  
 32 delegated by a registered nurse; creating s. 400.52,  
 33 F.S.; creating the Excellence in Home Health Program  
 34 within the agency; requiring the agency to adopt rules  
 35 establishing program criteria; requiring the agency to  
 36 annually evaluate certain home health agencies that  
 37 apply for a program award; providing eligibility  
 38 requirements; requiring an agency to reapply  
 39 biennially for the award designation; authorizing an  
 40 award recipient to use the designation in advertising  
 41 and marketing; prohibiting a home health agency from  
 42 using the award designation in any advertising or  
 43 marketing under certain circumstances; providing that  
 44 an application for an award designation under the  
 45 program is not an application for licensure and such  
 46 designation does not constitute final agency action  
 47 subject to certain administrative procedures; creating  
 48 s. 408.064, F.S.; providing definitions; requiring the  
 49 agency to develop and maintain a voluntary registry of  
 50 home care workers; providing requirements for the  
 51 registry; requiring a home care worker to apply to be  
 52 included in the registry; requiring the agency to

53 | develop a process by which a home health services  
54 | provider may include its employees on the registry;  
55 | requiring certain home care workers to undergo  
56 | background screening and training; requiring each page  
57 | of the registry website to contain a specified notice;  
58 | requiring the agency to adopt rules; creating s.  
59 | 408.822, F.S.; defining the term "direct care worker";  
60 | requiring certain licensees to provide specified  
61 | information about employees in a survey beginning on a  
62 | specified date; requiring that the survey be completed  
63 | on a form with a specified attestation adopted by the  
64 | agency in rule; requiring a licensee to submit such  
65 | survey before the agency renews its license; requiring  
66 | the agency to analyze the results of such survey and  
67 | publish its results on the agency's website; requiring  
68 | the agency to update such information monthly;  
69 | requiring the agency's analysis to include specified  
70 | information; creating s. 464.0156, F.S.; authorizing a  
71 | registered nurse to delegate tasks to a certified  
72 | nursing assistant or home health aide under certain  
73 | conditions; providing the criteria that a registered  
74 | nurse must consider in determining if a task may be  
75 | delegated; authorizing a registered nurse to delegate  
76 | medication administration to a certified nursing  
77 | assistant or home health aide if certain requirements  
78 | are met; requiring the Board of Nursing, in

79 |       consultation with the agency, to adopt rules; amending  
80 |       s. 464.018, F.S.; providing that a registered nurse  
81 |       who delegates certain tasks to a person the registered  
82 |       nurse knows or has reason to know is unqualified is  
83 |       grounds for licensure denial or disciplinary action;  
84 |       creating s. 464.2035, F.S.; authorizing a certified  
85 |       nursing assistant to administer certain prescription  
86 |       medications under certain conditions; requiring the  
87 |       certified nursing assistant to meet certain training  
88 |       and competency requirements; requiring the training,  
89 |       determination of competency, and annual validations to  
90 |       be performed by a registered nurse or a physician;  
91 |       requiring a certified nursing assistant to complete  
92 |       annual inservice training in medication administration  
93 |       and medication error prevention in addition to  
94 |       existing annual inservice training requirements;  
95 |       requiring the board, in consultation with the agency,  
96 |       to adopt rules; amending s. 456.0391, F.S.; requiring  
97 |       an autonomous physician assistant to submit certain  
98 |       information to the Department of Health; requiring the  
99 |       department to send a notice to autonomous physician  
100 |       assistants regarding the required information;  
101 |       requiring autonomous physician assistants who have  
102 |       submitted required information to update such  
103 |       information in writing; providing penalties; amending  
104 |       s. 456.041, F.S.; requiring the department to provide

105 a practitioner profile for an autonomous physician  
106 assistant; amending ss. 458.347 and 459.022, F.S.;  
107 defining the term "autonomous physician assistant";  
108 authorizing third-party payors to reimburse employers  
109 for services provided by autonomous physician  
110 assistants; deleting a requirement that a physician  
111 assistant must inform a patient of a right to see a  
112 physician before prescribing or dispensing a  
113 prescription; revising the requirements for physician  
114 assistant education and training programs; authorizing  
115 the Board of Medicine to impose certain penalties upon  
116 an autonomous physician assistant; requiring the board  
117 to register a physician assistant as an autonomous  
118 physician assistant if the applicant meets certain  
119 criteria; providing requirements; providing  
120 exceptions; requiring the department to distinguish  
121 such autonomous physician assistants' licenses;  
122 authorizing such autonomous physician assistants to  
123 perform specified acts without physician supervision  
124 or supervisory protocol; requiring biennial  
125 registration renewal; requiring the Council on  
126 Physician Assistants to establish rules; revising the  
127 membership and duties of the council; prohibiting a  
128 person who is not registered as an autonomous  
129 physician assistant from using the title; providing  
130 for the denial, suspension, or revocation of the

131 registration of an autonomous physician assistant;  
132 requiring the board to adopt rules; requiring  
133 autonomous physician assistants to report adverse  
134 incidents to the department; amending s. 464.012,  
135 F.S.; requiring applicants for registration as an  
136 advanced practice registered nurse to apply to the  
137 Board of Nursing; authorizing an advanced practice  
138 registered nurse to sign, certify, stamp, verify, or  
139 endorse a document that requires the signature,  
140 certification, stamp, verification, affidavit, or  
141 endorsement of a physician within the framework of an  
142 established protocol; providing an exception; creating  
143 s. 464.0123, F.S.; defining the term "autonomous  
144 practice"; providing for the registration of an  
145 advanced practice registered nurse to engage in  
146 autonomous practice; providing registration  
147 requirements; requiring the department to distinguish  
148 such advanced practice registered nurses' licenses and  
149 include the registration in their practitioner  
150 profiles; authorizing such advanced practice  
151 registered nurses to perform specified acts without  
152 physician supervision or supervisory protocol;  
153 requiring biennial registration renewal and continuing  
154 education; authorizing the Board of Nursing to  
155 establish an advisory committee to determine the  
156 medical acts that may be performed by such advanced



157 practice registered nurses; providing for appointment  
 158 and terms of committee members; requiring the board to  
 159 adopt rules; creating s. 464.0155, F.S.; requiring  
 160 advanced practice registered nurses registered to  
 161 engage in autonomous practice to report adverse  
 162 incidents to the Department of Health; providing  
 163 requirements; defining the term "adverse incident";  
 164 providing for department review of such reports;  
 165 authorizing the department to take disciplinary  
 166 action; amending s. 464.018, F.S.; providing  
 167 additional grounds for denial of a license or  
 168 disciplinary action for advanced practice registered  
 169 nurses registered to engage in autonomous practice;  
 170 amending s. 39.01, F.S.; revising the definition of  
 171 the term "licensed health care professional" to  
 172 include an autonomous physician assistant; amending s.  
 173 39.303, F.S.; authorizing a specified autonomous  
 174 physician assistant to review certain cases of abuse  
 175 or neglect and standards for face-to-face medical  
 176 evaluations by a Child Protection Team; amending s.  
 177 39.304, F.S.; authorizing an autonomous physician  
 178 assistant to perform or order an examination and  
 179 diagnose a child without parental consent under  
 180 certain circumstances; amending s. 110.12315, F.S.;  
 181 revising requirements for reimbursement of pharmacies  
 182 for specified prescription drugs and supplies under

183 the state employees' prescription drug program;  
184 amending s. 252.515, F.S.; providing immunity from  
185 civil liability for an autonomous physician assistant  
186 under the Postdisaster Relief Assistance Act; amending  
187 ss. 310.071, 310.073, and 310.081, F.S.; authorizing  
188 an autonomous physician assistant and a physician  
189 assistant to administer the physical examination  
190 required for deputy pilot certification and state  
191 pilot licensure; authorizing an applicant for a deputy  
192 pilot certificate or a state pilot license to use  
193 controlled substances prescribed by an autonomous  
194 physician assistant; amending s. 320.0848, F.S.;  
195 authorizing an autonomous physician assistant to  
196 certify that a person is disabled to satisfy  
197 requirements for certain permits; amending s.  
198 381.00315, F.S.; providing for the temporary  
199 reactivation of the registration of an autonomous  
200 physician assistant in a public health emergency;  
201 amending s. 381.00593, F.S.; revising the definition  
202 of the term "health care practitioner" to include an  
203 autonomous physician assistant for purposes of the  
204 Public School Volunteer Health Care Practitioner Act;  
205 amending s. 381.026, F.S.; revising the definition of  
206 the term "health care provider" to include an advanced  
207 practice registered nurse and an autonomous physician  
208 assistant for purposes of the Florida Patient's Bill

209 of Rights and Responsibilities; amending s. 382.008,  
 210 F.S.; authorizing an autonomous physician assistant, a  
 211 physician assistant, and an advanced practice  
 212 registered nurse to file a certificate of death or  
 213 fetal death under certain circumstances; authorizing a  
 214 certified nurse midwife to provide certain information  
 215 to the funeral director within a specified time  
 216 period; replacing the term "primary or attending  
 217 physician" with "primary or attending practitioner";  
 218 defining the term "primary or attending practitioner";  
 219 amending s. 382.011, F.S.; conforming a provision to  
 220 changes made by the act; amending s. 383.14, F.S.;  
 221 authorizing the release of certain newborn tests and  
 222 screening results to an autonomous physician  
 223 assistant; revising the definition of the term "health  
 224 care practitioner" to include an autonomous physician  
 225 assistant for purposes of screening for certain  
 226 disorders and risk factors; amending s. 390.0111,  
 227 F.S.; authorizing a certain action by an autonomous  
 228 physician assistant before an abortion procedure;  
 229 amending s. 390.012, F.S.; authorizing certain actions  
 230 by an autonomous physician assistant during and after  
 231 an abortion procedure; amending s. 394.463, F.S.;  
 232 authorizing an autonomous physician assistant, a  
 233 physician assistant, and an advanced practice  
 234 registered nurse to initiate an involuntary

235 examination for mental illness under certain  
 236 circumstances; authorizing a physician assistant to  
 237 examine a patient; amending s. 395.0191, F.S.;  
 238 providing an exception to certain onsite medical  
 239 direction requirements for a specified advanced  
 240 practice registered nurse; amending 395.602, F.S.;  
 241 authorizing the Department of Health to use certain  
 242 funds to increase the number of autonomous physician  
 243 assistants in rural areas; amending s. 397.501, F.S.;  
 244 prohibiting the denial of certain services to an  
 245 individual who takes medication prescribed by an  
 246 autonomous physician assistant, a physician assistant,  
 247 or an advanced practice registered nurse; amending ss.  
 248 397.679 and 397.6793, F.S.; authorizing an autonomous  
 249 physician assistant to execute a certificate for  
 250 emergency admission of a person who is substance abuse  
 251 impaired; amending s. 400.021, F.S.; revising the  
 252 definition of the term "geriatric outpatient clinic"  
 253 to include a site staffed by an autonomous physician  
 254 assistant; amending s. 400.172, F.S.; authorizing an  
 255 autonomous physician assistant and an advanced  
 256 practice registered nurse to provide certain medical  
 257 information to a prospective respite care resident;  
 258 amending s. 400.487, F.S.; authorizing an autonomous  
 259 physician assistant to establish treatment orders for  
 260 certain patients under certain circumstances; amending

261 s. 400.506, F.S.; requiring an autonomous physician  
 262 assistant to comply with specified treatment plan  
 263 requirements; amending ss. 400.9973, 400.9974,  
 264 400.9976, and 400.9979, F.S.; authorizing an  
 265 autonomous physician assistant to prescribe client  
 266 admission to a transitional living facility and care  
 267 for such client, order treatment plans, supervise and  
 268 record client medications, and order physical and  
 269 chemical restraints, respectively; amending s.  
 270 401.445, F.S.; prohibiting recovery of damages in  
 271 court against a registered autonomous physician  
 272 assistant under certain circumstances; requiring an  
 273 autonomous physician assistant to attempt to obtain a  
 274 person's consent before providing emergency services;  
 275 amending ss. 409.906 and 409.908, F.S.; authorizing  
 276 the agency to reimburse an autonomous physician  
 277 assistant for providing certain optional Medicaid  
 278 services; amending s. 409.973, F.S.; requiring managed  
 279 care plans to cover autonomous physician assistant  
 280 services; amending s. 429.26, F.S.; prohibiting  
 281 autonomous physician assistants from having a  
 282 financial interest in the assisted living facility at  
 283 which they are employed; authorizing an autonomous  
 284 physician assistant to examine an assisted living  
 285 facility resident before admission; amending s.  
 286 429.918, F.S.; revising the definition of the term

287 "ADRD participant" to include a participant who has a  
 288 specified diagnosis from an autonomous physician  
 289 assistant; authorizing an autonomous physician  
 290 assistant to provide signed documentation to an ADRD  
 291 participant; amending s. 440.102, F.S.; authorizing an  
 292 autonomous physician assistant to collect a specimen  
 293 for a drug test for specified purposes; amending s.  
 294 456.053, F.S.; revising definitions; authorizing an  
 295 advanced practice registered nurse registered to  
 296 engage in autonomous practice and an autonomous  
 297 physician assistant to make referrals under certain  
 298 circumstances; conforming a cross-reference; amending  
 299 s. 456.072, F.S.; providing penalties for an  
 300 autonomous physician assistant who prescribes or  
 301 dispenses a controlled substance in a certain manner;  
 302 amending s. 456.44, F.S.; revising the definition of  
 303 the term "registrant" to include an autonomous  
 304 physician assistant for purposes of controlled  
 305 substance prescribing; providing requirements for an  
 306 autonomous physician assistant who prescribes  
 307 controlled substances for the treatment of chronic  
 308 nonmalignant pain; amending ss. 458.3265 and 459.0137,  
 309 F.S.; requiring an autonomous physician assistant to  
 310 perform a physical examination of a patient at a pain-  
 311 management clinic under certain circumstances;  
 312 amending ss. 458.331 and 459.015, F.S.; providing

313 grounds for denial of a license or disciplinary action  
 314 against an autonomous physician assistant for certain  
 315 violations; amending s. 464.003, F.S.; revising the  
 316 definition of the term "practice of practical nursing"  
 317 to include an autonomous physician assistant for  
 318 purposes of authorizing such assistant to supervise a  
 319 licensed practical nurse; amending s. 464.0205, F.S.;  
 320 authorizing an autonomous physician assistant to  
 321 directly supervise a certified retired volunteer  
 322 nurse; amending s. 480.0475, F.S.; authorizing the  
 323 operation of a massage establishment during specified  
 324 hours if the massage therapy is prescribed by an  
 325 autonomous physician assistant; amending s. 493.6108,  
 326 F.S.; authorizing an autonomous physician assistant to  
 327 certify the physical fitness of a certain class of  
 328 applicants to bear a weapon or firearm; amending s.  
 329 626.9707, F.S.; prohibiting an insurer from refusing  
 330 to issue and deliver certain disability insurance that  
 331 covers any medical treatment or service furnished by  
 332 an autonomous physician assistant or an advanced  
 333 practice registered nurse; amending s. 627.357, F.S.;  
 334 revising the definition of the term "health care  
 335 provider" to include an autonomous physician assistant  
 336 for purposes of medical malpractice self-insurance;  
 337 amending s. 627.736, F.S.; requiring personal injury  
 338 protection insurance to cover a certain percentage of

339 medical services and care provided by specified health  
340 care providers; providing for specified reimbursement  
341 of advanced practice registered nurses registered to  
342 engage in autonomous practice or autonomous physician  
343 assistants; amending s. 633.412, F.S.; authorizing an  
344 autonomous physician assistant to medically examine an  
345 applicant for firefighter certification; amending s.  
346 641.495, F.S.; requiring certain health maintenance  
347 organization documents to disclose that certain  
348 services may be provided by autonomous physician  
349 assistants or advanced practice registered nurses;  
350 amending s. 744.2006, F.S.; authorizing an autonomous  
351 physician assistant to carry out guardianship  
352 functions under a contract with a public guardian;  
353 conforming terminology; amending s. 744.331, F.S.;  
354 authorizing an autonomous physician assistant or a  
355 physician assistant to be an eligible member of an  
356 examining committee; conforming terminology; amending  
357 s. 744.3675, F.S.; authorizing an advanced practice  
358 registered nurse, autonomous physician assistant, or  
359 physician assistant to provide the medical report of a  
360 ward in an annual guardianship plan; amending s.  
361 766.103, F.S.; prohibiting recovery of damages against  
362 an autonomous physician assistant under certain  
363 conditions; amending s. 766.105, F.S.; revising the  
364 definition of the term "health care provider" to



365 include an autonomous physician assistants for  
366 purposes of the Florida Patient's Compensation Fund;  
367 amending ss. 766.1115 and 766.1116, F.S.; revising the  
368 definitions of the terms "health care provider" and  
369 "health care practitioner," respectively, to include  
370 autonomous physician assistants for purposes of the  
371 Access to Health Care Act; amending s. 766.118, F.S.;  
372 revising the definition of the term "practitioner" to  
373 include an advanced practice registered nurse  
374 registered to engage in autonomous practice and an  
375 autonomous physician assistant; amending s. 768.135,  
376 F.S.; providing immunity from liability for an  
377 advanced practice registered nurse registered to  
378 engage in autonomous practice or an autonomous  
379 physician assistant who provides volunteer services  
380 under certain circumstances; amending s. 794.08, F.S.;  
381 providing an exception to medical procedures conducted  
382 by an autonomous physician assistant under certain  
383 circumstances; amending s. 893.02, F.S.; revising the  
384 definition of the term "practitioner" to include an  
385 autonomous physician assistant; amending s. 943.13,  
386 F.S.; authorizing an autonomous physician assistant to  
387 conduct a physical examination for a law enforcement  
388 or correctional officer to satisfy qualifications for  
389 employment or appointment; amending s. 945.603, F.S.;  
390 authorizing the Correctional Medical Authority to

391 review and make recommendations relating to the use of  
392 autonomous physician assistants as physician  
393 extenders; amending s. 948.03, F.S.; authorizing an  
394 autonomous physician assistant to prescribe drugs or  
395 narcotics to a probationer; amending ss. 984.03 and  
396 985.03, F.S.; revising the definition of the term  
397 "licensed health care professional" to include an  
398 autonomous physician assistant; amending ss. 1002.20  
399 and 1002.42, F.S.; providing immunity from liability  
400 for autonomous physician assistants who administer  
401 epinephrine auto-injectors in public and private  
402 schools; amending s. 1006.062, F.S.; authorizing an  
403 autonomous physician assistant to provide training in  
404 the administration of medication to designated school  
405 personnel; requiring an autonomous physician assistant  
406 to monitor such personnel; authorizing an autonomous  
407 physician assistant to determine whether such  
408 personnel may perform certain invasive medical  
409 services; amending s. 1006.20, F.S.; authorizing an  
410 autonomous physician assistant to medically evaluate a  
411 student athlete; amending s. 1009.65, F.S.;  
412 authorizing an autonomous physician assistant to  
413 participate in the Medical Education Reimbursement and  
414 Loan Repayment Program; providing appropriations and  
415 authorizing positions; providing an effective date.  
416

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

418 Section 1. Paragraph (v) is added to subsection (1) of  
419 section 400.141, Florida Statutes, to read:

420 400.141 Administration and management of nursing home  
421 facilities.—

422 (1) Every licensed facility shall comply with all  
423 applicable standards and rules of the agency and shall:

424 (v) Be allowed to use paid feeding assistants in  
425 accordance with federal nursing home regulations, if the paid  
426 feeding assistant has successfully completed a feeding assistant  
427 training program meeting federal nursing home requirements and  
428 approved by the agency. The feeding assistant training program  
429 must consist of a minimum of 12 hours of education.

430 Section 2. Paragraph (b) of subsection (3) of section  
431 400.23, Florida Statutes, is amended to read:

432 400.23 Rules; evaluation and deficiencies; licensure  
433 status.—

434 (3)

435 (b) Paid feeding assistants and nonnursing staff providing  
436 eating assistance to residents shall not count toward compliance  
437 with minimum staffing standards.

438 Section 3. Subsection (15) of section 400.462, Florida  
439 Statutes, is amended to read:

440 400.462 Definitions.—As used in this part, the term:

441 (15) "Home health aide" means a person who is trained or  
442 qualified, as provided by rule, and who provides hands-on

443 personal care, performs simple procedures as an extension of  
444 therapy or nursing services, assists in ambulation or exercises,  
445 or assists in administering medications as permitted in rule and  
446 for which the person has received training established by the  
447 agency under this part or performs tasks delegated to him or her  
448 pursuant to chapter 464 s. 400.497(1).

449 Section 4. Subsections (5) and (6) of section 400.464,  
450 Florida Statutes, are renumbered as subsections (6) and (7),  
451 respectively, present subsection (6) is amended, and a new  
452 subsection (5) is added to that section, to read:

453 400.464 Home health agencies to be licensed; expiration of  
454 license; exemptions; unlawful acts; penalties.—

455 (5) If a licensed home health agency authorizes a  
456 registered nurse to delegate tasks, including medication  
457 administration, to a certified nursing assistant pursuant to  
458 chapter 464 or a home health aide pursuant to s. 400.490, the  
459 licensed home health agency must ensure that such delegation  
460 meets the requirements of this chapter, chapter 464, and the  
461 rules adopted thereunder.

462 (7)(6) Any person, entity, or organization providing home  
463 health services which is exempt from licensure under subsection  
464 (6) ~~(5)~~ may voluntarily apply for a certificate of exemption  
465 from licensure under its exempt status with the agency on a form  
466 that specifies its name or names and addresses, a statement of  
467 the reasons why it is exempt from licensure as a home health  
468 agency, and other information deemed necessary by the agency. A

469 certificate of exemption is valid for a period of not more than  
470 2 years and is not transferable. The agency may charge an  
471 applicant \$100 for a certificate of exemption or charge the  
472 actual cost of processing the certificate.

473 Section 5. Subsections (2) and (3) of section 400.488,  
474 Florida Statutes, are amended to read:

475 400.488 Assistance with self-administration of  
476 medication.—

477 (2) Patients who are capable of self-administering their  
478 own medications without assistance shall be encouraged and  
479 allowed to do so. However, an unlicensed person may, consistent  
480 with a dispensed prescription's label or the package directions  
481 of an over-the-counter medication, assist a patient whose  
482 condition is medically stable with the self-administration of  
483 routine, regularly scheduled medications that are intended to be  
484 self-administered. Assistance with self-medication by an  
485 unlicensed person may occur only upon a documented request by,  
486 and the written informed consent of, a patient or the patient's  
487 surrogate, guardian, or attorney in fact. For purposes of this  
488 section, self-administered medications include both legend and  
489 over-the-counter oral dosage forms, topical dosage forms, and  
490 topical ophthalmic, otic, and nasal dosage forms, including  
491 solutions, suspensions, sprays, ~~and~~ inhalers, and nebulizer  
492 treatments.

493 (3) Assistance with self-administration of medication  
494 includes:

495 (a) Taking the medication, in its previously dispensed,  
 496 properly labeled container, from where it is stored and bringing  
 497 it to the patient.

498 (b) In the presence of the patient, confirming that the  
 499 medication is intended for that patient, orally advising the  
 500 patient of the medication name and purpose ~~reading the label,~~  
 501 opening the container, removing a prescribed amount of  
 502 medication from the container, and closing the container.

503 (c) Placing an oral dosage in the patient's hand or  
 504 placing the dosage in another container and helping the patient  
 505 by lifting the container to his or her mouth.

506 (d) Applying topical medications, including routine  
 507 preventive skin care and applying and replacing bandages for  
 508 minor cuts and abrasions as provided by the agency in rule.

509 (e) Returning the medication container to proper storage.

510 (f) For nebulizer treatments, assisting with setting up  
 511 and cleaning the device in the presence of the patient,  
 512 confirming that the medication is intended for that patient,  
 513 orally advising the patient of the medication name and purpose,  
 514 opening the container, removing the prescribed amount for a  
 515 single treatment dose from a properly labeled container, and  
 516 assisting the patient with placing the dose into the medicine  
 517 receptacle or mouthpiece.

518 (g) ~~(f)~~ Keeping a record of when a patient receives  
 519 assistance with self-administration under this section.

520 Section 6. Section 400.489, Florida Statutes, is created

521 to read:

522 400.489 Administration of medication by a home health  
 523 aide; staff training requirements.-

524 (1) A home health aide may administer oral, transdermal,  
 525 ophthalmic, otic, rectal, inhaled, enteral, or topical  
 526 prescription medications if the home health aide has been  
 527 delegated such task by a registered nurse licensed under chapter  
 528 464; has satisfactorily completed an initial 6-hour training  
 529 course approved by the agency; and has been found competent to  
 530 administer medication to a patient in a safe and sanitary  
 531 manner. The training, determination of competency, and initial  
 532 and annual validations required in this section shall be  
 533 conducted by a registered nurse licensed under chapter 464 or a  
 534 physician licensed under chapter 458 or chapter 459.

535 (2) A home health aide must annually and satisfactorily  
 536 complete a 2-hour inservice training course in medication  
 537 administration and medication error prevention approved by the  
 538 agency. The inservice training course shall be in addition to  
 539 the annual inservice training hours required by agency rules.

540 (3) The agency, in consultation with the Board of Nursing,  
 541 shall establish by rule standards and procedures that a home  
 542 health aide must follow when administering medication to a  
 543 patient. Such rules must, at a minimum, address qualification  
 544 requirements for trainers, requirements for labeling medication,  
 545 documentation and recordkeeping, the storage and disposal of  
 546 medication, instructions concerning the safe administration of

547 medication, informed-consent requirements and records, and the  
 548 training curriculum and validation procedures

549 Section 7. Section 400.490, Florida Statutes, is created  
 550 to read:

551 400.490 Nurse delegated tasks.—A certified nursing  
 552 assistant or home health aide may perform any task delegated by  
 553 a registered nurse as provided in chapter 464, including, but  
 554 not limited to, medication administration.

555 Section 8. Section 400.52, Florida Statutes, is created to  
 556 read:

557 400.52 Excellence in Home Health Program.—

558 (1) There is created within the agency the Excellence in  
 559 Home Health Program for the purpose of awarding home health  
 560 agencies that meet the criteria specified in this section.

561 (2)(a) The agency shall adopt rules establishing criteria  
 562 for the program which must include, at a minimum, meeting  
 563 standards relating to:

- 564 1. Patient satisfaction.
- 565 2. Patients requiring emergency care for wound infections.
- 566 3. Patients admitted or readmitted to an acute care  
 567 hospital.
- 568 4. Patient improvement in the activities of daily living.
- 569 5. Employee satisfaction.
- 570 6. Quality of employee training.
- 571 7. Employee retention rates.
- 572 8. High performance under federal Medicaid electronic



573 visit verification requirements.

574 (b) The agency must annually evaluate home health agencies  
575 seeking the award which apply on a form and in the manner  
576 designated by rule.

577 (3) The home health agency must:

578 (a) Be actively licensed and operating for at least 24  
579 months to be eligible to apply for a program award. An award  
580 under the program is not transferrable to another license,  
581 except when the existing home health agency is being relicensed  
582 in the name of an entity related to the current licenseholder by  
583 common control or ownership, and there will be no change in the  
584 management, operation, or programs of the home health agency as  
585 a result of the relicensure.

586 (b) Have had no licensure denials, revocations, or any  
587 Class I, Class II, or uncorrected Class III deficiencies within  
588 the 24 months preceding the application for the program award.

589 (4) The award designation shall expire on the same date as  
590 the home health agency's license. A home health agency must  
591 reapply and be approved for the award designation to continue  
592 using the award designation in the manner authorized under  
593 subsection (5).

594 (5) A home health agency that is awarded under the program  
595 may use the designation in advertising and marketing. A home  
596 health agency may not use the award designation in any  
597 advertising or marketing if the home health agency:

598 (a) Has not been awarded the designation;

599 (b) Fails to renew the award upon expiration of the award  
 600 designation;

601 (c) Has undergone a change in ownership that does not  
 602 qualify for an exception under paragraph (3) (a); or

603 (d) Has been notified that it no longer meets the criteria  
 604 for the award upon reapplication after expiration of the award  
 605 designation.

606 (6) An application for an award designation under the  
 607 program is not an application for licensure. A designation award  
 608 or denial by the agency under this section does not constitute  
 609 final agency action subject to chapter 120.

610 Section 9. Section 408.064, Florida Statutes, is created  
 611 to read:

612 408.064 Home Care Services Registry.—

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

614 (a) "Home care services provider" means a home health  
 615 agency licensed under part III of chapter 400 or a nurse  
 616 registry licensed under part III of chapter 400.

617 (b) "Home care worker" means a home health aide as defined  
 618 in s. 400.462 or a certified nursing assistant certified under  
 619 part II of chapter 464.

620 (2) The agency shall develop and maintain a voluntary  
 621 registry of home care workers. The agency shall display a link  
 622 to the registry on its website homepage.

623 (3) The registry shall include, at a minimum:

624 (a) Each home care worker's full name, date of birth,

625 social security number, and a full face, passport-type, color  
626 photograph of the home care worker. The home care worker's date  
627 of birth and social security number may not be publicly  
628 displayed on the website.

629 (b) Each home care worker's preferred contact information.  
630 If employed by a home care services provider, the home care  
631 worker may use the provider's contact information.

632 (c) Any other identifying information of the home care  
633 worker, as determined by the agency.

634 (d) The name of the state-approved training program  
635 successfully completed by the home care worker and the date on  
636 which such training was completed.

637 (e) The number of years the home care worker has provided  
638 home health care services for compensation. The agency may  
639 automatically populate employment history as provided by current  
640 and previous employers of the home care worker. The agency must  
641 provide a method for a home care worker to correct inaccuracies  
642 and supplement the automatically populated employment history.

643 (f) For a certified nursing assistant, any disciplinary  
644 action taken or pending against the nursing assistant's  
645 certification by the Department of Health. The agency may enter  
646 into an agreement with the Department of Health to obtain  
647 disciplinary history.

648 (g) Whether the home care worker provides services to  
649 special populations and the identities of such populations.

650 (4) A home care worker must submit an application on a

651 form adopted by the agency to be included in the registry. The  
 652 agency shall develop a process by which a home care services  
 653 provider may include its employees in the registry by providing  
 654 the information listed in subsection (3).

655 (5) A home care worker who is not employed by a home care  
 656 services provider must meet the background screening  
 657 requirements under s. 408.809 and chapter 435 and the training  
 658 requirements of part III of chapter 400 or part II of chapter  
 659 464, as applicable, which must be included in the registry.

660 (6) Each page of the registry website shall contain the  
 661 following notice in at least 14-point boldfaced type:

662  
 663 NOTICE  
 664

665 The Home Care Services Registry provides limited  
 666 information about home care workers. Information  
 667 contained in the registry is provided by third  
 668 parties. The Agency for Health Care Administration  
 669 does not guarantee the accuracy of such third-party  
 670 information and does not endorse any individual listed  
 671 in the registry. In particular, the information in the  
 672 registry may be outdated or the individuals listed in  
 673 the registry may have lapsed certifications or may  
 674 have been denied employment approval due to the  
 675 results of a background screening. It is the  
 676 responsibility of those accessing this registry to

677 verify the credentials, suitability, and competency of  
 678 any individual listed in the registry.

679  
 680 (7) The agency shall develop rules necessary to implement  
 681 the requirements of this section.

682 Section 10. Section 408.822, Florida Statutes, is created  
 683 to read:

684 408.822 Direct care workforce survey.-

685 (1) For purposes of this section, the term "direct care  
 686 worker" means a certified nursing assistant, home health aide,  
 687 personal care assistant, companion services or homemaker  
 688 services provider, paid feeding assistant, or other individuals  
 689 who provide personal care as defined in s. 400.462 to  
 690 individuals who are elderly, developmentally disabled, or  
 691 chronically ill.

692 (2) Beginning January 1, 2021, each licensee that applies  
 693 for licensure renewal as a nursing home facility licensed under  
 694 part II of chapter 400; an assisted living facility licensed  
 695 under part I of chapter 429; or a home health agency, nurse  
 696 registry, or a companion services or homemaker services provider  
 697 licensed under part III of chapter 400 must furnish the  
 698 following information to the agency in a survey on the direct  
 699 care workforce:

700 (a) The number of registered nurses, licensed practical  
 701 nurses, and direct care workers employed or contracted by the  
 702 licensee.

703       (b) The turnover and vacancy rates of employed registered  
704 nurses, licensed practical nurses, and direct care workers and  
705 contributing factors to the rates, as applicable.

706       (c) Average wage for registered nurses, licensed practical  
707 nurses, and each category of direct care workers, including  
708 employees and independent contractors.

709       (d) Employment benefits for employed direct care workers  
710 or contractors and average cost to the employer and employee or  
711 contractor, as applicable.

712       (e) Type and availability of training for employed  
713 registered nurses, licensed practical nurses, and direct care  
714 workers, as applicable.

715       (3) An administrator or designee shall include the  
716 information required in subsection (2) on a survey form  
717 developed by the agency in rule which must contain an  
718 attestation that the information provided is true and accurate  
719 to the best of his or her knowledge.

720       (4) The licensee must submit the completed survey at such  
721 time designated by the agency in rule. The agency may not issue  
722 a license renewal until the licensee submits a completed survey.

723       (5) The agency shall continually analyze the results of  
724 the survey and publish the results on its website. The agency  
725 must update the information published on its website monthly.  
726 The analysis must include the:

727       (a) Number of direct workers in the state, including the  
728 number of full-time workers and the number of part-time workers.

729 (b) Turnover rate and causes of turnover.

730 (c) Vacancy rate.

731 (d) Average hourly wage.

732 (e) Benefits offered.

733 (f) Availability of post-employment training.

734 Section 11. Section 464.0156, Florida Statutes, is created  
735 to read:

736 464.0156 Delegation of duties.—

737 (1) A registered nurse may delegate a task to a certified  
738 nursing assistant certified under part II of this chapter or a  
739 home health aide as defined in s. 400.462, if the registered  
740 nurse determines that the certified nursing assistant or home  
741 health aide is competent to perform the task, the task is  
742 delegable under federal law, and the task:

743 (a) Is within the nurse's scope of practice.

744 (b) Frequently recurs in the routine care of a patient or  
745 group of patients.

746 (c) Is performed according to an established sequence of  
747 steps.

748 (d) Involves little or no modification from one patient to  
749 another.

750 (e) May be performed with a predictable outcome.

751 (f) Does not inherently involve ongoing assessment,  
752 interpretation, or clinical judgement.

753 (g) Does not endanger a patient's life or well-being.

754 (2) A registered nurse may delegate to a certified nursing

755 assistant or a home health aide the administration of medication  
756 of oral, transdermal, ophthalmic, otic, rectal, inhaled,  
757 enteral, or topical prescription medications to a patient of a  
758 home health agency if the certified nursing assistant or home  
759 health aide meets the requirements of s. 464.2035 or s. 400.489,  
760 respectively. A registered nurse may not delegate the  
761 administration of any controlled substance listed in Schedule  
762 II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s.  
763 812.

764 (3) The board, in consultation with the Agency for Health  
765 Care Administration, shall adopt rules to implement this  
766 section.

767 Section 12. Paragraph (r) is added to subsection (1) of  
768 section 464.018, Florida Statutes, to read:

769 464.018 Disciplinary actions.—

770 (1) The following acts constitute grounds for denial of a  
771 license or disciplinary action, as specified in ss. 456.072(2)  
772 and 464.0095:

773 (r) Delegating professional responsibilities to a person  
774 when the nurse delegating such responsibilities knows or has  
775 reason to know that such person is not qualified by training,  
776 experience, certification, or licensure to perform them.

777 Section 13. Section 464.2035, Florida Statutes, is created  
778 to read:

779 464.2035 Administration of medication.—

780 (1) A certified nursing assistant may administer oral,



781 transdermal, ophthalmic, otic, rectal, inhaled, enteral, or  
 782 topical prescription medication to a patient of a home health  
 783 agency if the certified nursing assistant has been delegated  
 784 such task by a registered nurse licensed under part I of this  
 785 chapter, has satisfactorily completed an initial 6-hour training  
 786 course approved by the board, and has been found competent to  
 787 administer medication to a patient in a safe and sanitary  
 788 manner. The training, determination of competency, and initial  
 789 and annual validations required in this section shall be  
 790 conducted by a registered nurse licensed under this chapter or a  
 791 physician licensed under chapter 458 or chapter 459.

792 (2) A certified nursing assistant must annually and  
 793 satisfactorily complete 2 hours of inservice training in  
 794 medication administration and medication error prevention  
 795 approved by the board, in consultation with the Agency for  
 796 Health Care Administration. The inservice training is in  
 797 addition to the annual inservice training hours required under  
 798 this part.

799 (3) The board, in consultation with the Agency for Health  
 800 Care Administration, shall establish by rule standards and  
 801 procedures that a certified nursing assistant must follow when  
 802 administering medication to a patient of a home health agency.  
 803 Such rules must, at a minimum, address qualification  
 804 requirements for trainers, requirements for labeling medication,  
 805 documentation and recordkeeping, the storage and disposal of  
 806 medication, instructions concerning the safe administration of

807 medication, informed-consent requirements and records, and the  
808 training curriculum and validation procedures.

809 Section 14. Subsections (1), (2), and (3) of section  
810 456.0391, Florida Statutes, are amended to read:

811 456.0391 Advanced practice registered nurses and  
812 autonomous physician assistants; information required for  
813 licensure or registration.—

814 (1) (a) Each person who applies for initial licensure under  
815 s. 464.012 or initial registration under s. 458.347(8) or s.  
816 459.022(8) must, at the time of application, and each person  
817 licensed under s. 464.012 or registered under s. 458.347(8) or  
818 s. 459.022(8) who applies for licensure or registration renewal  
819 must, in conjunction with the renewal of such licensure or  
820 registration and under procedures adopted by the Department of  
821 Health, and in addition to any other information that may be  
822 required from the applicant, furnish the following information  
823 to the Department of Health:

824 1. The name of each school or training program that the  
825 applicant has attended, with the months and years of attendance  
826 and the month and year of graduation, and a description of all  
827 graduate professional education completed by the applicant,  
828 excluding any coursework taken to satisfy continuing education  
829 requirements.

830 2. The name of each location at which the applicant  
831 practices.

832 3. The address at which the applicant will primarily

833 | conduct his or her practice.

834 |         4. Any certification or designation that the applicant has  
835 | received from a specialty or certification board that is  
836 | recognized or approved by the regulatory board or department to  
837 | which the applicant is applying.

838 |         5. The year that the applicant received initial  
839 | certification, ~~or licensure,~~ or registration and began  
840 | practicing the profession in any jurisdiction and the year that  
841 | the applicant received initial certification, ~~or licensure,~~ or  
842 | registration in this state.

843 |         6. Any appointment which the applicant currently holds to  
844 | the faculty of a school related to the profession and an  
845 | indication as to whether the applicant has had the  
846 | responsibility for graduate education within the most recent 10  
847 | years.

848 |         7. A description of any criminal offense of which the  
849 | applicant has been found guilty, regardless of whether  
850 | adjudication of guilt was withheld, or to which the applicant  
851 | has pled guilty or nolo contendere. A criminal offense committed  
852 | in another jurisdiction which would have been a felony or  
853 | misdemeanor if committed in this state must be reported. If the  
854 | applicant indicates that a criminal offense is under appeal and  
855 | submits a copy of the notice for appeal of that criminal  
856 | offense, the department must state that the criminal offense is  
857 | under appeal if the criminal offense is reported in the  
858 | applicant's profile. If the applicant indicates to the

859 department that a criminal offense is under appeal, the  
860 applicant must, within 15 days after the disposition of the  
861 appeal, submit to the department a copy of the final written  
862 order of disposition.

863 8. A description of any final disciplinary action taken  
864 within the previous 10 years against the applicant by a  
865 licensing or regulatory body in any jurisdiction, by a specialty  
866 board that is recognized by the board or department, or by a  
867 licensed hospital, health maintenance organization, prepaid  
868 health clinic, ambulatory surgical center, or nursing home.  
869 Disciplinary action includes resignation from or nonrenewal of  
870 staff membership or the restriction of privileges at a licensed  
871 hospital, health maintenance organization, prepaid health  
872 clinic, ambulatory surgical center, or nursing home taken in  
873 lieu of or in settlement of a pending disciplinary case related  
874 to competence or character. If the applicant indicates that the  
875 disciplinary action is under appeal and submits a copy of the  
876 document initiating an appeal of the disciplinary action, the  
877 department must state that the disciplinary action is under  
878 appeal if the disciplinary action is reported in the applicant's  
879 profile.

880 (b) In addition to the information required under  
881 paragraph (a), each applicant for initial licensure or  
882 registration or licensure or registration renewal must provide  
883 the information required of licensees pursuant to s. 456.049.

884 (2) The Department of Health shall send a notice to each

885 person licensed under s. 464.012 or registered under s.  
 886 458.347(8) or s. 459.022(8) at the licensee's or registrant's  
 887 last known address of record regarding the requirements for  
 888 information to be submitted by such person ~~advanced practice~~  
 889 ~~registered nurses~~ pursuant to this section in conjunction with  
 890 the renewal of such license or registration.

891 (3) Each person licensed under s. 464.012 or registered  
 892 under s. 458.347(8) or s. 459.022(8) who has submitted  
 893 information pursuant to subsection (1) must update that  
 894 information in writing by notifying the Department of Health  
 895 within 45 days after the occurrence of an event or the  
 896 attainment of a status that is required to be reported by  
 897 subsection (1). Failure to comply with the requirements of this  
 898 subsection to update and submit information constitutes a ground  
 899 for disciplinary action under the applicable practice act  
 900 ~~chapter 464~~ and s. 456.072(1)(k). For failure to comply with the  
 901 requirements of this subsection to update and submit  
 902 information, the department or board, as appropriate, may:

903 (a) Refuse to issue a license or registration to any  
 904 person applying for initial licensure or registration who fails  
 905 to submit and update the required information.

906 (b) Issue a citation to any certificateholder, ~~or~~  
 907 licensee, or registrant who fails to submit and update the  
 908 required information and may fine the certificateholder, ~~or~~  
 909 licensee, or registrant up to \$50 for each day that the  
 910 certificateholder, ~~or~~ licensee, or registrant is not in

911 compliance with this subsection. The citation must clearly state  
 912 that the certificateholder, ~~or~~ licensee, or registrant may  
 913 choose, in lieu of accepting the citation, to follow the  
 914 procedure under s. 456.073. If the certificateholder, ~~or~~  
 915 licensee, or registrant disputes the matter in the citation, the  
 916 procedures set forth in s. 456.073 must be followed. However, if  
 917 the certificateholder, ~~or~~ licensee, or registrant does not  
 918 dispute the matter in the citation with the department within 30  
 919 days after the citation is served, the citation becomes a final  
 920 order and constitutes discipline. Service of a citation may be  
 921 made by personal service or certified mail, restricted delivery,  
 922 to the subject at the certificateholder's, ~~or~~ licensee's, or  
 923 registrant's last known address.

924 Section 15. Subsection (6) of section 456.041, Florida  
 925 Statutes, is amended to read:

926 456.041 Practitioner profile; creation.—

927 (6) The Department of Health shall provide in each  
 928 practitioner profile for every physician, autonomous physician  
 929 assistant, or advanced practice registered nurse terminated for  
 930 cause from participating in the Medicaid program, pursuant to s.  
 931 409.913, or sanctioned by the Medicaid program a statement that  
 932 the practitioner has been terminated from participating in the  
 933 Florida Medicaid program or sanctioned by the Medicaid program.

934 Section 16. Subsections (8) through (17) of section  
 935 458.347, Florida Statutes, are renumbered as subsections (9)  
 936 through (18), respectively, subsection (2), paragraphs (b), (e),

937 and (f) of subsection (4), paragraph (a) of subsection (6),  
 938 paragraphs (a) and (f) of subsection (7), present subsection  
 939 (9), and present subsections (11) through (13) are amended,  
 940 paragraph (b) is added to subsection (2), and new subsections  
 941 (8) and (19) are added to that section, to read:

942 458.347 Physician assistants.—

943 (2) DEFINITIONS.—As used in this section:

944 (a) "Approved program" means a program, formally approved  
 945 by the boards, for the education of physician assistants.

946 (b) "Autonomous physician assistant" means a physician  
 947 assistant who meets the requirements of subsection (8) to  
 948 practice primary care without physician supervision.

949 (c) ~~(b)~~ "Boards" means the Board of Medicine and the Board  
 950 of Osteopathic Medicine.

951 (d) ~~(h)~~ "Continuing medical education" means courses  
 952 recognized and approved by the boards, the American Academy of  
 953 Physician Assistants, the American Medical Association, the  
 954 American Osteopathic Association, or the Accreditation Council  
 955 on Continuing Medical Education.

956 (e) ~~(e)~~ "Council" means the Council on Physician  
 957 Assistants.

958 (f) ~~(e)~~ "Physician assistant" means a person who is a  
 959 graduate of an approved program or its equivalent or meets  
 960 standards approved by the boards and is licensed to perform  
 961 medical services delegated by the supervising physician.

962 (g) "Proficiency examination" means an entry-level

963 examination approved by the boards, including, but not limited  
964 to, those examinations administered by the National Commission  
965 on Certification of Physician Assistants.

966 (h)~~(f)~~ "Supervision" means responsible supervision and  
967 control. Except in cases of emergency, supervision requires the  
968 easy availability or physical presence of the licensed physician  
969 for consultation and direction of the actions of the physician  
970 assistant. For the purposes of this definition, the term "easy  
971 availability" includes the ability to communicate by way of  
972 telecommunication. The boards shall establish rules as to what  
973 constitutes responsible supervision of the physician assistant.

974 (i)~~(d)~~ "Trainee" means a person who is currently enrolled  
975 in an approved program.

976 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

977 (b) This chapter does not prevent third-party payors from  
978 reimbursing employers of autonomous physician assistants or  
979 physician assistants for covered services rendered by registered  
980 autonomous physician assistants or licensed physician  
981 assistants.

982 (e) A supervising physician may delegate to a fully  
983 licensed physician assistant the authority to prescribe or  
984 dispense any medication used in the supervising physician's  
985 practice unless such medication is listed on the formulary  
986 created pursuant to paragraph (f). A fully licensed physician  
987 assistant may only prescribe or dispense such medication under  
988 the following circumstances:



989 1. A physician assistant must clearly identify to the  
 990 patient that he or she is a physician assistant ~~and inform the~~  
 991 ~~patient that the patient has the right to see the physician~~  
 992 ~~before a prescription is prescribed or dispensed by the~~  
 993 ~~physician assistant.~~

994 2. The supervising physician must notify the department of  
 995 his or her intent to delegate, on a department-approved form,  
 996 before delegating such authority and of any change in  
 997 prescriptive privileges of the physician assistant. Authority to  
 998 dispense may be delegated only by a supervising physician who is  
 999 registered as a dispensing practitioner in compliance with s.  
 1000 465.0276.

1001 3. The physician assistant must complete a minimum of 10  
 1002 continuing medical education hours in the specialty practice in  
 1003 which the physician assistant has prescriptive privileges with  
 1004 each licensure renewal. Three of the 10 hours must consist of a  
 1005 continuing education course on the safe and effective  
 1006 prescribing of controlled substance medications which is offered  
 1007 by a statewide professional association of physicians in this  
 1008 state accredited to provide educational activities designated  
 1009 for the American Medical Association Physician's Recognition  
 1010 Award Category 1 credit or designated by the American Academy of  
 1011 Physician Assistants as a Category 1 credit.

1012 4. The department may issue a prescriber number to the  
 1013 physician assistant granting authority for the prescribing of  
 1014 medicinal drugs authorized within this paragraph upon completion

1015 of the requirements of this paragraph. The physician assistant  
 1016 is not required to independently register pursuant to s.  
 1017 465.0276.

1018 5. The prescription may be in paper or electronic form but  
 1019 must comply with ss. 456.0392(1) and 456.42(1) and chapter 499  
 1020 and must contain, in addition to the supervising physician's  
 1021 name, address, and telephone number, the physician assistant's  
 1022 prescriber number. Unless it is a drug or drug sample dispensed  
 1023 by the physician assistant, the prescription must be filled in a  
 1024 pharmacy permitted under chapter 465 and must be dispensed in  
 1025 that pharmacy by a pharmacist licensed under chapter 465. The  
 1026 inclusion of the prescriber number creates a presumption that  
 1027 the physician assistant is authorized to prescribe the medicinal  
 1028 drug and the prescription is valid.

1029 6. The physician assistant must note the prescription or  
 1030 dispensing of medication in the appropriate medical record.

1031 (f)1. The council shall establish a formulary of medicinal  
 1032 drugs that a registered autonomous physician assistant or fully  
 1033 licensed physician assistant having prescribing authority under  
 1034 this section or s. 459.022 may not prescribe. The formulary must  
 1035 include general anesthetics and radiographic contrast materials  
 1036 and must limit the prescription of Schedule II controlled  
 1037 substances as listed in s. 893.03 or 21 U.S.C. s. 812 to a 7-day  
 1038 supply. The formulary must also restrict the prescribing of  
 1039 psychiatric mental health controlled substances for children  
 1040 younger than 18 years of age.

1041           2. In establishing the formulary, the council shall  
 1042 consult with a pharmacist licensed under chapter 465, but not  
 1043 licensed under this chapter or chapter 459, who shall be  
 1044 selected by the State Surgeon General.

1045           3. Only the council shall add to, delete from, or modify  
 1046 the formulary. Any person who requests an addition, a deletion,  
 1047 or a modification of a medicinal drug listed on such formulary  
 1048 has the burden of proof to show cause why such addition,  
 1049 deletion, or modification should be made.

1050           4. The boards shall adopt the formulary required by this  
 1051 paragraph, and each addition, deletion, or modification to the  
 1052 formulary, by rule. Notwithstanding any provision of chapter 120  
 1053 to the contrary, the formulary rule shall be effective 60 days  
 1054 after the date it is filed with the Secretary of State. Upon  
 1055 adoption of the formulary, the department shall mail a copy of  
 1056 such formulary to each registered autonomous physician assistant  
 1057 or fully licensed physician assistant having prescribing  
 1058 authority under this section or s. 459.022, and to each pharmacy  
 1059 licensed by the state. The boards shall establish, by rule, a  
 1060 fee not to exceed \$200 to fund ~~the provisions of~~ this paragraph  
 1061 and paragraph (e).

1062           (6) PROGRAM APPROVAL.—

1063           (a) The boards shall approve programs, ~~based on~~  
 1064 ~~recommendations by the council,~~ for the education and training  
 1065 of physician assistants which meet standards established by rule  
 1066 of the boards. ~~The council may recommend only those physician~~

1067 ~~assistant programs that hold full accreditation or provisional~~  
1068 ~~accreditation from the Commission on Accreditation of Allied~~  
1069 ~~Health Programs or its successor organization. Any educational~~  
1070 ~~institution offering a physician assistant program approved by~~  
1071 ~~the boards pursuant to this paragraph may also offer the~~  
1072 ~~physician assistant program authorized in paragraph (c) for~~  
1073 ~~unlicensed physicians.~~

1074 (7) PHYSICIAN ASSISTANT LICENSURE.—

1075 (a) Any person desiring to be licensed as a physician  
1076 assistant must apply to the department. The department shall  
1077 issue a license to any person certified by the council as having  
1078 met the following requirements:

1079 1. Is at least 18 years of age.

1080 2. Has satisfactorily passed a proficiency examination by  
1081 an acceptable score established by the National Commission on  
1082 Certification of Physician Assistants. If an applicant does not  
1083 hold a current certificate issued by the National Commission on  
1084 Certification of Physician Assistants and has not actively  
1085 practiced as a physician assistant within the immediately  
1086 preceding 4 years, the applicant must retake and successfully  
1087 complete the entry-level examination of the National Commission  
1088 on Certification of Physician Assistants to be eligible for  
1089 licensure.

1090 3. Has completed the application form and remitted an  
1091 application fee not to exceed \$300 as set by the boards. An  
1092 application for licensure made by a physician assistant must

1093 include:

1094 a. Has graduated from a board-approved ~~A certificate of~~  
 1095 ~~completion of a~~ physician assistant training program as  
 1096 specified in subsection (6).

1097 b. Acknowledgment of any prior felony convictions.

1098 c. Acknowledgment of any previous revocation or denial of  
 1099 licensure or certification in any state.

1100 d. A copy of course transcripts and a copy of the course  
 1101 description from a physician assistant training program  
 1102 describing course content in pharmacotherapy, if the applicant  
 1103 wishes to apply for prescribing authority. These documents must  
 1104 meet the evidence requirements for prescribing authority.

1105 (f) The Board of Medicine may impose any of the penalties  
 1106 authorized under ss. 456.072 and 458.331(2) upon an autonomous  
 1107 physician assistant or a physician assistant if the autonomous  
 1108 physician assistant, physician assistant, or ~~the~~ supervising  
 1109 physician has been found guilty of or is being investigated for  
 1110 any act that constitutes a violation of this chapter or chapter  
 1111 456.

1112 (8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.-

1113 (a) The boards shall register a physician assistant as an  
 1114 autonomous physician assistant if the applicant demonstrates  
 1115 that he or she:

1116 1. Holds an active, unencumbered license to practice as a  
 1117 physician assistant in this state.

1118 2. Has not been subject to any disciplinary action as

1119 specified in s. 456.072, s. 458.331, or s. 459.015, or any  
1120 similar disciplinary action in any jurisdiction of the United  
1121 States, within the 5 years immediately preceding the  
1122 registration request.

1123 3. Has completed, in any jurisdiction of the United  
1124 States, at least 2,000 clinical practice hours within the 3  
1125 years immediately preceding the submission of the registration  
1126 request while practicing as a physician assistant under the  
1127 supervision of an allopathic or osteopathic physician who held  
1128 an active, unencumbered license issued by another state, the  
1129 District of Columbia, or a possession or territory of the United  
1130 States during the period of such supervision.

1131 4. Has completed a graduate-level course in pharmacology.

1132 5. Obtains and maintains professional liability coverage  
1133 at the same level and in the same manner as in s. 458.320(1)(b)  
1134 or (c). However, the requirements of this subparagraph do not  
1135 apply to:

1136 a. Any person registered under this subsection who  
1137 practices exclusively as an officer, employee, or agent of the  
1138 Federal Government or of the state or its agencies or its  
1139 subdivisions.

1140 b. Any person whose license has become inactive and who is  
1141 not practicing as an autonomous physician assistant in this  
1142 state.

1143 c. Any person who practices as an autonomous physician  
1144 assistant only in conjunction with his or her teaching duties at

1145 an accredited school or its main teaching hospitals. Such  
 1146 practice is limited to that which is incidental to and a  
 1147 necessary part of duties in connection with the teaching  
 1148 position.

1149 d. Any person who holds an active registration under this  
 1150 subsection who is not practicing as an autonomous physician  
 1151 assistant in this state. If such person initiates or resumes any  
 1152 practice as an autonomous physician assistant, he or she must  
 1153 notify the department of such activity and fulfill the  
 1154 professional liability coverage requirements of this  
 1155 subparagraph.

1156 (b) The department shall conspicuously distinguish an  
 1157 autonomous physician assistant license if he or she is  
 1158 registered under this subsection.

1159 (c) An autonomous physician assistant may:

1160 1. Render only primary care services as defined by rule of  
 1161 the boards without physician supervision.

1162 2. Provide any service that is within the scope of the  
 1163 autonomous physician assistant's education and experience and  
 1164 provided in accordance with rules adopted by the board without  
 1165 physician supervision.

1166 3. Prescribe, dispense, administer, or order any medicinal  
 1167 drug, including those medicinal drugs to the extent authorized  
 1168 under paragraph (4) (f) and the formulary adopted in that  
 1169 paragraph.

1170 4. Order any medication for administration to a patient in

1171 a facility licensed under chapter 395 or part II of chapter 400,  
 1172 notwithstanding chapter 465 or chapter 893.

1173 5. Provide a signature, certification, stamp,  
 1174 verification, affidavit, or other endorsement that is otherwise  
 1175 required by law to be provided by a physician.

1176 (d) An autonomous physician assistant must biennially  
 1177 renew his or her registration under this subsection. The  
 1178 biennial renewal shall coincide with the autonomous physician  
 1179 assistant's biennial renewal period for physician assistant  
 1180 licensure.

1181 (e) The council shall develop rules defining the primary  
 1182 care practice of autonomous physician assistants, which may  
 1183 include internal medicine, general pediatrics, family medicine,  
 1184 geriatrics, and general obstetrics and gynecology practices.

1185 (10)-(9) COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on  
 1186 Physician Assistants is created within the department.

1187 (a) The council shall consist of five members appointed as  
 1188 follows:

1189 1. The chairperson of the Board of Medicine shall appoint  
 1190 one member who is a physician and a member ~~three members who are~~  
 1191 ~~physicians and members~~ of the Board of Medicine. ~~One of The~~  
 1192 physician ~~physicians~~ must supervise a physician assistant in his  
 1193 or her ~~the physician's~~ practice.

1194 2. The chairperson of the Board of Osteopathic Medicine  
 1195 shall appoint one member who is a physician and a member of the  
 1196 Board of Osteopathic Medicine. The physician must supervise a



1197 physician assistant in his or her practice.

1198           3. The State Surgeon General or his or her designee shall  
 1199 appoint three ~~a~~ fully licensed physician assistants ~~assistant~~  
 1200 licensed under this chapter or chapter 459.

1201           (b) ~~Two of the members appointed to the council must be~~  
 1202 ~~physicians who supervise physician assistants in their practice.~~

1203 Members shall be appointed to terms of 4 years, except that of  
 1204 the initial appointments, two members shall be appointed to  
 1205 terms of 2 years, two members shall be appointed to terms of 3  
 1206 years, and one member shall be appointed to a term of 4 years,  
 1207 as established by rule of the boards. Council members may not  
 1208 serve more than two consecutive terms. The council shall  
 1209 annually elect a chairperson from among its members.

1210           (c) The council shall:

1211           1. Recommend to the department the licensure of physician  
 1212 assistants.

1213           2. Develop all rules regulating the primary care practice  
 1214 of autonomous physician assistants and the use of physician  
 1215 assistants by physicians under this chapter and chapter 459,  
 1216 except for rules relating to the formulary developed under  
 1217 paragraph (4) (f). The council shall also develop rules to ensure  
 1218 that the continuity of supervision is maintained in each  
 1219 practice setting. The boards shall consider adopting a proposed  
 1220 rule developed by the council at the regularly scheduled meeting  
 1221 immediately following the submission of the proposed rule by the  
 1222 council. A proposed rule submitted by the council may not be

1223 adopted by either board unless both boards have accepted and  
 1224 approved the identical language contained in the proposed rule.  
 1225 The language of all proposed rules submitted by the council must  
 1226 be approved by both boards pursuant to each respective board's  
 1227 guidelines and standards regarding the adoption of proposed  
 1228 rules. If either board rejects the council's proposed rule, that  
 1229 board must specify its objection to the council with  
 1230 particularity and include any recommendations it may have for  
 1231 the modification of the proposed rule.

1232 3. Make recommendations to the boards regarding all  
 1233 matters relating to autonomous physician assistants and  
 1234 physician assistants.

1235 4. Address concerns and problems of practicing autonomous  
 1236 physician assistants and physician assistants in order to  
 1237 improve safety in the clinical practices of registered  
 1238 autonomous physician assistants and licensed physician  
 1239 assistants.

1240 (d) When the council finds that an applicant for licensure  
 1241 has failed to meet, to the council's satisfaction, each of the  
 1242 requirements for licensure set forth in this section, the  
 1243 council may enter an order to:

- 1244 1. Refuse to certify the applicant for licensure;
- 1245 2. Approve the applicant for licensure with restrictions  
 1246 on the scope of practice or license; or
- 1247 3. Approve the applicant for conditional licensure. Such  
 1248 conditions may include placement of the licensee on probation

1249 for a period of time and subject to such conditions as the  
 1250 council may specify, including but not limited to, requiring the  
 1251 licensee to undergo treatment, to attend continuing education  
 1252 courses, to work under the direct supervision of a physician  
 1253 licensed in this state, or to take corrective action.

1254 (12)~~(11)~~ PENALTY.—Any person who has not been registered  
 1255 or licensed by the council and approved by the department and  
 1256 who holds himself or herself out as an autonomous physician  
 1257 assistant or a physician assistant or who uses any other term in  
 1258 indicating or implying that he or she is an autonomous physician  
 1259 assistant or a physician assistant commits a felony of the third  
 1260 degree, punishable as provided in s. 775.082 or s. 775.084 or by  
 1261 a fine not exceeding \$5,000.

1262 (13)~~(12)~~ DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—  
 1263 The boards may deny, suspend, or revoke the registration of an  
 1264 autonomous physician assistant or the license of a physician  
 1265 assistant license if a board determines that the autonomous  
 1266 physician assistant or physician assistant has violated this  
 1267 chapter.

1268 (14)~~(13)~~ RULES.—The boards shall adopt rules to implement  
 1269 this section, including rules detailing the contents of the  
 1270 application for licensure and notification pursuant to  
 1271 subsection (7), rules relating to the registration of autonomous  
 1272 physician assistants under subsection (8), and rules to ensure  
 1273 ~~both~~ the continued competency of autonomous physician assistants  
 1274 and physician assistants and the proper utilization of them by

1275 | physicians or groups of physicians.

1276 |       (19) ADVERSE INCIDENTS.—An autonomous physician assistant  
 1277 | must report adverse incidents to the department in accordance  
 1278 | with s. 458.351.

1279 |       Section 17. Subsections (8) through (17) of section  
 1280 | 459.022, Florida Statutes, are renumbered as subsections (9)  
 1281 | through (18), respectively, subsection (2), paragraphs (b) and  
 1282 | (e) of subsection (4), paragraph (a) of subsection (6),  
 1283 | paragraphs (a) and (f) of subsection (7), present subsection  
 1284 | (9), and present subsections (11) through (13) are amended,  
 1285 | paragraph (b) is added to subsection (2), and new subsections  
 1286 | (8) and (19) are added to that section, to read:

1287 |       459.022 Physician assistants.—

1288 |       (2) DEFINITIONS.—As used in this section:

1289 |       (a) "Approved program" means a program, formally approved  
 1290 | by the boards, for the education of physician assistants.

1291 |       **(b) "Autonomous physician assistant" means a physician**  
 1292 | **assistant who meets the requirements of subsection (8) to**  
 1293 | **practice primary care without physician supervision.**

1294 |       **(c) ~~(b)~~ "Boards" means the Board of Medicine and the Board**  
 1295 | **of Osteopathic Medicine.**

1296 |       **(d) ~~(h)~~ "Continuing medical education" means courses**  
 1297 | **recognized and approved by the boards, the American Academy of**  
 1298 | **Physician Assistants, the American Medical Association, the**  
 1299 | **American Osteopathic Association, or the Accreditation Council**  
 1300 | **on Continuing Medical Education.**

1301            (e)~~(e)~~ "Council" means the Council on Physician  
 1302 Assistants.

1303            (f)~~(e)~~ "Physician assistant" means a person who is a  
 1304 graduate of an approved program or its equivalent or meets  
 1305 standards approved by the boards and is licensed to perform  
 1306 medical services delegated by the supervising physician.

1307            (g) "Proficiency examination" means an entry-level  
 1308 examination approved by the boards, including, but not limited  
 1309 to, those examinations administered by the National Commission  
 1310 on Certification of Physician Assistants.

1311            (h)~~(f)~~ "Supervision" means responsible supervision and  
 1312 control. Except in cases of emergency, supervision requires the  
 1313 easy availability or physical presence of the licensed physician  
 1314 for consultation and direction of the actions of the physician  
 1315 assistant. For the purposes of this definition, the term "easy  
 1316 availability" includes the ability to communicate by way of  
 1317 telecommunication. The boards shall establish rules as to what  
 1318 constitutes responsible supervision of the physician assistant.

1319            (i)~~(d)~~ "Trainee" means a person who is currently enrolled  
 1320 in an approved program.

1321            (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

1322            (b) This chapter does not prevent third-party payors from  
 1323 reimbursing employers of autonomous physician assistants or  
 1324 physician assistants for covered services rendered by registered  
 1325 autonomous physician assistants or licensed physician  
 1326 assistants.

1327 (e) A supervising physician may delegate to a fully  
1328 licensed physician assistant the authority to prescribe or  
1329 dispense any medication used in the supervising physician's  
1330 practice unless such medication is listed on the formulary  
1331 created pursuant to s. 458.347. A fully licensed physician  
1332 assistant may only prescribe or dispense such medication under  
1333 the following circumstances:

1334 1. A physician assistant must clearly identify to the  
1335 patient that she or he is a physician assistant ~~and must inform~~  
1336 ~~the patient that the patient has the right to see the physician~~  
1337 ~~before a prescription is prescribed or dispensed by the~~  
1338 ~~physician assistant.~~

1339 2. The supervising physician must notify the department of  
1340 her or his intent to delegate, on a department-approved form,  
1341 before delegating such authority and of any change in  
1342 prescriptive privileges of the physician assistant. Authority to  
1343 dispense may be delegated only by a supervising physician who is  
1344 registered as a dispensing practitioner in compliance with s.  
1345 465.0276.

1346 3. The physician assistant must complete a minimum of 10  
1347 continuing medical education hours in the specialty practice in  
1348 which the physician assistant has prescriptive privileges with  
1349 each licensure renewal.

1350 4. The department may issue a prescriber number to the  
1351 physician assistant granting authority for the prescribing of  
1352 medicinal drugs authorized within this paragraph upon completion

1353 of the requirements of this paragraph. The physician assistant  
 1354 is not required to independently register pursuant to s.  
 1355 465.0276.

1356 5. The prescription may be in paper or electronic form but  
 1357 must comply with ss. 456.0392(1) and 456.42(1) and chapter 499  
 1358 and must contain, in addition to the supervising physician's  
 1359 name, address, and telephone number, the physician assistant's  
 1360 prescriber number. Unless it is a drug or drug sample dispensed  
 1361 by the physician assistant, the prescription must be filled in a  
 1362 pharmacy permitted under chapter 465, and must be dispensed in  
 1363 that pharmacy by a pharmacist licensed under chapter 465. The  
 1364 inclusion of the prescriber number creates a presumption that  
 1365 the physician assistant is authorized to prescribe the medicinal  
 1366 drug and the prescription is valid.

1367 6. The physician assistant must note the prescription or  
 1368 dispensing of medication in the appropriate medical record.

1369 (6) PROGRAM APPROVAL.—

1370 (a) The boards shall approve programs, ~~based on~~  
 1371 ~~recommendations by the council,~~ for the education and training  
 1372 of physician assistants which meet standards established by rule  
 1373 of the boards. ~~The council may recommend only those physician~~  
 1374 ~~assistant programs that hold full accreditation or provisional~~  
 1375 ~~accreditation from the Commission on Accreditation of Allied~~  
 1376 ~~Health Programs or its successor organization.~~

1377 (7) PHYSICIAN ASSISTANT LICENSURE.—

1378 (a) Any person desiring to be licensed as a physician

1379 assistant must apply to the department. The department shall  
 1380 issue a license to any person certified by the council as having  
 1381 met the following requirements:

1382 1. Is at least 18 years of age.

1383 2. Has satisfactorily passed a proficiency examination by  
 1384 an acceptable score established by the National Commission on  
 1385 Certification of Physician Assistants. If an applicant does not  
 1386 hold a current certificate issued by the National Commission on  
 1387 Certification of Physician Assistants and has not actively  
 1388 practiced as a physician assistant within the immediately  
 1389 preceding 4 years, the applicant must retake and successfully  
 1390 complete the entry-level examination of the National Commission  
 1391 on Certification of Physician Assistants to be eligible for  
 1392 licensure.

1393 3. Has completed the application form and remitted an  
 1394 application fee not to exceed \$300 as set by the boards. An  
 1395 application for licensure made by a physician assistant must  
 1396 include:

1397 a. Has graduated from a board-approved ~~A certificate of~~  
 1398 ~~completion of a~~ physician assistant training program as  
 1399 specified in subsection (6).

1400 b. Acknowledgment of any prior felony convictions.

1401 c. Acknowledgment of any previous revocation or denial of  
 1402 licensure or certification in any state.

1403 d. A copy of course transcripts and a copy of the course  
 1404 description from a physician assistant training program



1405 describing course content in pharmacotherapy, if the applicant  
 1406 wishes to apply for prescribing authority. These documents must  
 1407 meet the evidence requirements for prescribing authority.

1408 (f) The Board of Osteopathic Medicine may impose any of  
 1409 the penalties authorized under ss. 456.072 and 459.015(2) upon  
 1410 an autonomous physician assistant or a physician assistant if  
 1411 the autonomous physician assistant, physician assistant, or the  
 1412 supervising physician has been found guilty of or is being  
 1413 investigated for any act that constitutes a violation of this  
 1414 chapter or chapter 456.

1415 (8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.-

1416 (a) The boards shall register a physician assistant as an  
 1417 autonomous physician assistant if the applicant demonstrates  
 1418 that he or she:

1419 1. Holds an active, unencumbered license to practice as a  
 1420 physician assistant in this state.

1421 2. Has not been subject to any disciplinary action as  
 1422 specified in s. 456.072, s. 458.331, or s. 459.015, or any  
 1423 similar disciplinary action in any jurisdiction of the United  
 1424 States, within the 5 years immediately preceding the  
 1425 registration request.

1426 3. Has completed, in any jurisdiction of the United  
 1427 States, at least 2,000 clinical practice hours within the 3  
 1428 years immediately preceding the submission of the registration  
 1429 request while practicing as a physician assistant under the  
 1430 supervision of an allopathic or osteopathic physician who held

1431 an active, unencumbered license issued by any state, the  
1432 District of Columbia, or a possession or territory of the United  
1433 States during the period of such supervision.

1434 4. Has completed a graduate-level course in pharmacology.

1435 5. Obtains and maintains professional liability coverage  
1436 at the same level and in the same manner as in s. 458.320(1)(b)  
1437 or (c). However, the requirements of this subparagraph do not  
1438 apply to:

1439 a. Any person registered under this subsection who  
1440 practices exclusively as an officer, employee, or agent of the  
1441 Federal Government or of the state or its agencies or its  
1442 subdivisions.

1443 b. Any person whose license has become inactive and who is  
1444 not practicing as an autonomous physician assistant in this  
1445 state.

1446 c. Any person who practices as an autonomous physician  
1447 assistant only in conjunction with his or her teaching duties at  
1448 an accredited school or its main teaching hospitals. Such  
1449 practice is limited to that which is incidental to and a  
1450 necessary part of duties in connection with the teaching  
1451 position.

1452 d. Any person who holds an active registration under this  
1453 subsection who is not practicing as an autonomous physician  
1454 assistant in this state. If such person initiates or resumes any  
1455 practice as an autonomous physician assistant, he or she must  
1456 notify the department of such activity and fulfill the

1457 professional liability coverage requirements of this  
1458 subparagraph.

1459 (b) The department shall conspicuously distinguish an  
1460 autonomous physician assistant license if he or she is  
1461 registered under this subsection.

1462 (c) An autonomous physician assistant may:

1463 1. Render only primary care services as defined by rule of  
1464 the boards without physician supervision.

1465 2. Provide any service that is within the scope of the  
1466 autonomous physician assistant's education and experience and  
1467 provided in accordance with rules adopted by the board without  
1468 physician supervision.

1469 3. Prescribe, dispense, administer, or order any medicinal  
1470 drug, including those medicinal drugs to the extent authorized  
1471 under paragraph (4) (f) and the formulary adopted thereunder.

1472 4. Order any medication for administration to a patient in  
1473 a facility licensed under chapter 395 or part II of chapter 400,  
1474 notwithstanding chapter 465 or chapter 893.

1475 5. Provide a signature, certification, stamp,  
1476 verification, affidavit, or other endorsement that is otherwise  
1477 required by law to be provided by a physician.

1478 (d) An autonomous physician assistant must biennially  
1479 renew his or her registration under this subsection. The  
1480 biennial renewal shall coincide with the autonomous physician  
1481 assistant's biennial renewal period for physician assistant  
1482 licensure.

1483           (e) The council shall develop rules defining the primary  
 1484 care practice of autonomous physician assistants, which may  
 1485 include internal medicine, general pediatrics, family medicine,  
 1486 geriatrics, and general obstetrics and gynecology practices.

1487           ~~(10)-(9)~~ COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on  
 1488 Physician Assistants is created within the department.

1489           (a) The council shall consist of five members appointed as  
 1490 follows:

1491           1. The chairperson of the Board of Medicine shall appoint  
 1492 one member who is a physician and a member ~~three members who are~~  
 1493 ~~physicians and members~~ of the Board of Medicine. ~~One of The~~  
 1494 physician ~~physicians~~ must supervise a physician assistant in his  
 1495 or her ~~the physician's~~ practice.

1496           2. The chairperson of the Board of Osteopathic Medicine  
 1497 shall appoint one member who is a physician and a member of the  
 1498 Board of Osteopathic Medicine. The physician must supervise a  
 1499 physician assistant in his or her practice.

1500           3. The State Surgeon General or her or his designee shall  
 1501 appoint three ~~a~~ fully licensed physician assistants ~~assistant~~  
 1502 licensed under chapter 458 or this chapter.

1503           ~~(b) Two of the members appointed to the council must be~~  
 1504 ~~physicians who supervise physician assistants in their practice.~~  
 1505 Members shall be appointed to terms of 4 years, except that of  
 1506 the initial appointments, two members shall be appointed to  
 1507 terms of 2 years, two members shall be appointed to terms of 3  
 1508 years, and one member shall be appointed to a term of 4 years,

1509 as established by rule of the boards. Council members may not  
 1510 serve more than two consecutive terms. The council shall  
 1511 annually elect a chairperson from among its members.

1512 (c) The council shall:

1513 1. Recommend to the department the licensure of physician  
 1514 assistants.

1515 2. Develop all rules regulating the primary care practice  
 1516 of autonomous physician assistants and the use of physician  
 1517 assistants by physicians under chapter 458 and this chapter,  
 1518 except for rules relating to the formulary developed under s.  
 1519 458.347. The council shall also develop rules to ensure that the  
 1520 continuity of supervision is maintained in each practice  
 1521 setting. The boards shall consider adopting a proposed rule  
 1522 developed by the council at the regularly scheduled meeting  
 1523 immediately following the submission of the proposed rule by the  
 1524 council. A proposed rule submitted by the council may not be  
 1525 adopted by either board unless both boards have accepted and  
 1526 approved the identical language contained in the proposed rule.  
 1527 The language of all proposed rules submitted by the council must  
 1528 be approved by both boards pursuant to each respective board's  
 1529 guidelines and standards regarding the adoption of proposed  
 1530 rules. If either board rejects the council's proposed rule, that  
 1531 board must specify its objection to the council with  
 1532 particularity and include any recommendations it may have for  
 1533 the modification of the proposed rule.

1534 3. Make recommendations to the boards regarding all

1535 matters relating to autonomous physician assistants and  
 1536 physician assistants.

1537 4. Address concerns and problems of practicing autonomous  
 1538 physician assistants and physician assistants in order to  
 1539 improve safety in the clinical practices of registered  
 1540 autonomous physician assistants and licensed physician  
 1541 assistants.

1542 (d) When the council finds that an applicant for licensure  
 1543 has failed to meet, to the council's satisfaction, each of the  
 1544 requirements for licensure set forth in this section, the  
 1545 council may enter an order to:

- 1546 1. Refuse to certify the applicant for licensure;
- 1547 2. Approve the applicant for licensure with restrictions  
 1548 on the scope of practice or license; or
- 1549 3. Approve the applicant for conditional licensure. Such  
 1550 conditions may include placement of the licensee on probation  
 1551 for a period of time and subject to such conditions as the  
 1552 council may specify, including but not limited to, requiring the  
 1553 licensee to undergo treatment, to attend continuing education  
 1554 courses, to work under the direct supervision of a physician  
 1555 licensed in this state, or to take corrective action.

1556 ~~(12)-(11)~~ PENALTY.—Any person who has not been registered  
 1557 or licensed by the council and approved by the department and  
 1558 who holds herself or himself out as an autonomous physician  
 1559 assistant or a physician assistant or who uses any other term in  
 1560 indicating or implying that she or he is an autonomous physician

1561 assistant or a physician assistant commits a felony of the third  
 1562 degree, punishable as provided in s. 775.082 or s. 775.084 or by  
 1563 a fine not exceeding \$5,000.

1564 (13)~~(12)~~ DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—  
 1565 The boards may deny, suspend, or revoke the registration of an  
 1566 autonomous physician assistant or the license of a physician  
 1567 assistant license if a board determines that the autonomous  
 1568 physician assistant or physician assistant has violated this  
 1569 chapter.

1570 (14)~~(13)~~ RULES.—The boards shall adopt rules to implement  
 1571 this section, including rules detailing the contents of the  
 1572 application for licensure and notification pursuant to  
 1573 subsection (7), rules relating to the registration of autonomous  
 1574 physician assistants under subsection (8), and rules to ensure  
 1575 ~~both~~ the continued competency of autonomous physician assistants  
 1576 and physician assistants and the proper utilization of them by  
 1577 physicians or groups of physicians.

1578 (19) ADVERSE INCIDENTS.—An autonomous physician assistant  
 1579 must report adverse incidents to the department in accordance  
 1580 with s. 459.026.

1581 Section 18. Subsections (1) and (3) of section 464.012,  
 1582 Florida Statutes, are amended to read:

1583 464.012 Licensure of advanced practice registered nurses;  
 1584 fees; controlled substance prescribing.—

1585 (1) Any nurse desiring to be licensed as an advanced  
 1586 practice registered nurse must apply to the board ~~department~~ and

1587 submit proof that he or she holds a current license to practice  
1588 professional nursing or holds an active multistate license to  
1589 practice professional nursing pursuant to s. 464.0095 and ~~that~~  
1590 ~~he or she~~ meets one or more of the following requirements ~~as~~  
1591 ~~determined by the board:~~

1592 (a) Certification by an appropriate specialty board. Such  
1593 certification is required for initial state licensure and any  
1594 licensure renewal as a certified nurse midwife, certified nurse  
1595 practitioner, certified registered nurse anesthetist, clinical  
1596 nurse specialist, or psychiatric nurse. The board may by rule  
1597 provide for provisional state licensure of certified registered  
1598 nurse anesthetists, clinical nurse specialists, certified nurse  
1599 practitioners, psychiatric nurses, and certified nurse midwives  
1600 for a period of time determined to be appropriate for preparing  
1601 for and passing the national certification examination.

1602 (b) Graduation from a ~~program leading to a~~ master's degree  
1603 program in a nursing clinical specialty area with preparation in  
1604 specialized practitioner skills. For applicants graduating on or  
1605 after October 1, 1998, graduation from a master's degree program  
1606 is required for initial licensure as a certified nurse  
1607 practitioner under paragraph (4) (a).

1608 1. For applicants graduating on or after October 1, 2001,  
1609 graduation from a master's degree program is required for  
1610 initial licensure as a certified registered nurse anesthetist  
1611 who may perform the acts listed in paragraph (4) (b).

1612 2. For applicants graduating on or after October 1, 1998,



1613 graduation from a master's degree program is required for  
1614 initial licensure as a certified nurse midwife who may perform  
1615 the acts listed in paragraph (4) (c).

1616 3. For applicants graduating on or after July 1, 2007,  
1617 graduation from a master's degree program is required for  
1618 initial licensure as a clinical nurse specialist who may perform  
1619 the acts listed in paragraph (4) (d).

1620 (3) An advanced practice registered nurse shall perform  
1621 those functions authorized in this section within the framework  
1622 of an established protocol that must be maintained on site at  
1623 the location or locations at which an advanced practice  
1624 registered nurse practices, unless the advanced practice  
1625 registered nurse is registered to engage in autonomous practice  
1626 under s. 464.0123. In the case of multiple supervising  
1627 physicians in the same group, an advanced practice registered  
1628 nurse must enter into a supervisory protocol with at least one  
1629 physician within the physician group practice. A practitioner  
1630 currently licensed under chapter 458, chapter 459, or chapter  
1631 466 shall maintain supervision for directing the specific course  
1632 of medical treatment. Within the established framework, an  
1633 advanced practice registered nurse may:

1634 (a) Prescribe, dispense, administer, or order any drug;  
1635 however, an advanced practice registered nurse may prescribe or  
1636 dispense a controlled substance as defined in s. 893.03 only if  
1637 the advanced practice registered nurse has graduated from a  
1638 program leading to a master's or doctoral degree in a clinical

1639 nursing specialty area with training in specialized practitioner  
 1640 skills.

1641 (b) Initiate appropriate therapies for certain conditions.

1642 (c) Perform additional functions as may be determined by  
 1643 rule in accordance with s. 464.003(2).

1644 (d) Order diagnostic tests and physical and occupational  
 1645 therapy.

1646 (e) Order any medication for administration to a patient  
 1647 in a facility licensed under chapter 395 or part II of chapter  
 1648 400, notwithstanding any provisions in chapter 465 or chapter  
 1649 893.

1650 (f) Sign, certify, stamp, verify, or endorse a document  
 1651 that requires the signature, certification, stamp, verification,  
 1652 affidavit, or endorsement of a physician. However, a supervisory  
 1653 physician may not delegate the authority to issue a documented  
 1654 approval to release a patient from a receiving facility or its  
 1655 contractor under s. 394.463(2)(f) to an advanced practice  
 1656 registered nurse.

1657 Section 19. Section 464.0123, Florida Statutes, is created  
 1658 to read:

1659 464.0123 Autonomous practice by an advanced practice  
 1660 registered nurse.—

1661 (1) For purposes of this section, the term "autonomous  
 1662 practice" means advanced or specialized nursing practice by an  
 1663 advanced practice registered nurse who is not subject to  
 1664 supervision by a physician or a supervisory protocol.

1665           (2) The board shall register an advanced practice  
 1666 registered nurse as an autonomous advanced practice registered  
 1667 nurse if the applicant demonstrates that he or she:

1668           (a) Holds an active, unencumbered license to practice  
 1669 advanced or specialized nursing in this state.

1670           (b) Has not been subject to any disciplinary action as  
 1671 specified in s. 456.072 or s. 464.018, or any similar  
 1672 disciplinary action in any other jurisdiction of the United  
 1673 States, within the 5 years immediately preceding the  
 1674 registration request.

1675           (c) Has completed, in any jurisdiction of the United  
 1676 States, at least 2,000 clinical practice hours or clinical  
 1677 instructional hours within the 5 years immediately preceding the  
 1678 registration request while practicing as an advanced practice  
 1679 registered nurse under the supervision of an allopathic or  
 1680 osteopathic physician who held an active, unencumbered license  
 1681 issued by any state, the District of Columbia, or a possession  
 1682 or territory of the United States during the period of such  
 1683 supervision.

1684           (d) Has completed a graduate-level course in pharmacology.

1685           (3) The board may provide by rule additional requirements  
 1686 for an advanced practice registered nurse who is registered  
 1687 under this section when performing acts within his or her  
 1688 specialty pursuant to s. 464.012(4).

1689           (4) (a) An advanced practice registered nurse registered  
 1690 under this section must by one of the following methods

1691 demonstrate to the satisfaction of the board and the department  
 1692 financial responsibility to pay claims and costs ancillary  
 1693 thereto arising out of the rendering of, or the failure to  
 1694 render, medical or nursing care or services:

1695 1. Obtaining and maintaining professional liability  
 1696 coverage in an amount not less than \$100,000 per claim, with a  
 1697 minimum annual aggregate of not less than \$300,000, from an  
 1698 authorized insurer as defined in s. 624.09, from a surplus lines  
 1699 insurer as defined in s. 626.914(2), from a risk retention group  
 1700 as defined in s. 627.942, from the Joint Underwriting  
 1701 Association established under s. 627.351(4), or through a plan  
 1702 of self-insurance as provided in s. 627.357; or

1703 2. Obtaining and maintaining an unexpired, irrevocable  
 1704 letter of credit, established pursuant to chapter 675, in an  
 1705 amount of not less than \$100,000 per claim, with a minimum  
 1706 aggregate availability of credit of not less than \$300,000. The  
 1707 letter of credit must be payable to the advanced practice  
 1708 registered nurse as beneficiary upon presentment of a final  
 1709 judgment indicating liability and awarding damages to be paid by  
 1710 the advanced practice registered nurse or upon presentment of a  
 1711 settlement agreement signed by all parties to such agreement  
 1712 when such final judgment or settlement is a result of a claim  
 1713 arising out of the rendering of, or the failure to render,  
 1714 medical or nursing care and services.

1715 (b) The requirements of paragraph (a) do not apply to:

1716 1. Any person registered under this subsection who

1717 practices exclusively as an officer, employee, or agent of the  
1718 Federal Government or of the state or its agencies or its  
1719 subdivisions.

1720 2. Any person whose license has become inactive and who is  
1721 not practicing as an advanced practice registered nurse  
1722 registered under this section in this state.

1723 3. Any person who practices as an advanced practice  
1724 registered nurse registered under this section only in  
1725 conjunction with his or her teaching duties at an accredited  
1726 school or its main teaching hospitals. Such practice is limited  
1727 to that which is incidental to and a necessary part of duties in  
1728 connection with the teaching position.

1729 4. Any person who holds an active registration under this  
1730 section who is not practicing as an autonomous advanced practice  
1731 registered nurse registered under this section in this state. If  
1732 such person initiates or resumes any practice as an autonomous  
1733 advanced practice registered nurse, he or she must notify the  
1734 department of such activity and fulfill the professional  
1735 liability coverage requirements of paragraph (a).

1736 (5) The department shall conspicuously distinguish an  
1737 advanced practice registered nurse's license if he or she is  
1738 registered with the board under this section and include the  
1739 registration in the advanced practice registered nurse's  
1740 practitioner profile created under s. 456.041.

1741 (6) An advanced practice registered nurse who is  
1742 registered under this section may perform the general functions

1743 of an advanced practice registered nurse under s. 464.012(3),  
1744 the acts within his or her specialty under s. 464.012(4), and  
1745 the following:

1746 (a) For a patient who requires the services of a health  
1747 care facility, as defined in s. 408.032(8):

1748 1. Admit the patient to the facility.

1749 2. Manage the care received by the patient in the  
1750 facility.

1751 3. Discharge the patient from the facility, unless  
1752 prohibited by federal law or rule.

1753 (b) Provide a signature, certification, stamp,  
1754 verification, affidavit, or endorsement that is otherwise  
1755 required by law to be provided by a physician.

1756 (7) (a) An advanced practice registered nurse must  
1757 biennially renew his or her registration under this section. The  
1758 biennial renewal for registration shall coincide with the  
1759 advanced practice registered nurse's biennial renewal period for  
1760 licensure.

1761 (b) To renew his or her registration under this section,  
1762 an advanced practice registered nurse must complete at least 10  
1763 hours of continuing education approved by the board in addition  
1764 to completing the continuing education requirements established  
1765 by board rule pursuant to s. 464.013. If the initial renewal  
1766 period occurs before January 1, 2021, an advanced practice  
1767 registered nurse who is registered under this section is not  
1768 required to complete the continuing education requirement under

1769 this paragraph until the following biennial renewal period.

1770 (8) The board may establish an advisory committee to make  
 1771 evidence-based recommendations about medical acts that an  
 1772 advanced practice registered nurse who is registered under this  
 1773 section may perform. The committee must consist of four advanced  
 1774 practice registered nurses licensed under this chapter,  
 1775 appointed by the board; two physicians licensed under chapter  
 1776 458 or chapter 459 who have professional experience with  
 1777 advanced practice registered nurses, appointed by the Board of  
 1778 Medicine; and the State Surgeon General or his or her designee.  
 1779 Each committee member appointed by a board shall serve a term of  
 1780 4 years, unless a shorter term is required to establish or  
 1781 maintain staggered terms. The Board of Nursing shall act upon  
 1782 the recommendations from the committee within 90 days after the  
 1783 submission of such recommendations.

1784 (9) The board shall adopt rules as necessary to implement  
 1785 this section.

1786 Section 20. Section 464.0155, Florida Statutes, is created  
 1787 to read:

1788 464.0155 Reports of adverse incidents by advanced practice  
 1789 registered nurses.—

1790 (1) An advanced practice registered nurse registered to  
 1791 engage in autonomous practice under s. 464.0123 must report an  
 1792 adverse incident to the department in accordance with this  
 1793 section.

1794 (2) The report must be in writing, sent to the department

1795 by certified mail, and postmarked within 15 days after the  
 1796 occurrence of the adverse incident if the adverse incident  
 1797 occurs when the patient is at the office of the advanced  
 1798 practice registered nurse. If the adverse incident occurs when  
 1799 the patient is not at the office of the advanced practice  
 1800 registered nurse, the report must be postmarked within 15 days  
 1801 after the advanced practice registered nurse discovers, or  
 1802 reasonably should have discovered, the occurrence of the adverse  
 1803 incident.

1804 (3) For purposes of this section, the term "adverse  
 1805 incident" means any of the following events when it is  
 1806 reasonable to believe that the event is attributable to the  
 1807 prescription of a controlled substance regulated under chapter  
 1808 893 or 21 U.S.C. s. 812 by the advanced practice registered  
 1809 nurse:

1810 (a) A condition that requires the transfer of a patient to  
 1811 a hospital licensed under chapter 395.

1812 (b) Permanent physical injury to the patient.

1813 (c) Death of the patient.

1814 (4) The department shall review each report of an adverse  
 1815 incident and determine whether the adverse incident was  
 1816 attributable to conduct by the advanced practice registered  
 1817 nurse. Upon such a determination, the board may take  
 1818 disciplinary action pursuant to s. 456.073.

1819 Section 21. Paragraph (r) is added to subsection (1) of  
 1820 section 464.018, Florida Statutes, to read:



1821 464.018 Disciplinary actions.—

1822 (1) The following acts constitute grounds for denial of a  
 1823 license or disciplinary action, as specified in ss. 456.072(2)  
 1824 and 464.0095:

1825 (r) For an advanced practice registered nurse registered  
 1826 to engage in autonomous practice under s. 464.0123:

1827 1. Paying or receiving any commission, bonus, kickback, or  
 1828 rebate from, or engaging in any split-fee arrangement in any  
 1829 form whatsoever with, a health care practitioner, organization,  
 1830 agency, or person, either directly or implicitly, for referring  
 1831 patients to providers of health care goods or services,  
 1832 including, but not limited to, hospitals, nursing homes,  
 1833 clinical laboratories, ambulatory surgical centers, or  
 1834 pharmacies. This subparagraph may not be construed to prevent an  
 1835 advanced practice registered nurse from receiving a fee for  
 1836 professional consultation services.

1837 2. Exercising influence within a patient-advanced practice  
 1838 registered nurse relationship for purposes of engaging a patient  
 1839 in sexual activity. A patient shall be presumed to be incapable  
 1840 of giving free, full, and informed consent to sexual activity  
 1841 with his or her advanced practice registered nurse.

1842 3. Making deceptive, untrue, or fraudulent representations  
 1843 in or related to, or employing a trick or scheme in or related  
 1844 to, advanced or specialized nursing practice.

1845 4. Soliciting patients, either personally or through an  
 1846 agent, by the use of fraud, intimidation, undue influence, or a

1847 form of overreaching or vexatious conduct. As used in this  
 1848 subparagraph, the term "soliciting" means directly or implicitly  
 1849 requesting an immediate oral response from the recipient.

1850 5. Failing to keep legible, as defined by department rule  
 1851 in consultation with the board, medical records that identify  
 1852 the advanced practice registered nurse by name and professional  
 1853 title who is responsible for rendering, ordering, supervising,  
 1854 or billing for each diagnostic or treatment procedure and that  
 1855 justify the course of treatment of the patient, including, but  
 1856 not limited to, patient histories; examination results; test  
 1857 results; records of drugs prescribed, dispensed, or  
 1858 administered; and reports of consultations or referrals.

1859 6. Exercising influence on the patient to exploit the  
 1860 patient for the financial gain of the advanced practice  
 1861 registered nurse or a third party, including, but not limited  
 1862 to, the promoting or selling of services, goods, appliances, or  
 1863 drugs.

1864 7. Performing professional services that have not been  
 1865 duly authorized by the patient, or his or her legal  
 1866 representative, except as provided in s. 766.103 or s. 768.13.

1867 8. Performing any procedure or prescribing any therapy  
 1868 that, by the prevailing standards of advanced or specialized  
 1869 nursing practice in the community, would constitute  
 1870 experimentation on a human subject, without first obtaining  
 1871 full, informed, and written consent.

1872 9. Delegating professional responsibilities to a person

1873 when the advanced practice registered nurse delegating such  
 1874 responsibilities knows or has reason to believe that such person  
 1875 is not qualified by training, experience, or licensure to  
 1876 perform such responsibilities.

1877 10. Committing, or conspiring with another to commit, an  
 1878 act that would tend to coerce, intimidate, or preclude another  
 1879 advanced practice registered nurse from lawfully advertising his  
 1880 or her services.

1881 11. Advertising or holding himself or herself out as  
 1882 having certification in a specialty that the he or she has not  
 1883 received.

1884 12. Failing to comply with the requirements of ss. 381.026  
 1885 and 381.0261 related to providing patients with information  
 1886 about their rights and how to file a complaint.

1887 13. Providing deceptive or fraudulent expert witness  
 1888 testimony related to advanced or specialized nursing practice.

1889 Section 22. Subsection (43) of section 39.01, Florida  
 1890 Statutes, is amended to read:

1891 39.01 Definitions.—When used in this chapter, unless the  
 1892 context otherwise requires:

1893 (43) "Licensed health care professional" means a physician  
 1894 licensed under chapter 458, an osteopathic physician licensed  
 1895 under chapter 459, a nurse licensed under part I of chapter 464,  
 1896 an autonomous physician assistant or a physician assistant  
 1897 registered or licensed under chapter 458 or chapter 459, or a  
 1898 dentist licensed under chapter 466.

1899           Section 23. Paragraphs (d) and (e) of subsection (5) of  
 1900 section 39.303, Florida Statutes, are redesignated as paragraphs  
 1901 (e) and (f), respectively, a new paragraph (d) is added to that  
 1902 subsection, and paragraph (a) of subsection (6) of that section  
 1903 is amended, to read:

1904           39.303 Child Protection Teams and sexual abuse treatment  
 1905 programs; services; eligible cases.—

1906           (5) All abuse and neglect cases transmitted for  
 1907 investigation to a circuit by the hotline must be simultaneously  
 1908 transmitted to the Child Protection Team for review. For the  
 1909 purpose of determining whether a face-to-face medical evaluation  
 1910 by a Child Protection Team is necessary, all cases transmitted  
 1911 to the Child Protection Team which meet the criteria in  
 1912 subsection (4) must be timely reviewed by:

1913           (d) An autonomous physician assistant registered under  
 1914 chapter 458 or chapter 459 who has a specialty in pediatrics or  
 1915 family medicine and is member of the Child Protection Team;

1916           (6) A face-to-face medical evaluation by a Child  
 1917 Protection Team is not necessary when:

1918           (a) The child was examined for the alleged abuse or  
 1919 neglect by a physician who is not a member of the Child  
 1920 Protection Team, and a consultation between the Child Protection  
 1921 Team medical director or a Child Protection Team board-certified  
 1922 pediatrician, advanced practice registered nurse, autonomous  
 1923 physician assistant, or physician assistant working under the  
 1924 supervision of a Child Protection Team medical director or a

1925 Child Protection Team board-certified pediatrician, or  
 1926 registered nurse working under the direct supervision of a Child  
 1927 Protection Team medical director or a Child Protection Team  
 1928 board-certified pediatrician, and the examining physician  
 1929 concludes that a further medical evaluation is unnecessary;

1930  
 1931 Notwithstanding paragraphs (a), (b), and (c), a Child Protection  
 1932 Team medical director or a Child Protection Team pediatrician,  
 1933 as authorized in subsection (5), may determine that a face-to-  
 1934 face medical evaluation is necessary.

1935 Section 24. Paragraph (b) of subsection (1) of section  
 1936 39.304, Florida Statutes, is amended to read:

1937 39.304 Photographs, medical examinations, X rays, and  
 1938 medical treatment of abused, abandoned, or neglected child.—

1939 (1)

1940 (b) If the areas of trauma visible on a child indicate a  
 1941 need for a medical examination, or if the child verbally  
 1942 complains or otherwise exhibits distress as a result of injury  
 1943 through suspected child abuse, abandonment, or neglect, or is  
 1944 alleged to have been sexually abused, the person required to  
 1945 investigate may cause the child to be referred for diagnosis to  
 1946 a licensed physician or an emergency department in a hospital  
 1947 without the consent of the child's parents or legal custodian.  
 1948 Such examination may be performed by any licensed physician,  
 1949 registered autonomous physician assistant, licensed physician  
 1950 assistant, or ~~an~~ advanced practice registered nurse licensed or

1951 registered under ~~pursuant to~~ part I of chapter 464. Any licensed  
 1952 physician, registered autonomous physician assistant, licensed  
 1953 physician assistant, or advanced practice registered nurse  
 1954 licensed or registered under ~~pursuant to~~ part I of chapter 464  
 1955 who has reasonable cause to suspect that an injury was the  
 1956 result of child abuse, abandonment, or neglect may authorize a  
 1957 radiological examination to be performed on the child without  
 1958 the consent of the child's parent or legal custodian.

1959 Section 25. Paragraph (d) of subsection (2) of section  
 1960 110.12315, Florida Statutes, is amended to read:

1961 110.12315 Prescription drug program.—The state employees'  
 1962 prescription drug program is established. This program shall be  
 1963 administered by the Department of Management Services, according  
 1964 to the terms and conditions of the plan as established by the  
 1965 relevant provisions of the annual General Appropriations Act and  
 1966 implementing legislation, subject to the following conditions:

1967 (2) In providing for reimbursement of pharmacies for  
 1968 prescription drugs and supplies dispensed to members of the  
 1969 state group health insurance plan and their dependents under the  
 1970 state employees' prescription drug program:

1971 (d) The department shall establish the reimbursement  
 1972 schedule for prescription drugs and supplies dispensed under the  
 1973 program. Reimbursement rates for a prescription drug or supply  
 1974 must be based on the cost of the generic equivalent drug or  
 1975 supply if a generic equivalent exists, unless the physician,  
 1976 advanced practice registered nurse, autonomous physician

1977 assistant, or physician assistant prescribing the drug or supply  
 1978 clearly states on the prescription that the brand name drug or  
 1979 supply is medically necessary or that the drug or supply is  
 1980 included on the formulary of drugs and supplies that may not be  
 1981 interchanged as provided in chapter 465, in which case  
 1982 reimbursement must be based on the cost of the brand name drug  
 1983 or supply as specified in the reimbursement schedule adopted by  
 1984 the department.

1985 Section 26. Paragraph (a) of subsection (3) of section  
 1986 252.515, Florida Statutes, is amended to read:

1987 252.515 Postdisaster Relief Assistance Act; immunity from  
 1988 civil liability.—

1989 (3) As used in this section, the term:

1990 (a) "Emergency first responder" means:

- 1991 1. A physician licensed under chapter 458.
- 1992 2. An osteopathic physician licensed under chapter 459.
- 1993 3. A chiropractic physician licensed under chapter 460.
- 1994 4. A podiatric physician licensed under chapter 461.
- 1995 5. A dentist licensed under chapter 466.
- 1996 6. An advanced practice registered nurse licensed under s.  
 1997 464.012.

1998 7. An autonomous physician assistant or a physician  
 1999 assistant registered or licensed under chapter 458 ~~s. 458.347~~ or  
 2000 chapter 459 ~~s. 459.022~~.

2001 8. A worker employed by a public or private hospital in  
 2002 the state.

2003 9. A paramedic as defined in s. 401.23(17).  
 2004 10. An emergency medical technician as defined in s.  
 2005 401.23(11).  
 2006 11. A firefighter as defined in s. 633.102.  
 2007 12. A law enforcement officer as defined in s. 943.10.  
 2008 13. A member of the Florida National Guard.  
 2009 14. Any other personnel designated as emergency personnel  
 2010 by the Governor pursuant to a declared emergency.  
 2011 Section 27. Paragraph (c) of subsection (1) of section  
 2012 310.071, Florida Statutes, is amended to read:  
 2013 310.071 Deputy pilot certification.—  
 2014 (1) In addition to meeting other requirements specified in  
 2015 this chapter, each applicant for certification as a deputy pilot  
 2016 must:  
 2017 (c) Be in good physical and mental health, as evidenced by  
 2018 documentary proof of having satisfactorily passed a complete  
 2019 physical examination administered by a licensed physician within  
 2020 the preceding 6 months. The board shall adopt rules to establish  
 2021 requirements for passing the physical examination, which rules  
 2022 shall establish minimum standards for the physical or mental  
 2023 capabilities necessary to carry out the professional duties of a  
 2024 certificated deputy pilot. Such standards shall include zero  
 2025 tolerance for any controlled substance regulated under chapter  
 2026 893 unless that individual is under the care of a physician, an  
 2027 advanced practice registered nurse, an autonomous physician  
 2028 assistant, or a physician assistant and that controlled



2029 substance was prescribed by that physician, advanced practice  
 2030 registered nurse, autonomous physician assistant, or physician  
 2031 assistant. To maintain eligibility as a certificated deputy  
 2032 pilot, each certificated deputy pilot must annually provide  
 2033 documentary proof of having satisfactorily passed a complete  
 2034 physical examination administered by a licensed physician. The  
 2035 physician must know the minimum standards and certify that the  
 2036 certificateholder satisfactorily meets the standards. The  
 2037 standards for certificateholders shall include a drug test.

2038 Section 28. Subsection (3) of section 310.073, Florida  
 2039 Statutes, is amended to read:

2040 310.073 State pilot licensing.—In addition to meeting  
 2041 other requirements specified in this chapter, each applicant for  
 2042 license as a state pilot must:

2043 (3) Be in good physical and mental health, as evidenced by  
 2044 documentary proof of having satisfactorily passed a complete  
 2045 physical examination administered by a licensed physician within  
 2046 the preceding 6 months. The board shall adopt rules to establish  
 2047 requirements for passing the physical examination, which rules  
 2048 shall establish minimum standards for the physical or mental  
 2049 capabilities necessary to carry out the professional duties of a  
 2050 licensed state pilot. Such standards shall include zero  
 2051 tolerance for any controlled substance regulated under chapter  
 2052 893 unless that individual is under the care of a physician, an  
 2053 advanced practice registered nurse, an autonomous physician  
 2054 assistant, or a physician assistant and that controlled

2055 substance was prescribed by that physician, advanced practice  
 2056 registered nurse, autonomous physician assistant, or physician  
 2057 assistant. To maintain eligibility as a licensed state pilot,  
 2058 each licensed state pilot must annually provide documentary  
 2059 proof of having satisfactorily passed a complete physical  
 2060 examination administered by a licensed physician. The physician  
 2061 must know the minimum standards and certify that the licensee  
 2062 satisfactorily meets the standards. The standards for licensees  
 2063 shall include a drug test.

2064 Section 29. Paragraph (b) of subsection (3) of section  
 2065 310.081, Florida Statutes, is amended to read:

2066 310.081 Department to examine and license state pilots and  
 2067 certificate deputy pilots; vacancies.-

2068 (3) Pilots shall hold their licenses or certificates  
 2069 pursuant to the requirements of this chapter so long as they:

2070 (b) Are in good physical and mental health as evidenced by  
 2071 documentary proof of having satisfactorily passed a physical  
 2072 examination administered by a licensed physician or physician  
 2073 assistant within each calendar year. The board shall adopt rules  
 2074 to establish requirements for passing the physical examination,  
 2075 which rules shall establish minimum standards for the physical  
 2076 or mental capabilities necessary to carry out the professional  
 2077 duties of a licensed state pilot or a certificated deputy pilot.  
 2078 Such standards shall include zero tolerance for any controlled  
 2079 substance regulated under chapter 893 unless that individual is  
 2080 under the care of a physician, an advanced practice registered

2081 nurse, an autonomous physician assistant, or a physician  
 2082 assistant and that controlled substance was prescribed by that  
 2083 physician, advanced practice registered nurse, autonomous  
 2084 physician assistant, or physician assistant. To maintain  
 2085 eligibility as a certificated deputy pilot or licensed state  
 2086 pilot, each certificated deputy pilot or licensed state pilot  
 2087 must annually provide documentary proof of having satisfactorily  
 2088 passed a complete physical examination administered by a  
 2089 licensed physician. The physician must know the minimum  
 2090 standards and certify that the certificateholder or licensee  
 2091 satisfactorily meets the standards. The standards for  
 2092 certificateholders and for licensees shall include a drug test.

2093  
 2094 Upon resignation or in the case of disability permanently  
 2095 affecting a pilot's ability to serve, the state license or  
 2096 certificate issued under this chapter shall be revoked by the  
 2097 department.

2098 Section 30. Paragraph (b) of subsection (1) of section  
 2099 320.0848, Florida Statutes, is amended to read:

2100 320.0848 Persons who have disabilities; issuance of  
 2101 disabled parking permits; temporary permits; permits for certain  
 2102 providers of transportation services to persons who have  
 2103 disabilities.—

2104 (1)

2105 (b)1. The person must be currently certified as being  
 2106 legally blind or as having any of the following disabilities

2107 that render him or her unable to walk 200 feet without stopping  
 2108 to rest:

2109 a. Inability to walk without the use of or assistance from  
 2110 a brace, cane, crutch, prosthetic device, or other assistive  
 2111 device, or without the assistance of another person. If the  
 2112 assistive device significantly restores the person's ability to  
 2113 walk to the extent that the person can walk without severe  
 2114 limitation, the person is not eligible for the exemption parking  
 2115 permit.

2116 b. The need to permanently use a wheelchair.

2117 c. Restriction by lung disease to the extent that the  
 2118 person's forced (respiratory) expiratory volume for 1 second,  
 2119 when measured by spirometry, is less than 1 liter, or the  
 2120 person's arterial oxygen is less than 60 mm/hg on room air at  
 2121 rest.

2122 d. Use of portable oxygen.

2123 e. Restriction by cardiac condition to the extent that the  
 2124 person's functional limitations are classified in severity as  
 2125 Class III or Class IV according to standards set by the American  
 2126 Heart Association.

2127 f. Severe limitation in the person's ability to walk due  
 2128 to an arthritic, neurological, or orthopedic condition.

2129 2. The certification of disability which is required under  
 2130 subparagraph 1. must be provided by a physician licensed under  
 2131 chapter 458, chapter 459, or chapter 460, by a podiatric  
 2132 physician licensed under chapter 461, by an optometrist licensed

2133 | under chapter 463, by an advanced practice registered nurse  
 2134 | licensed under chapter 464 under the protocol of a licensed  
 2135 | physician as stated in this subparagraph, by an autonomous  
 2136 | physician assistant or a physician assistant registered or  
 2137 | licensed under chapter 458 or chapter 459, or by a similarly  
 2138 | licensed physician from another state if the application is  
 2139 | accompanied by documentation of the physician's licensure in the  
 2140 | other state and a form signed by the out-of-state physician  
 2141 | verifying his or her knowledge of this state's eligibility  
 2142 | guidelines.

2143 |         Section 31. Paragraph (c) of subsection (1) of section  
 2144 | 381.00315, Florida Statutes, is amended to read:

2145 |         381.00315 Public health advisories; public health  
 2146 | emergencies; isolation and quarantines.—The State Health Officer  
 2147 | is responsible for declaring public health emergencies, issuing  
 2148 | public health advisories, and ordering isolation or quarantines.

2149 |         (1) As used in this section, the term:

2150 |         (c) "Public health emergency" means any occurrence, or  
 2151 | threat thereof, whether natural or manmade, which results or may  
 2152 | result in substantial injury or harm to the public health from  
 2153 | infectious disease, chemical agents, nuclear agents, biological  
 2154 | toxins, or situations involving mass casualties or natural  
 2155 | disasters. Before declaring a public health emergency, the State  
 2156 | Health Officer shall, to the extent possible, consult with the  
 2157 | Governor and shall notify the Chief of Domestic Security. The  
 2158 | declaration of a public health emergency shall continue until

2159 | the State Health Officer finds that the threat or danger has  
2160 | been dealt with to the extent that the emergency conditions no  
2161 | longer exist and he or she terminates the declaration. However,  
2162 | a declaration of a public health emergency may not continue for  
2163 | longer than 60 days unless the Governor concurs in the renewal  
2164 | of the declaration. The State Health Officer, upon declaration  
2165 | of a public health emergency, may take actions that are  
2166 | necessary to protect the public health. Such actions include,  
2167 | but are not limited to:

2168 |       1. Directing manufacturers of prescription drugs or over-  
2169 | the-counter drugs who are permitted under chapter 499 and  
2170 | wholesalers of prescription drugs located in this state who are  
2171 | permitted under chapter 499 to give priority to the shipping of  
2172 | specified drugs to pharmacies and health care providers within  
2173 | geographic areas that have been identified by the State Health  
2174 | Officer. The State Health Officer must identify the drugs to be  
2175 | shipped. Manufacturers and wholesalers located in the state must  
2176 | respond to the State Health Officer's priority shipping  
2177 | directive before shipping the specified drugs.

2178 |       2. Notwithstanding chapters 465 and 499 and rules adopted  
2179 | thereunder, directing pharmacists employed by the department to  
2180 | compound bulk prescription drugs and provide these bulk  
2181 | prescription drugs to physicians and nurses of county health  
2182 | departments or any qualified person authorized by the State  
2183 | Health Officer for administration to persons as part of a  
2184 | prophylactic or treatment regimen.

2185           3. Notwithstanding s. 456.036, temporarily reactivating  
 2186 the inactive license or registration of the following health  
 2187 care practitioners, when such practitioners are needed to  
 2188 respond to the public health emergency: physicians, autonomous  
 2189 physician assistants, or physician assistants licensed or  
 2190 registered under chapter 458 or chapter 459; ~~physician~~  
 2191 ~~assistants licensed under chapter 458 or chapter 459;~~ licensed  
 2192 practical nurses, registered nurses, and advanced practice  
 2193 registered nurses licensed under part I of chapter 464;  
 2194 respiratory therapists licensed under part V of chapter 468; and  
 2195 emergency medical technicians and paramedics certified under  
 2196 part III of chapter 401. Only those health care practitioners  
 2197 specified in this paragraph who possess an unencumbered inactive  
 2198 license and who request that such license be reactivated are  
 2199 eligible for reactivation. An inactive license that is  
 2200 reactivated under this paragraph shall return to inactive status  
 2201 when the public health emergency ends or before the end of the  
 2202 public health emergency if the State Health Officer determines  
 2203 that the health care practitioner is no longer needed to provide  
 2204 services during the public health emergency. Such licenses may  
 2205 only be reactivated for a period not to exceed 90 days without  
 2206 meeting the requirements of s. 456.036 or chapter 401, as  
 2207 applicable.

2208           4. Ordering an individual to be examined, tested,  
 2209 vaccinated, treated, isolated, or quarantined for communicable  
 2210 diseases that have significant morbidity or mortality and

2211 present a severe danger to public health. Individuals who are  
 2212 unable or unwilling to be examined, tested, vaccinated, or  
 2213 treated for reasons of health, religion, or conscience may be  
 2214 subjected to isolation or quarantine.

2215 a. Examination, testing, vaccination, or treatment may be  
 2216 performed by any qualified person authorized by the State Health  
 2217 Officer.

2218 b. If the individual poses a danger to the public health,  
 2219 the State Health Officer may subject the individual to isolation  
 2220 or quarantine. If there is no practical method to isolate or  
 2221 quarantine the individual, the State Health Officer may use any  
 2222 means necessary to vaccinate or treat the individual.

2223  
 2224 Any order of the State Health Officer given to effectuate this  
 2225 paragraph shall be immediately enforceable by a law enforcement  
 2226 officer under s. 381.0012.

2227 Section 32. Subsection (3) of section 381.00593, Florida  
 2228 Statutes, is amended to read:

2229 381.00593 Public school volunteer health care practitioner  
 2230 program.—

2231 (3) For purposes of this section, the term "health care  
 2232 practitioner" means a physician or autonomous physician  
 2233 assistant licensed or registered under chapter 458; an  
 2234 osteopathic physician or autonomous physician assistant licensed  
 2235 or registered under chapter 459; a chiropractic physician  
 2236 licensed under chapter 460; a podiatric physician licensed under



2237 chapter 461; an optometrist licensed under chapter 463; an  
 2238 advanced practice registered nurse, registered nurse, or  
 2239 licensed practical nurse licensed under part I of chapter 464; a  
 2240 pharmacist licensed under chapter 465; a dentist or dental  
 2241 hygienist licensed under chapter 466; a midwife licensed under  
 2242 chapter 467; a speech-language pathologist or audiologist  
 2243 licensed under part I of chapter 468; a dietitian/nutritionist  
 2244 licensed under part X of chapter 468; or a physical therapist  
 2245 licensed under chapter 486.

2246 Section 33. Paragraph (c) of subsection (2) of section  
 2247 381.026, Florida Statutes, is amended to read:

2248 381.026 Florida Patient's Bill of Rights and  
 2249 Responsibilities.—

2250 (2) DEFINITIONS.—As used in this section and s. 381.0261,  
 2251 the term:

2252 (c) "Health care provider" means a physician licensed  
 2253 under chapter 458, an osteopathic physician licensed under  
 2254 chapter 459, ~~or~~ a podiatric physician licensed under chapter  
 2255 461, an autonomous physician assistant registered under s.  
 2256 458.347(8), or an advanced practice registered nurse registered  
 2257 to engage in autonomous practice under s. 464.0123.

2258 Section 34. Paragraph (a) of subsection (2) and  
 2259 subsections (3), (4), and (5) of section 382.008, Florida  
 2260 Statutes, are amended to read:

2261 382.008 Death, fetal death, and nonviable birth  
 2262 registration.—

2263 (2) (a) The funeral director who first assumes custody of a  
 2264 dead body or fetus shall file the certificate of death or fetal  
 2265 death. In the absence of the funeral director, the physician,  
 2266 autonomous physician assistant, physician assistant, advanced  
 2267 practice registered nurse, or other person in attendance at or  
 2268 after the death or the district medical examiner of the county  
 2269 in which the death occurred or the body was found shall file the  
 2270 certificate of death or fetal death. The person who files the  
 2271 certificate shall obtain personal data from a legally authorized  
 2272 person as described in s. 497.005 or the best qualified person  
 2273 or source available. The medical certification of cause of death  
 2274 shall be furnished to the funeral director, either in person or  
 2275 via certified mail or electronic transfer, by the physician,  
 2276 autonomous physician assistant, physician assistant, advanced  
 2277 practice registered nurse, or medical examiner responsible for  
 2278 furnishing such information. For fetal deaths, the physician,  
 2279 certified nurse midwife, midwife, or hospital administrator  
 2280 shall provide any medical or health information to the funeral  
 2281 director within 72 hours after expulsion or extraction.

2282 (3) Within 72 hours after receipt of a death or fetal  
 2283 death certificate from the funeral director, the medical  
 2284 certification of cause of death shall be completed and made  
 2285 available to the funeral director by the decedent's primary or  
 2286 attending practitioner ~~physician~~ or, if s. 382.011 applies, the  
 2287 district medical examiner of the county in which the death  
 2288 occurred or the body was found. The primary or attending

2289 practitioner ~~physician~~ or the medical examiner shall certify  
 2290 over his or her signature the cause of death to the best of his  
 2291 or her knowledge and belief. As used in this section, the term  
 2292 "primary or attending practitioner ~~physician~~" means a physician,  
 2293 autonomous physician assistant, physician assistant, or advanced  
 2294 practice registered nurse who treated the decedent through  
 2295 examination, medical advice, or medication during the 12 months  
 2296 preceding the date of death.

2297 (a) The department may grant the funeral director an  
 2298 extension of time upon a good and sufficient showing of any of  
 2299 the following conditions:

- 2300 1. An autopsy is pending.
- 2301 2. Toxicology, laboratory, or other diagnostic reports  
 2302 have not been completed.
- 2303 3. The identity of the decedent is unknown and further  
 2304 investigation or identification is required.

2305 (b) If the decedent's primary or attending practitioner  
 2306 ~~physician~~ or the district medical examiner of the county in  
 2307 which the death occurred or the body was found indicates that he  
 2308 or she will sign and complete the medical certification of cause  
 2309 of death but will not be available until after the 5-day  
 2310 registration deadline, the local registrar may grant an  
 2311 extension of 5 days. If a further extension is required, the  
 2312 funeral director must provide written justification to the  
 2313 registrar.

2314 (4) If the department or local registrar grants an

2315 extension of time to provide the medical certification of cause  
 2316 of death, the funeral director shall file a temporary  
 2317 certificate of death or fetal death which shall contain all  
 2318 available information, including the fact that the cause of  
 2319 death is pending. The decedent's primary or attending  
 2320 practitioner ~~physician~~ or the district medical examiner of the  
 2321 county in which the death occurred or the body was found shall  
 2322 provide an estimated date for completion of the permanent  
 2323 certificate.

2324 (5) A permanent certificate of death or fetal death,  
 2325 containing the cause of death and any other information that was  
 2326 previously unavailable, shall be registered as a replacement for  
 2327 the temporary certificate. The permanent certificate may also  
 2328 include corrected information if the items being corrected are  
 2329 noted on the back of the certificate and dated and signed by the  
 2330 funeral director, physician, autonomous physician assistant,  
 2331 physician assistant, advanced practice registered nurse, or  
 2332 district medical examiner of the county in which the death  
 2333 occurred or the body was found, as appropriate.

2334 Section 35. Subsection (1) of section 382.011, Florida  
 2335 Statutes, is amended to read:

2336 382.011 Medical examiner determination of cause of death.—

2337 (1) In the case of any death or fetal death due to causes  
 2338 or conditions listed in s. 406.11, any death that occurred more  
 2339 than 12 months after the decedent was last treated by a primary  
 2340 or attending physician ~~as defined in s. 382.008(3),~~ or any death

2341 for which there is reason to believe that the death may have  
 2342 been due to an unlawful act or neglect, the funeral director or  
 2343 other person to whose attention the death may come shall refer  
 2344 the case to the district medical examiner of the county in which  
 2345 the death occurred or the body was found for investigation and  
 2346 determination of the cause of death.

2347 Section 36. Paragraph (c) of subsection (1) of section  
 2348 383.14, Florida Statutes, is amended to read:

2349 383.14 Screening for metabolic disorders, other hereditary  
 2350 and congenital disorders, and environmental risk factors.—

2351 (1) SCREENING REQUIREMENTS.—To help ensure access to the  
 2352 maternal and child health care system, the Department of Health  
 2353 shall promote the screening of all newborns born in Florida for  
 2354 metabolic, hereditary, and congenital disorders known to result  
 2355 in significant impairment of health or intellect, as screening  
 2356 programs accepted by current medical practice become available  
 2357 and practical in the judgment of the department. The department  
 2358 shall also promote the identification and screening of all  
 2359 newborns in this state and their families for environmental risk  
 2360 factors such as low income, poor education, maternal and family  
 2361 stress, emotional instability, substance abuse, and other high-  
 2362 risk conditions associated with increased risk of infant  
 2363 mortality and morbidity to provide early intervention,  
 2364 remediation, and prevention services, including, but not limited  
 2365 to, parent support and training programs, home visitation, and  
 2366 case management. Identification, perinatal screening, and

2367 intervention efforts shall begin before ~~prior to~~ and immediately  
 2368 following the birth of the child by the attending health care  
 2369 provider. Such efforts shall be conducted in hospitals,  
 2370 perinatal centers, county health departments, school health  
 2371 programs that provide prenatal care, and birthing centers, and  
 2372 reported to the Office of Vital Statistics.

2373 (c) Release of screening results.—Notwithstanding any law  
 2374 to the contrary, the State Public Health Laboratory may release,  
 2375 directly or through the Children's Medical Services program, the  
 2376 results of a newborn's hearing and metabolic tests or screenings  
 2377 to the newborn's health care practitioner, the newborn's parent  
 2378 or legal guardian, the newborn's personal representative, or a  
 2379 person designated by the newborn's parent or legal guardian. As  
 2380 used in this paragraph, the term "health care practitioner"  
 2381 means a physician, autonomous physician assistant, or physician  
 2382 assistant licensed or registered under chapter 458; an  
 2383 osteopathic physician, autonomous physician assistant, or  
 2384 physician assistant licensed or registered under chapter 459; an  
 2385 advanced practice registered nurse, registered nurse, or  
 2386 licensed practical nurse licensed under part I of chapter 464; a  
 2387 midwife licensed under chapter 467; a speech-language  
 2388 pathologist or audiologist licensed under part I of chapter 468;  
 2389 or a dietician or nutritionist licensed under part X of chapter  
 2390 468.

2391 Section 37. Paragraph (a) of subsection (3) of section  
 2392 390.0111, Florida Statutes, is amended to read:

2393 | 390.0111 Termination of pregnancies.—

2394 | (3) CONSENTS REQUIRED.—A termination of pregnancy may not  
 2395 | be performed or induced except with the voluntary and informed  
 2396 | written consent of the pregnant woman or, in the case of a  
 2397 | mental incompetent, the voluntary and informed written consent  
 2398 | of her court-appointed guardian.

2399 | (a) Except in the case of a medical emergency, consent to  
 2400 | a termination of pregnancy is voluntary and informed only if:

2401 | 1. The physician who is to perform the procedure, or the  
 2402 | referring physician, has, at a minimum, orally, while physically  
 2403 | present in the same room, and at least 24 hours before the  
 2404 | procedure, informed the woman of:

2405 | a. The nature and risks of undergoing or not undergoing  
 2406 | the proposed procedure that a reasonable patient would consider  
 2407 | material to making a knowing and willful decision of whether to  
 2408 | terminate a pregnancy.

2409 | b. The probable gestational age of the fetus, verified by  
 2410 | an ultrasound, at the time the termination of pregnancy is to be  
 2411 | performed.

2412 | (I) The ultrasound must be performed by the physician who  
 2413 | is to perform the abortion or by a person having documented  
 2414 | evidence that he or she has completed a course in the operation  
 2415 | of ultrasound equipment as prescribed by rule and who is working  
 2416 | in conjunction with the physician.

2417 | (II) The person performing the ultrasound must offer the  
 2418 | woman the opportunity to view the live ultrasound images and

2419 | hear an explanation of them. If the woman accepts the  
2420 | opportunity to view the images and hear the explanation, a  
2421 | physician or a registered nurse, licensed practical nurse,  
2422 | advanced practice registered nurse, autonomous physician  
2423 | assistant, or physician assistant working in conjunction with  
2424 | the physician must contemporaneously review and explain the  
2425 | images to the woman before the woman gives informed consent to  
2426 | having an abortion procedure performed.

2427 |         (III) The woman has a right to decline to view and hear  
2428 | the explanation of the live ultrasound images after she is  
2429 | informed of her right and offered an opportunity to view the  
2430 | images and hear the explanation. If the woman declines, the  
2431 | woman shall complete a form acknowledging that she was offered  
2432 | an opportunity to view and hear the explanation of the images  
2433 | but that she declined that opportunity. The form must also  
2434 | indicate that the woman's decision was not based on any undue  
2435 | influence from any person to discourage her from viewing the  
2436 | images or hearing the explanation and that she declined of her  
2437 | own free will.

2438 |         (IV) Unless requested by the woman, the person performing  
2439 | the ultrasound may not offer the opportunity to view the images  
2440 | and hear the explanation and the explanation may not be given  
2441 | if, at the time the woman schedules or arrives for her  
2442 | appointment to obtain an abortion, a copy of a restraining  
2443 | order, police report, medical record, or other court order or  
2444 | documentation is presented which provides evidence that the



2445 woman is obtaining the abortion because the woman is a victim of  
2446 rape, incest, domestic violence, or human trafficking or that  
2447 the woman has been diagnosed as having a condition that, on the  
2448 basis of a physician's good faith clinical judgment, would  
2449 create a serious risk of substantial and irreversible impairment  
2450 of a major bodily function if the woman delayed terminating her  
2451 pregnancy.

2452 c. The medical risks to the woman and fetus of carrying  
2453 the pregnancy to term.

2454

2455 The physician may provide the information required in this  
2456 subparagraph within 24 hours before the procedure if requested  
2457 by the woman at the time she schedules or arrives for her  
2458 appointment to obtain an abortion and if she presents to the  
2459 physician a copy of a restraining order, police report, medical  
2460 record, or other court order or documentation evidencing that  
2461 she is obtaining the abortion because she is a victim of rape,  
2462 incest, domestic violence, or human trafficking.

2463 2. Printed materials prepared and provided by the  
2464 department have been provided to the pregnant woman, if she  
2465 chooses to view these materials, including:

2466 a. A description of the fetus, including a description of  
2467 the various stages of development.

2468 b. A list of entities that offer alternatives to  
2469 terminating the pregnancy.

2470 c. Detailed information on the availability of medical

2471 assistance benefits for prenatal care, childbirth, and neonatal  
 2472 care.

2473 3. The woman acknowledges in writing, before the  
 2474 termination of pregnancy, that the information required to be  
 2475 provided under this subsection has been provided.

2476  
 2477 Nothing in this paragraph is intended to prohibit a physician  
 2478 from providing any additional information which the physician  
 2479 deems material to the woman's informed decision to terminate her  
 2480 pregnancy.

2481 Section 38. Paragraphs (c), (e), and (f) of subsection (3)  
 2482 of section 390.012, Florida Statutes, are amended to read:

2483 390.012 Powers of agency; rules; disposal of fetal  
 2484 remains.—

2485 (3) For clinics that perform or claim to perform abortions  
 2486 after the first trimester of pregnancy, the agency shall adopt  
 2487 rules pursuant to ss. 120.536(1) and 120.54 to implement the  
 2488 provisions of this chapter, including the following:

2489 (c) Rules relating to abortion clinic personnel. At a  
 2490 minimum, these rules shall require that:

2491 1. The abortion clinic designate a medical director who is  
 2492 licensed to practice medicine in this state, and all physicians  
 2493 who perform abortions in the clinic have admitting privileges at  
 2494 a hospital within reasonable proximity to the clinic, unless the  
 2495 clinic has a written patient transfer agreement with a hospital  
 2496 within reasonable proximity to the clinic which includes the

2497 transfer of the patient's medical records held by both the  
2498 clinic and the treating physician.

2499 2. If a physician is not present after an abortion is  
2500 performed, a registered nurse, licensed practical nurse,  
2501 advanced practice registered nurse, autonomous physician  
2502 assistant, or physician assistant be present and remain at the  
2503 clinic to provide postoperative monitoring and care until the  
2504 patient is discharged.

2505 3. Surgical assistants receive training in counseling,  
2506 patient advocacy, and the specific responsibilities associated  
2507 with the services the surgical assistants provide.

2508 4. Volunteers receive training in the specific  
2509 responsibilities associated with the services the volunteers  
2510 provide, including counseling and patient advocacy as provided  
2511 in the rules adopted by the director for different types of  
2512 volunteers based on their responsibilities.

2513 (e) Rules relating to the abortion procedure. At a  
2514 minimum, these rules shall require:

2515 1. That a physician, registered nurse, licensed practical  
2516 nurse, advanced practice registered nurse, autonomous physician  
2517 assistant, or physician assistant is available to all patients  
2518 throughout the abortion procedure.

2519 2. Standards for the safe conduct of abortion procedures  
2520 that conform to obstetric standards in keeping with established  
2521 standards of care regarding the estimation of fetal age as  
2522 defined in rule.

- 2523           3. Appropriate use of general and local anesthesia,  
 2524 analgesia, and sedation if ordered by the physician.
- 2525           4. Appropriate precautions, such as the establishment of  
 2526 intravenous access at least for patients undergoing post-first  
 2527 trimester abortions.
- 2528           5. Appropriate monitoring of the vital signs and other  
 2529 defined signs and markers of the patient's status throughout the  
 2530 abortion procedure and during the recovery period until the  
 2531 patient's condition is deemed to be stable in the recovery room.
- 2532           (f) Rules that prescribe minimum recovery room standards.  
 2533 At a minimum, these rules must require that:
- 2534           1. Postprocedure recovery rooms be supervised and staffed  
 2535 to meet the patients' needs.
- 2536           2. Immediate postprocedure care consist of observation in  
 2537 a supervised recovery room for as long as the patient's  
 2538 condition warrants.
- 2539           3. A registered nurse, licensed practical nurse, advanced  
 2540 practice registered nurse, autonomous physician assistant, or  
 2541 physician assistant who is trained in the management of the  
 2542 recovery area and is capable of providing basic cardiopulmonary  
 2543 resuscitation and related emergency procedures remain on the  
 2544 premises of the abortion clinic until all patients are  
 2545 discharged.
- 2546           4. A physician sign the discharge order and be readily  
 2547 accessible and available until the last patient is discharged to  
 2548 facilitate the transfer of emergency cases if hospitalization of

2549 | the patient or viable fetus is necessary.

2550 |         5. A physician discuss Rho(D) immune globulin with each  
 2551 | patient for whom it is indicated and ensure that it is offered  
 2552 | to the patient in the immediate postoperative period or will be  
 2553 | available to her within 72 hours after completion of the  
 2554 | abortion procedure. If the patient refuses the Rho(D) immune  
 2555 | globulin, she and a witness must sign a refusal form approved by  
 2556 | the agency which must be included in the medical record.

2557 |         6. Written instructions with regard to postabortion  
 2558 | coitus, signs of possible problems, and general aftercare which  
 2559 | are specific to the patient be given to each patient. The  
 2560 | instructions must include information regarding access to  
 2561 | medical care for complications, including a telephone number for  
 2562 | use in the event of a medical emergency.

2563 |         7. A minimum length of time be specified, by type of  
 2564 | abortion procedure and duration of gestation, during which a  
 2565 | patient must remain in the recovery room.

2566 |         8. The physician ensure that, with the patient's consent,  
 2567 | a registered nurse, licensed practical nurse, advanced practice  
 2568 | registered nurse, autonomous physician assistant, or physician  
 2569 | assistant from the abortion clinic makes a good faith effort to  
 2570 | contact the patient by telephone within 24 hours after surgery  
 2571 | to assess the patient's recovery.

2572 |         9. Equipment and services be readily accessible to provide  
 2573 | appropriate emergency resuscitative and life support procedures  
 2574 | pending the transfer of the patient or viable fetus to the

2575 hospital.

2576 Section 39. Paragraphs (a) and (f) of subsection (2) of  
 2577 section 394.463, Florida Statutes, are amended to read:

2578 394.463 Involuntary examination.—

2579 (2) INVOLUNTARY EXAMINATION.—

2580 (a) An involuntary examination may be initiated by any one  
 2581 of the following means:

2582 1. A circuit or county court may enter an ex parte order  
 2583 stating that a person appears to meet the criteria for  
 2584 involuntary examination and specifying the findings on which  
 2585 that conclusion is based. The ex parte order for involuntary  
 2586 examination must be based on written or oral sworn testimony  
 2587 that includes specific facts that support the findings. If other  
 2588 less restrictive means are not available, such as voluntary  
 2589 appearance for outpatient evaluation, a law enforcement officer,  
 2590 or other designated agent of the court, shall take the person  
 2591 into custody and deliver him or her to an appropriate, or the  
 2592 nearest, facility within the designated receiving system  
 2593 pursuant to s. 394.462 for involuntary examination. The order of  
 2594 the court shall be made a part of the patient's clinical record.  
 2595 A fee may not be charged for the filing of an order under this  
 2596 subsection. A facility accepting the patient based on this order  
 2597 must send a copy of the order to the department within 5 working  
 2598 days. The order may be submitted electronically through existing  
 2599 data systems, if available. The order shall be valid only until  
 2600 the person is delivered to the facility or for the period

2601 specified in the order itself, whichever comes first. If ~~a no~~  
2602 time limit is not specified in the order, the order is ~~shall be~~  
2603 valid for 7 days after the date that the order was signed.

2604 2. A law enforcement officer shall take a person who  
2605 appears to meet the criteria for involuntary examination into  
2606 custody and deliver the person or have him or her delivered to  
2607 an appropriate, or the nearest, facility within the designated  
2608 receiving system pursuant to s. 394.462 for examination. The  
2609 officer shall execute a written report detailing the  
2610 circumstances under which the person was taken into custody,  
2611 which must be made a part of the patient's clinical record. Any  
2612 facility accepting the patient based on this report must send a  
2613 copy of the report to the department within 5 working days.

2614 3. A physician, autonomous physician assistant, physician  
2615 assistant, clinical psychologist, psychiatric nurse, advanced  
2616 practice registered nurse, mental health counselor, marriage and  
2617 family therapist, or clinical social worker may execute a  
2618 certificate stating that he or she has examined a person within  
2619 the preceding 48 hours and finds that the person appears to meet  
2620 the criteria for involuntary examination and stating the  
2621 observations upon which that conclusion is based. If other less  
2622 restrictive means, such as voluntary appearance for outpatient  
2623 evaluation, are not available, a law enforcement officer shall  
2624 take into custody the person named in the certificate and  
2625 deliver him or her to the appropriate, or nearest, facility  
2626 within the designated receiving system pursuant to s. 394.462

2627 for involuntary examination. The law enforcement officer shall  
 2628 execute a written report detailing the circumstances under which  
 2629 the person was taken into custody. The report and certificate  
 2630 shall be made a part of the patient's clinical record. Any  
 2631 facility accepting the patient based on this certificate must  
 2632 send a copy of the certificate to the department within 5  
 2633 working days. The document may be submitted electronically  
 2634 through existing data systems, if applicable.

2635  
 2636 When sending the order, report, or certificate to the  
 2637 department, a facility shall, at a minimum, provide information  
 2638 about which action was taken regarding the patient under  
 2639 paragraph (g), which information shall also be made a part of  
 2640 the patient's clinical record.

2641 (f) A patient shall be examined by a physician, physician  
 2642 assistant, or ~~a~~ clinical psychologist, or by a psychiatric nurse  
 2643 performing within the framework of an established protocol with  
 2644 a psychiatrist, at a facility without unnecessary delay to  
 2645 determine if the criteria for involuntary services are met.  
 2646 Emergency treatment may be provided upon the order of a  
 2647 physician if the physician determines that such treatment is  
 2648 necessary for the safety of the patient or others. The patient  
 2649 may not be released by the receiving facility or its contractor  
 2650 without the documented approval of a psychiatrist or a clinical  
 2651 psychologist or, if the receiving facility is owned or operated  
 2652 by a hospital or health system, the release may also be approved



2653 | by a psychiatric nurse performing within the framework of an  
 2654 | established protocol with a psychiatrist, or an attending  
 2655 | emergency department physician with experience in the diagnosis  
 2656 | and treatment of mental illness after completion of an  
 2657 | involuntary examination pursuant to this subsection. A  
 2658 | psychiatric nurse may not approve the release of a patient if  
 2659 | the involuntary examination was initiated by a psychiatrist  
 2660 | unless the release is approved by the initiating psychiatrist.

2661 | Section 40. Paragraph (b) of subsection (2) of section  
 2662 | 395.0191, Florida Statutes, is amended to read:

2663 | 395.0191 Staff membership and clinical privileges.—

2664 | (2)

2665 | (b) An advanced practice registered nurse who is certified  
 2666 | as a registered nurse anesthetist licensed under part I of  
 2667 | chapter 464 shall administer anesthesia under the onsite medical  
 2668 | direction of a professional licensed under chapter 458, chapter  
 2669 | 459, or chapter 466, and in accordance with an established  
 2670 | protocol approved by the medical staff. The medical direction  
 2671 | shall specifically address the needs of the individual patient.  
 2672 | This paragraph does not apply to a certified registered nurse  
 2673 | anesthetist registered to engage in autonomous practice under s.  
 2674 | 464.0123.

2675 | Section 41. Subsection (3) of section 395.602, Florida  
 2676 | Statutes, is amended to read:

2677 | 395.602 Rural hospitals.—

2678 | (3) USE OF FUNDS.—It is the intent of the Legislature that

2679 funds as appropriated shall be utilized by the department for  
 2680 the purpose of increasing the number of primary care physicians,  
 2681 autonomous physician assistants, physician assistants, certified  
 2682 nurse midwives, nurse practitioners, and nurses in rural areas,  
 2683 either through the Medical Education Reimbursement and Loan  
 2684 Repayment Program as defined by s. 1009.65 or through a federal  
 2685 loan repayment program which requires state matching funds. The  
 2686 department may use funds appropriated for the Medical Education  
 2687 Reimbursement and Loan Repayment Program as matching funds for  
 2688 federal loan repayment programs for health care personnel, such  
 2689 as that authorized in Pub. L. No. 100-177, s. 203. If the  
 2690 department receives federal matching funds, the department shall  
 2691 only implement the federal program. Reimbursement through either  
 2692 program shall be limited to:

2693 (a) Primary care physicians, autonomous physician  
 2694 assistants, physician assistants, certified nurse midwives,  
 2695 nurse practitioners, and nurses employed by or affiliated with  
 2696 rural hospitals, as defined in this act; and

2697 (b) Primary care physicians, autonomous physician  
 2698 assistants, physician assistants, certified nurse midwives,  
 2699 nurse practitioners, and nurses employed by or affiliated with  
 2700 rural area health education centers, as defined in this section.

2701 These personnel shall practice:

- 2702 1. In a county with a population density of no greater
- 2703 than 100 persons per square mile; or
- 2704 2. Within the boundaries of a hospital tax district which

2705 encompasses a population of no greater than 100 persons per  
2706 square mile.

2707

2708 If the department administers a federal loan repayment program,  
2709 priority shall be given to obligating state and federal matching  
2710 funds pursuant to paragraphs (a) and (b). The department may use  
2711 federal matching funds in other health workforce shortage areas  
2712 and medically underserved areas in the state for loan repayment  
2713 programs for primary care physicians, autonomous physician  
2714 assistants, physician assistants, certified nurse midwives,  
2715 nurse practitioners, and nurses who are employed by publicly  
2716 financed health care programs that serve medically indigent  
2717 persons.

2718 Section 42. Paragraph (a) of subsection (2) of section  
2719 397.501, Florida Statutes, is amended to read:

2720 397.501 Rights of individuals.—Individuals receiving  
2721 substance abuse services from any service provider are  
2722 guaranteed protection of the rights specified in this section,  
2723 unless otherwise expressly provided, and service providers must  
2724 ensure the protection of such rights.

2725 (2) RIGHT TO NONDISCRIMINATORY SERVICES.—

2726 (a) Service providers may not deny an individual access to  
2727 substance abuse services solely on the basis of race, gender,  
2728 ethnicity, age, sexual preference, human immunodeficiency virus  
2729 status, prior service departures against medical advice,  
2730 disability, or number of relapse episodes. Service providers may

2731 not deny an individual who takes medication prescribed by a  
 2732 physician, autonomous physician assistant, physician assistant,  
 2733 or advanced practice registered nurse access to substance abuse  
 2734 services solely on that basis. Service providers who receive  
 2735 state funds to provide substance abuse services may not, if  
 2736 space and sufficient state resources are available, deny access  
 2737 to services based solely on inability to pay.

2738 Section 43. Section 397.679, Florida Statutes, is amended  
 2739 to read:

2740 397.679 Emergency admission; circumstances justifying.—A  
 2741 person who meets the criteria for involuntary admission in s.  
 2742 397.675 may be admitted to a hospital or to a licensed  
 2743 detoxification facility or addictions receiving facility for  
 2744 emergency assessment and stabilization, or to a less intensive  
 2745 component of a licensed service provider for assessment only,  
 2746 upon receipt by the facility of a certificate by a physician, an  
 2747 autonomous physician assistant, an advanced practice registered  
 2748 nurse, a psychiatric nurse, a clinical psychologist, a clinical  
 2749 social worker, a marriage and family therapist, a mental health  
 2750 counselor, a physician assistant working under the scope of  
 2751 practice of the supervising physician, or a master's-level-  
 2752 certified addictions professional for substance abuse services,  
 2753 if the certificate is specific to substance abuse impairment,  
 2754 and the completion of an application for emergency admission.

2755 Section 44. Subsection (1) of section 397.6793, Florida  
 2756 Statutes, is amended to read:

2757 397.6793 Professional's certificate for emergency  
 2758 admission.—

2759 (1) A physician, a clinical psychologist, an autonomous  
 2760 physician assistant, a physician assistant working under the  
 2761 scope of practice of the supervising physician, a psychiatric  
 2762 nurse, an advanced practice registered nurse, a mental health  
 2763 counselor, a marriage and family therapist, a master's-level-  
 2764 certified addictions professional for substance abuse services,  
 2765 or a clinical social worker may execute a professional's  
 2766 certificate for emergency admission. The professional's  
 2767 certificate must include the name of the person to be admitted,  
 2768 the relationship between the person and the professional  
 2769 executing the certificate, the relationship between the  
 2770 applicant and the professional, any relationship between the  
 2771 professional and the licensed service provider, a statement that  
 2772 the person has been examined and assessed within the preceding 5  
 2773 days after the application date, and factual allegations with  
 2774 respect to the need for emergency admission, including:

2775 (a) The reason for the belief that the person is substance  
 2776 abuse impaired;

2777 (b) The reason for the belief that because of such  
 2778 impairment the person has lost the power of self-control with  
 2779 respect to substance abuse; and

2780 (c)1. The reason for the belief that, without care or  
 2781 treatment, the person is likely to suffer from neglect or refuse  
 2782 to care for himself or herself; that such neglect or refusal

2783 | poses a real and present threat of substantial harm to his or  
 2784 | her well-being; and that it is not apparent that such harm may  
 2785 | be avoided through the help of willing family members or friends  
 2786 | or the provision of other services, or there is substantial  
 2787 | likelihood that the person has inflicted or, unless admitted, is  
 2788 | likely to inflict, physical harm on himself, herself, or  
 2789 | another; or

2790 |         2. The reason for the belief that the person's refusal to  
 2791 | voluntarily receive care is based on judgment so impaired by  
 2792 | reason of substance abuse that the person is incapable of  
 2793 | appreciating his or her need for care and of making a rational  
 2794 | decision regarding his or her need for care.

2795 |         Section 45. Subsection (8) of section 400.021, Florida  
 2796 | Statutes, is amended to read:

2797 |         400.021 Definitions.—When used in this part, unless the  
 2798 | context otherwise requires, the term:

2799 |         (8) "Geriatric outpatient clinic" means a site for  
 2800 | providing outpatient health care to persons 60 years of age or  
 2801 | older, which is staffed by a registered nurse, a physician  
 2802 | assistant, or a licensed practical nurse under the direct  
 2803 | supervision of a registered nurse, advanced practice registered  
 2804 | nurse, physician assistant, autonomous physician assistant, or  
 2805 | physician.

2806 |         Section 46. Subsection (3) of section 400.172, Florida  
 2807 | Statutes, is amended to read:

2808 |         400.172 Respite care provided in nursing home facilities.—

2809 (3) A prospective respite care resident must provide  
 2810 medical information from a physician, autonomous physician  
 2811 assistant, physician assistant, or nurse practitioner and any  
 2812 other information provided by the primary caregiver required by  
 2813 the facility before or when the person is admitted to receive  
 2814 respite care. The medical information must include a physician's  
 2815 order for respite care and proof of a physical examination by a  
 2816 licensed physician, autonomous physician assistant, physician  
 2817 assistant, or nurse practitioner. The physician's order and  
 2818 physical examination may be used to provide intermittent respite  
 2819 care for up to 12 months after the date the order is written.

2820 Section 47. Subsection (2) of section 400.487, Florida  
 2821 Statutes, is amended to read:

2822 400.487 Home health service agreements; physician's,  
 2823 physician assistant's, autonomous physician assistant's, and  
 2824 advanced practice registered nurse's treatment orders; patient  
 2825 assessment; establishment and review of plan of care; provision  
 2826 of services; orders not to resuscitate.—

2827 (2) When required by ~~the provisions of~~ chapter 464; part  
 2828 I, part III, or part V of chapter 468; or chapter 486, the  
 2829 attending physician, autonomous physician assistant, physician  
 2830 assistant, or advanced practice registered nurse, acting within  
 2831 his or her respective scope of practice, shall establish  
 2832 treatment orders for a patient who is to receive skilled care.  
 2833 The treatment orders must be signed by the physician, autonomous  
 2834 physician assistant, physician assistant, or advanced practice

2835 registered nurse before a claim for payment for the skilled  
2836 services is submitted by the home health agency. If the claim is  
2837 submitted to a managed care organization, the treatment orders  
2838 must be signed within the time allowed under the provider  
2839 agreement. The treatment orders shall be reviewed, as frequently  
2840 as the patient's illness requires, by the physician, autonomous  
2841 physician assistant, physician assistant, or advanced practice  
2842 registered nurse in consultation with the home health agency.

2843 Section 48. Paragraph (a) of subsection (13) of section  
2844 400.506, Florida Statutes, is amended to read:

2845 400.506 Licensure of nurse registries; requirements;  
2846 penalties.—

2847 (13) All persons referred for contract in private  
2848 residences by a nurse registry must comply with the following  
2849 requirements for a plan of treatment:

2850 (a) When, in accordance with the privileges and  
2851 restrictions imposed upon a nurse under part I of chapter 464,  
2852 the delivery of care to a patient is under the direction or  
2853 supervision of a physician or when a physician is responsible  
2854 for the medical care of the patient, a medical plan of treatment  
2855 must be established for each patient receiving care or treatment  
2856 provided by a licensed nurse in the home. The original medical  
2857 plan of treatment must be timely signed by the physician,  
2858 autonomous physician assistant, physician assistant, or advanced  
2859 practice registered nurse, acting within his or her respective  
2860 scope of practice, and reviewed in consultation with the



2861 licensed nurse at least every 2 months. Any additional order or  
2862 change in orders must be obtained from the physician, autonomous  
2863 physician assistant, physician assistant, or advanced practice  
2864 registered nurse and reduced to writing and timely signed by the  
2865 physician, autonomous physician assistant, physician assistant,  
2866 or advanced practice registered nurse. The delivery of care  
2867 under a medical plan of treatment must be substantiated by the  
2868 appropriate nursing notes or documentation made by the nurse in  
2869 compliance with nursing practices established under part I of  
2870 chapter 464.

2871 Section 49. Subsection (5) and paragraph (b) of subsection  
2872 (7) of section 400.9973, Florida Statutes, are amended to read:

2873 400.9973 Client admission, transfer, and discharge.—

2874 (5) A client admitted to a transitional living facility  
2875 must be admitted upon prescription by a licensed physician,  
2876 autonomous physician assistant, physician assistant, or advanced  
2877 practice registered nurse and must remain under the care of a  
2878 licensed physician, autonomous physician assistant, physician  
2879 assistant, or advanced practice registered nurse for the  
2880 duration of the client's stay in the facility.

2881 (7) A person may not be admitted to a transitional living  
2882 facility if the person:

2883 (b) Is a danger to himself or herself or others as  
2884 determined by a physician, autonomous physician assistant,  
2885 physician assistant, advanced practice registered nurse, or a  
2886 mental health practitioner licensed under chapter 490 or chapter

2887 491, unless the facility provides adequate staffing and support  
 2888 to ensure patient safety;

2889 Section 50. Paragraphs (a) and (b) of subsection (2) of  
 2890 section 400.9974, Florida Statutes, are amended to read:

2891 400.9974 Client comprehensive treatment plans; client  
 2892 services.—

2893 (2) The comprehensive treatment plan must include:

2894 (a) Orders obtained from the physician, autonomous  
 2895 physician assistant, physician assistant, or advanced practice  
 2896 registered nurse and the client's diagnosis, medical history,  
 2897 physical examination, and rehabilitative or restorative needs.

2898 (b) A preliminary nursing evaluation, including orders for  
 2899 immediate care provided by the physician, autonomous physician  
 2900 assistant, physician assistant, or advanced practice registered  
 2901 nurse, which shall be completed when the client is admitted.

2902 Section 51. Section 400.9976, Florida Statutes, is amended  
 2903 to read:

2904 400.9976 Administration of medication.—

2905 (1) An individual medication administration record must be  
 2906 maintained for each client. A dose of medication, including a  
 2907 self-administered dose, shall be properly recorded in the  
 2908 client's record. A client who self-administers medication shall  
 2909 be given a pill organizer. Medication must be placed in the pill  
 2910 organizer by a nurse. A nurse shall document the date and time  
 2911 that medication is placed into each client's pill organizer. All  
 2912 medications must be administered in compliance with orders of a

2913 physician, autonomous physician assistant, physician assistant,  
 2914 or advanced practice registered nurse.

2915 (2) If an interdisciplinary team determines that self-  
 2916 administration of medication is an appropriate objective, and if  
 2917 the physician, autonomous physician assistant, physician  
 2918 assistant, or advanced practice registered nurse does not  
 2919 specify otherwise, the client must be instructed by the  
 2920 physician, autonomous physician assistant, physician assistant,  
 2921 or advanced practice registered nurse to self-administer his or  
 2922 her medication without the assistance of a staff person. All  
 2923 forms of self-administration of medication, including  
 2924 administration orally, by injection, and by suppository, shall  
 2925 be included in the training. The client's physician, autonomous  
 2926 physician assistant, physician assistant, or advanced practice  
 2927 registered nurse must be informed of the interdisciplinary  
 2928 team's decision that self-administration of medication is an  
 2929 objective for the client. A client may not self-administer  
 2930 medication until he or she demonstrates the competency to take  
 2931 the correct medication in the correct dosage at the correct  
 2932 time, to respond to missed doses, and to contact the appropriate  
 2933 person with questions.

2934 (3) Medication administration discrepancies and adverse  
 2935 drug reactions must be recorded and reported immediately to a  
 2936 physician, autonomous physician assistant, physician assistant,  
 2937 or advanced practice registered nurse.

2938 Section 52. Subsections (2) through (5) of section

2939 400.9979, Florida Statutes, are amended to read:

2940 400.9979 Restraint and seclusion; client safety.—

2941 (2) The use of physical restraints must be ordered and  
 2942 documented by a physician, autonomous physician assistant,  
 2943 physician assistant, or advanced practice registered nurse and  
 2944 must be consistent with the policies and procedures adopted by  
 2945 the facility. The client or, if applicable, the client's  
 2946 representative shall be informed of the facility's physical  
 2947 restraint policies and procedures when the client is admitted.

2948 (3) The use of chemical restraints shall be limited to  
 2949 prescribed dosages of medications as ordered by a physician,  
 2950 autonomous physician assistant, physician assistant, or advanced  
 2951 practice registered nurse and must be consistent with the  
 2952 client's diagnosis and the policies and procedures adopted by  
 2953 the facility. The client and, if applicable, the client's  
 2954 representative shall be informed of the facility's chemical  
 2955 restraint policies and procedures when the client is admitted.

2956 (4) Based on the assessment by a physician, autonomous  
 2957 physician assistant, physician assistant, or advanced practice  
 2958 registered nurse, if a client exhibits symptoms that present an  
 2959 immediate risk of injury or death to himself or herself or  
 2960 others, a physician, physician assistant, or advanced practice  
 2961 registered nurse may issue an emergency treatment order to  
 2962 immediately administer rapid-response psychotropic medications  
 2963 or other chemical restraints. Each emergency treatment order  
 2964 must be documented and maintained in the client's record.

2965 (a) An emergency treatment order is not effective for more  
 2966 than 24 hours.

2967 (b) Whenever a client is medicated under this subsection,  
 2968 the client's representative or a responsible party and the  
 2969 client's physician, autonomous physician assistant, physician  
 2970 assistant, or advanced practice registered nurse shall be  
 2971 notified as soon as practicable.

2972 (5) A client who is prescribed and receives a medication  
 2973 that can serve as a chemical restraint for a purpose other than  
 2974 an emergency treatment order must be evaluated by his or her  
 2975 physician, autonomous physician assistant, physician assistant,  
 2976 or advanced practice registered nurse at least monthly to  
 2977 assess:

2978 (a) The continued need for the medication.

2979 (b) The level of the medication in the client's blood.

2980 (c) The need for adjustments to the prescription.

2981 Section 53. Subsections (1) and (2) of section 401.445,  
 2982 Florida Statutes, are amended to read:

2983 401.445 Emergency examination and treatment of  
 2984 incapacitated persons.—

2985 (1) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in  
 2986 this state against any emergency medical technician, paramedic,  
 2987 or physician as defined in this chapter, any advanced practice  
 2988 registered nurse licensed under s. 464.012, or any autonomous  
 2989 physician assistant or physician assistant registered or  
 2990 licensed under s. 458.347 or s. 459.022, or any person acting

2991 | under the direct medical supervision of a physician, in an  
 2992 | action brought for examining or treating a patient without his  
 2993 | or her informed consent if:

2994 |       (a) The patient at the time of examination or treatment is  
 2995 | intoxicated, under the influence of drugs, or otherwise  
 2996 | incapable of providing informed consent as provided in s.  
 2997 | 766.103;

2998 |       (b) The patient at the time of examination or treatment is  
 2999 | experiencing an emergency medical condition; and

3000 |       (c) The patient would reasonably, under all the  
 3001 | surrounding circumstances, undergo such examination, treatment,  
 3002 | or procedure if he or she were advised by the emergency medical  
 3003 | technician, paramedic, physician, advanced practice registered  
 3004 | nurse, autonomous physician assistant, or physician assistant in  
 3005 | accordance with s. 766.103(3).

3006 |  
 3007 | Examination and treatment provided under this subsection shall  
 3008 | be limited to reasonable examination of the patient to determine  
 3009 | the medical condition of the patient and treatment reasonably  
 3010 | necessary to alleviate the emergency medical condition or to  
 3011 | stabilize the patient.

3012 |       (2) In examining and treating a person who is apparently  
 3013 | intoxicated, under the influence of drugs, or otherwise  
 3014 | incapable of providing informed consent, the emergency medical  
 3015 | technician, paramedic, physician, advanced practice registered  
 3016 | nurse, autonomous physician assistant, or physician assistant,

3017 or any person acting under the direct medical supervision of a  
 3018 physician, shall proceed wherever possible with the consent of  
 3019 the person. If the person reasonably appears to be incapacitated  
 3020 and refuses his or her consent, the person may be examined,  
 3021 treated, or taken to a hospital or other appropriate treatment  
 3022 resource if he or she is in need of emergency attention, without  
 3023 his or her consent, but unreasonable force shall not be used.

3024 Section 54. Subsection (18) of section 409.906, Florida  
 3025 Statutes, is amended to read:

3026 409.906 Optional Medicaid services.—Subject to specific  
 3027 appropriations, the agency may make payments for services which  
 3028 are optional to the state under Title XIX of the Social Security  
 3029 Act and are furnished by Medicaid providers to recipients who  
 3030 are determined to be eligible on the dates on which the services  
 3031 were provided. Any optional service that is provided shall be  
 3032 provided only when medically necessary and in accordance with  
 3033 state and federal law. Optional services rendered by providers  
 3034 in mobile units to Medicaid recipients may be restricted or  
 3035 prohibited by the agency. Nothing in this section shall be  
 3036 construed to prevent or limit the agency from adjusting fees,  
 3037 reimbursement rates, lengths of stay, number of visits, or  
 3038 number of services, or making any other adjustments necessary to  
 3039 comply with the availability of moneys and any limitations or  
 3040 directions provided for in the General Appropriations Act or  
 3041 chapter 216. If necessary to safeguard the state's systems of  
 3042 providing services to elderly and disabled persons and subject

3043 to the notice and review provisions of s. 216.177, the Governor  
 3044 may direct the Agency for Health Care Administration to amend  
 3045 the Medicaid state plan to delete the optional Medicaid service  
 3046 known as "Intermediate Care Facilities for the Developmentally  
 3047 Disabled." Optional services may include:

3048 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for  
 3049 all services provided to a recipient by an autonomous physician  
 3050 assistant or a physician assistant registered or licensed under  
 3051 s. 458.347 or s. 459.022. Reimbursement for such services must  
 3052 be not less than 80 percent of the reimbursement that would be  
 3053 paid to a physician who provided the same services.

3054 Section 55. Paragraph (m) of subsection (3) of section  
 3055 409.908, Florida Statutes, is amended to read:

3056 409.908 Reimbursement of Medicaid providers.—Subject to  
 3057 specific appropriations, the agency shall reimburse Medicaid  
 3058 providers, in accordance with state and federal law, according  
 3059 to methodologies set forth in the rules of the agency and in  
 3060 policy manuals and handbooks incorporated by reference therein.  
 3061 These methodologies may include fee schedules, reimbursement  
 3062 methods based on cost reporting, negotiated fees, competitive  
 3063 bidding pursuant to s. 287.057, and other mechanisms the agency  
 3064 considers efficient and effective for purchasing services or  
 3065 goods on behalf of recipients. If a provider is reimbursed based  
 3066 on cost reporting and submits a cost report late and that cost  
 3067 report would have been used to set a lower reimbursement rate  
 3068 for a rate semester, then the provider's rate for that semester



3069 shall be retroactively calculated using the new cost report, and  
 3070 full payment at the recalculated rate shall be effected  
 3071 retroactively. Medicare-granted extensions for filing cost  
 3072 reports, if applicable, shall also apply to Medicaid cost  
 3073 reports. Payment for Medicaid compensable services made on  
 3074 behalf of Medicaid eligible persons is subject to the  
 3075 availability of moneys and any limitations or directions  
 3076 provided for in the General Appropriations Act or chapter 216.  
 3077 Further, nothing in this section shall be construed to prevent  
 3078 or limit the agency from adjusting fees, reimbursement rates,  
 3079 lengths of stay, number of visits, or number of services, or  
 3080 making any other adjustments necessary to comply with the  
 3081 availability of moneys and any limitations or directions  
 3082 provided for in the General Appropriations Act, provided the  
 3083 adjustment is consistent with legislative intent.

3084 (3) Subject to any limitations or directions provided for  
 3085 in the General Appropriations Act, the following Medicaid  
 3086 services and goods may be reimbursed on a fee-for-service basis.  
 3087 For each allowable service or goods furnished in accordance with  
 3088 Medicaid rules, policy manuals, handbooks, and state and federal  
 3089 law, the payment shall be the amount billed by the provider, the  
 3090 provider's usual and customary charge, or the maximum allowable  
 3091 fee established by the agency, whichever amount is less, with  
 3092 the exception of those services or goods for which the agency  
 3093 makes payment using a methodology based on capitation rates,  
 3094 average costs, or negotiated fees.

3095 (m) Autonomous physician assistant and physician assistant  
 3096 services.

3097 Section 56. Paragraphs (c) through (cc) of subsection (1)  
 3098 of section 409.973, Florida Statutes, are redesignated as  
 3099 paragraphs (d) through (dd), respectively, and a new paragraph  
 3100 (c) is added to that subsection to read:

3101 409.973 Benefits.—

3102 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a  
 3103 minimum, the following services:

3104 (c) Autonomous physician assistant services.

3105 Section 57. Subsections (2), (4), and (5) of section  
 3106 429.26, Florida Statutes, are amended to read:

3107 429.26 Appropriateness of placements; examinations of  
 3108 residents.—

3109 (2) A physician, autonomous physician assistant, physician  
 3110 assistant, or nurse practitioner who is employed by an assisted  
 3111 living facility to provide an initial examination for admission  
 3112 purposes may not have financial interest in the facility.

3113 (4) If possible, each resident shall have been examined by  
 3114 a licensed physician, an autonomous physician assistant, a  
 3115 licensed physician assistant, or a licensed nurse practitioner  
 3116 within 60 days before admission to the facility. The signed and  
 3117 completed medical examination report shall be submitted to the  
 3118 owner or administrator of the facility who shall use the  
 3119 information contained therein to assist in the determination of  
 3120 the appropriateness of the resident's admission and continued

3121 stay in the facility. The medical examination report shall  
 3122 become a permanent part of the record of the resident at the  
 3123 facility and shall be made available to the agency during  
 3124 inspection or upon request. An assessment that has been  
 3125 completed through the Comprehensive Assessment and Review for  
 3126 Long-Term Care Services (CARES) Program fulfills the  
 3127 requirements for a medical examination under this subsection and  
 3128 s. 429.07(3)(b)6.

3129 (5) Except as provided in s. 429.07, if a medical  
 3130 examination has not been completed within 60 days before the  
 3131 admission of the resident to the facility, a licensed physician,  
 3132 a registered autonomous physician assistant, a licensed  
 3133 physician assistant, or a licensed nurse practitioner shall  
 3134 examine the resident and complete a medical examination form  
 3135 provided by the agency within 30 days following the admission to  
 3136 the facility to enable the facility owner or administrator to  
 3137 determine the appropriateness of the admission. The medical  
 3138 examination form shall become a permanent part of the record of  
 3139 the resident at the facility and shall be made available to the  
 3140 agency during inspection by the agency or upon request.

3141 Section 58. Paragraph (a) of subsection (2) and paragraph  
 3142 (a) of subsection (7) of section 429.918, Florida Statutes, are  
 3143 amended to read:

3144 429.918 Licensure designation as a specialized Alzheimer's  
 3145 services adult day care center.—

3146 (2) As used in this section, the term:

3147 (a) "ADRD participant" means a participant who has a  
 3148 documented diagnosis of Alzheimer's disease or a dementia-  
 3149 related disorder (ADRD) from a licensed physician, a registered  
 3150 autonomous physician assistant, a licensed physician assistant,  
 3151 or a licensed advanced practice registered nurse.

3152 (7) (a) An ADRD participant admitted to an adult day care  
 3153 center having a license designated under this section, or the  
 3154 caregiver when applicable, must:

3155 1. Require ongoing supervision to maintain the highest  
 3156 level of medical or custodial functioning and have a  
 3157 demonstrated need for a responsible party to oversee his or her  
 3158 care.

3159 2. Not actively demonstrate aggressive behavior that  
 3160 places himself, herself, or others at risk of harm.

3161 3. Provide the following medical documentation signed by a  
 3162 licensed physician, a registered autonomous physician assistant,  
 3163 a licensed physician assistant, or a licensed advanced practice  
 3164 registered nurse:

3165 a. Any physical, health, or emotional conditions that  
 3166 require medical care.

3167 b. A listing of the ADRD participant's current prescribed  
 3168 and over-the-counter medications and dosages, diet restrictions,  
 3169 mobility restrictions, and other physical limitations.

3170 4. Provide documentation signed by a health care provider  
 3171 licensed in this state which indicates that the ADRD participant  
 3172 is free of the communicable form of tuberculosis and free of

3173 signs and symptoms of other communicable diseases.

3174 Section 59. Paragraph (e) of subsection (5) of section  
3175 440.102, Florida Statutes, is amended to read:

3176 440.102 Drug-free workplace program requirements.—The  
3177 following provisions apply to a drug-free workplace program  
3178 implemented pursuant to law or to rules adopted by the Agency  
3179 for Health Care Administration:

3180 (5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen  
3181 collection and testing for drugs under this section shall be  
3182 performed in accordance with the following procedures:

3183 (e) A specimen for a drug test may be taken or collected  
3184 by any of the following persons:

3185 1. A physician, an autonomous physician assistant, a  
3186 physician assistant, a registered professional nurse, a licensed  
3187 practical nurse, or a nurse practitioner or a certified  
3188 paramedic who is present at the scene of an accident for the  
3189 purpose of rendering emergency medical service or treatment.

3190 2. A qualified person employed by a licensed or certified  
3191 laboratory as described in subsection (9).

3192 Section 60. Paragraphs (a), (i), (o), and (r) of  
3193 subsection (3) and paragraph (g) of subsection (5) of section  
3194 456.053, Florida Statutes, are amended to read:

3195 456.053 Financial arrangements between referring health  
3196 care providers and providers of health care services.—

3197 (3) DEFINITIONS.—For the purpose of this section, the  
3198 word, phrase, or term:

3199 (a) "Board" means any of the following boards relating to  
 3200 the respective professions: the Board of Medicine as created in  
 3201 s. 458.307; the Board of Osteopathic Medicine as created in s.  
 3202 459.004; the Board of Chiropractic Medicine as created in s.  
 3203 460.404; the Board of Podiatric Medicine as created in s.  
 3204 461.004; the Board of Optometry as created in s. 463.003; the  
 3205 Board of Nursing as created in s. 464.004; the Board of Pharmacy  
 3206 as created in s. 465.004; and the Board of Dentistry as created  
 3207 in s. 466.004.

3208 (i) "Health care provider" means a ~~any~~ physician licensed  
 3209 under chapter 458, chapter 459, chapter 460, or chapter 461; an  
 3210 autonomous physician assistant registered under chapter 458 or  
 3211 chapter 459; an advanced practice registered nurse registered to  
 3212 engage in autonomous practice under s. 464.0123;~~7~~ or any health  
 3213 care provider licensed under chapter 463 or chapter 466.

3214 (o) "Referral" means any referral of a patient by a health  
 3215 care provider for health care services, including, without  
 3216 limitation:

3217 1. The forwarding of a patient by a health care provider  
 3218 to another health care provider or to an entity which provides  
 3219 or supplies designated health services or any other health care  
 3220 item or service; or

3221 2. The request or establishment of a plan of care by a  
 3222 health care provider, which includes the provision of designated  
 3223 health services or other health care item or service.

3224 3. The following orders, recommendations, or plans of care

3225 shall not constitute a referral by a health care provider:  
 3226       a. By a radiologist for diagnostic-imaging services.  
 3227       b. By a physician specializing in the provision of  
 3228 radiation therapy services for such services.  
 3229       c. By a medical oncologist for drugs and solutions to be  
 3230 prepared and administered intravenously to such oncologist's  
 3231 patient, as well as for the supplies and equipment used in  
 3232 connection therewith to treat such patient for cancer and the  
 3233 complications thereof.  
 3234       d. By a cardiologist for cardiac catheterization services.  
 3235       e. By a pathologist for diagnostic clinical laboratory  
 3236 tests and pathological examination services, if furnished by or  
 3237 under the supervision of such pathologist pursuant to a  
 3238 consultation requested by another physician.  
 3239       f. By a health care provider who is the sole provider or  
 3240 member of a group practice for designated health services or  
 3241 other health care items or services that are prescribed or  
 3242 provided solely for such referring health care provider's or  
 3243 group practice's own patients, and that are provided or  
 3244 performed by or under the direct supervision of such referring  
 3245 health care provider or group practice; provided, however, ~~that~~  
 3246 ~~effective July 1, 1999,~~ a health care provider ~~physician~~  
 3247 ~~licensed pursuant to chapter 458, chapter 459, chapter 460, or~~  
 3248 ~~chapter 461~~ may refer a patient to a sole provider or group  
 3249 practice for diagnostic imaging services, excluding radiation  
 3250 therapy services, for which the sole provider or group practice

3251 billed both the technical and the professional fee for or on  
3252 behalf of the patient, if the referring health care provider  
3253 does not have an ~~physician has no~~ investment interest in the  
3254 practice. The diagnostic imaging service referred to a group  
3255 practice or sole provider must be a diagnostic imaging service  
3256 normally provided within the scope of practice to the patients  
3257 of the group practice or sole provider. The group practice or  
3258 sole provider may accept no more than 15 percent of their  
3259 patients receiving diagnostic imaging services from outside  
3260 referrals, excluding radiation therapy services.

3261 g. By a health care provider for services provided by an  
3262 ambulatory surgical center licensed under chapter 395.

3263 h. By a urologist for lithotripsy services.

3264 i. By a dentist for dental services performed by an  
3265 employee of or health care provider who is an independent  
3266 contractor with the dentist or group practice of which the  
3267 dentist is a member.

3268 j. By a physician for infusion therapy services to a  
3269 patient of that physician or a member of that physician's group  
3270 practice.

3271 k. By a nephrologist for renal dialysis services and  
3272 supplies, except laboratory services.

3273 l. By a health care provider whose principal professional  
3274 practice consists of treating patients in their private  
3275 residences for services to be rendered in such private  
3276 residences, except for services rendered by a home health agency



3277 licensed under chapter 400. For purposes of this sub-  
 3278 subparagraph, the term "private residences" includes patients'  
 3279 private homes, independent living centers, and assisted living  
 3280 facilities, but does not include skilled nursing facilities.

3281 m. By a health care provider for sleep-related testing.

3282 (r) "Sole provider" means one health care provider  
 3283 licensed under chapter 458, chapter 459, chapter 460, or chapter  
 3284 461, or registered under s. 464.0123, who maintains a separate  
 3285 medical office and a medical practice separate from any other  
 3286 health care provider and who bills for his or her services  
 3287 separately from the services provided by any other health care  
 3288 provider. A sole provider shall not share overhead expenses or  
 3289 professional income with any other person or group practice.

3290 (5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as  
 3291 provided in this section:

3292 (g) A violation of this section by a health care provider  
 3293 shall constitute grounds for disciplinary action to be taken by  
 3294 the applicable board pursuant to s. 458.331(2), s. 459.015(2),  
 3295 s. 460.413(2), s. 461.013(2), s. 463.016(2), s. 464.018, or s.  
 3296 466.028(2). Any hospital licensed under chapter 395 found in  
 3297 violation of this section shall be subject to s. 395.0185(2).

3298 Section 61. Subsection (7) of section 456.072, Florida  
 3299 Statutes, is amended to read:

3300 456.072 Grounds for discipline; penalties; enforcement.—

3301 (7) Notwithstanding subsection (2), upon a finding that a  
 3302 physician or autonomous physician assistant has prescribed or

3303 dispensed a controlled substance, or caused a controlled  
 3304 substance to be prescribed or dispensed, in a manner that  
 3305 violates the standard of practice set forth in s. 458.331(1)(q)  
 3306 or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s.  
 3307 466.028(1)(p) or (x), or that an advanced practice registered  
 3308 nurse has prescribed or dispensed a controlled substance, or  
 3309 caused a controlled substance to be prescribed or dispensed, in  
 3310 a manner that violates the standard of practice set forth in s.  
 3311 464.018(1)(n) or (p)6., the physician, autonomous physician  
 3312 assistant, or advanced practice registered nurse shall be  
 3313 suspended for a period of not less than 6 months and pay a fine  
 3314 of not less than \$10,000 per count. Repeated violations shall  
 3315 result in increased penalties.

3316 Section 62. Paragraph (h) of subsection (1) and subsection  
 3317 (2) of section 456.44, Florida Statutes, are amended to read:

3318 456.44 Controlled substance prescribing.—

3319 (1) DEFINITIONS.—As used in this section, the term:

3320 (h) "Registrant" means a physician, an autonomous  
 3321 physician assistant, a physician assistant, or an advanced  
 3322 practice registered nurse who meets the requirements of  
 3323 subsection (2).

3324 (2) REGISTRATION.—A physician licensed under chapter 458,  
 3325 chapter 459, chapter 461, or chapter 466, an autonomous  
 3326 physician assistant or a physician assistant registered or  
 3327 licensed under chapter 458 or chapter 459, or an advanced  
 3328 practice registered nurse licensed under part I of chapter 464

3329 | who prescribes any controlled substance, listed in Schedule II,  
 3330 | Schedule III, or Schedule IV as defined in s. 893.03, for the  
 3331 | treatment of chronic nonmalignant pain, must:

3332 |       (a) Designate himself or herself as a controlled substance  
 3333 | prescribing practitioner on his or her practitioner profile.

3334 |       (b) Comply with the requirements of this section and  
 3335 | applicable board rules.

3336 |       Section 63. Paragraph (c) of subsection (3) of section  
 3337 | 458.3265, Florida Statutes, is amended to read:

3338 |       458.3265 Pain-management clinics.—

3339 |       (3) PHYSICIAN RESPONSIBILITIES.—These responsibilities  
 3340 | apply to any physician who provides professional services in a  
 3341 | pain-management clinic that is required to be registered in  
 3342 | subsection (1).

3343 |       (c) A physician, an autonomous physician assistant, a  
 3344 | physician assistant, or an advanced practice registered nurse  
 3345 | must perform a physical examination of a patient on the same day  
 3346 | that the physician prescribes a controlled substance to a  
 3347 | patient at a pain-management clinic. If the physician prescribes  
 3348 | more than a 72-hour dose of controlled substances for the  
 3349 | treatment of chronic nonmalignant pain, the physician must  
 3350 | document in the patient's record the reason for prescribing that  
 3351 | quantity.

3352 |       Section 64. Paragraph (ii) of subsection (1) and  
 3353 | subsection (10) of section 458.331, Florida Statutes, are  
 3354 | amended to read:

3355 458.331 Grounds for disciplinary action; action by the  
 3356 board and department.—

3357 (1) The following acts constitute grounds for denial of a  
 3358 license or disciplinary action, as specified in s. 456.072(2):

3359 (ii) Failing to report to the department any licensee  
 3360 under this chapter or under chapter 459 who the physician,  
 3361 autonomous physician assistant, or physician assistant knows has  
 3362 violated the grounds for disciplinary action set out in the law  
 3363 under which that person is licensed and who provides health care  
 3364 services in a facility licensed under chapter 395, or a health  
 3365 maintenance organization certificated under part I of chapter  
 3366 641, in which the physician, autonomous physician assistant, or  
 3367 physician assistant also provides services.

3368 (10) A probable cause panel convened to consider  
 3369 disciplinary action against an autonomous physician assistant or  
 3370 a physician assistant alleged to have violated s. 456.072 or  
 3371 this section must include one physician assistant. The physician  
 3372 assistant must hold a valid license to practice as a physician  
 3373 assistant in this state and be appointed to the panel by the  
 3374 Council of Physician Assistants. The physician assistant may  
 3375 hear only cases involving disciplinary actions against a  
 3376 physician assistant. If the appointed physician assistant is not  
 3377 present at the disciplinary hearing, the panel may consider the  
 3378 matter and vote on the case in the absence of the physician  
 3379 assistant. The training requirements set forth in s. 458.307(4)  
 3380 do not apply to the appointed physician assistant. Rules need

3381 not be adopted to implement this subsection.

3382 Section 65. Paragraph (c) of subsection (3) of section  
3383 459.0137, Florida Statutes, is amended to read:

3384 459.0137 Pain-management clinics.—

3385 (3) PHYSICIAN RESPONSIBILITIES.—These responsibilities  
3386 apply to any osteopathic physician who provides professional  
3387 services in a pain-management clinic that is required to be  
3388 registered in subsection (1).

3389 (c) An osteopathic physician, an autonomous physician  
3390 assistant, a physician assistant, or an advanced practice  
3391 registered nurse must perform a physical examination of a  
3392 patient on the same day that the physician prescribes a  
3393 controlled substance to a patient at a pain-management clinic.  
3394 If the osteopathic physician prescribes more than a 72-hour dose  
3395 of controlled substances for the treatment of chronic  
3396 nonmalignant pain, the osteopathic physician must document in  
3397 the patient's record the reason for prescribing that quantity.

3398 Section 66. Paragraph (11) of subsection (1) and  
3399 subsection (10) of section 459.015, Florida Statutes, are  
3400 amended to read:

3401 459.015 Grounds for disciplinary action; action by the  
3402 board and department.—

3403 (1) The following acts constitute grounds for denial of a  
3404 license or disciplinary action, as specified in s. 456.072(2):

3405 (11) Failing to report to the department any licensee  
3406 under chapter 458 or under this chapter who the osteopathic

3407 physician, autonomous physician assistant, or physician  
 3408 assistant knows has violated the grounds for disciplinary action  
 3409 set out in the law under which that person is licensed and who  
 3410 provides health care services in a facility licensed under  
 3411 chapter 395, or a health maintenance organization certificated  
 3412 under part I of chapter 641, in which the osteopathic physician,  
 3413 autonomous physician assistant, or physician assistant also  
 3414 provides services.

3415 (10) A probable cause panel convened to consider  
 3416 disciplinary action against an autonomous physician assistant or  
 3417 a physician assistant alleged to have violated s. 456.072 or  
 3418 this section must include one physician assistant. The physician  
 3419 assistant must hold a valid license to practice as a physician  
 3420 assistant in this state and be appointed to the panel by the  
 3421 Council of Physician Assistants. The physician assistant may  
 3422 hear only cases involving disciplinary actions against a  
 3423 physician assistant. If the appointed physician assistant is not  
 3424 present at the disciplinary hearing, the panel may consider the  
 3425 matter and vote on the case in the absence of the physician  
 3426 assistant. The training requirements set forth in s. 458.307(4)  
 3427 do not apply to the appointed physician assistant. Rules need  
 3428 not be adopted to implement this subsection.

3429 Section 67. Subsection (17) of section 464.003, Florida  
 3430 Statutes, is amended to read:

3431 464.003 Definitions.—As used in this part, the term:

3432 (17) "Practice of practical nursing" means the performance

3433 of selected acts, including the administration of treatments and  
 3434 medications, in the care of the ill, injured, or infirm; the  
 3435 promotion of wellness, maintenance of health, and prevention of  
 3436 illness of others under the direction of a registered nurse, a  
 3437 licensed physician, a licensed osteopathic physician, a licensed  
 3438 podiatric physician, a registered autonomous physician  
 3439 assistant, or a licensed dentist; and the teaching of general  
 3440 principles of health and wellness to the public and to students  
 3441 other than nursing students. A practical nurse is responsible  
 3442 and accountable for making decisions that are based upon the  
 3443 individual's educational preparation and experience in nursing.

3444 Section 68. Paragraph (a) of subsection (4) of section  
 3445 464.0205, Florida Statutes, is amended to read:

3446 464.0205 Retired volunteer nurse certificate.—

3447 (4) A retired volunteer nurse receiving certification from  
 3448 the board shall:

3449 (a) Work under the direct supervision of the director of a  
 3450 county health department, a physician working under a limited  
 3451 license issued pursuant to s. 458.317 or s. 459.0075, a  
 3452 physician or an autonomous physician assistant licensed or  
 3453 registered under chapter 458 or chapter 459, an advanced  
 3454 practice registered nurse licensed under s. 464.012, or a  
 3455 registered nurse licensed under s. 464.008 or s. 464.009.

3456 Section 69. Paragraph (b) of subsection (1) of section  
 3457 480.0475, Florida Statutes, is amended to read:

3458 480.0475 Massage establishments; prohibited practices.—

3459 (1) A person may not operate a massage establishment  
 3460 between the hours of midnight and 5 a.m. This subsection does  
 3461 not apply to a massage establishment:

3462 (b) In which every massage performed between the hours of  
 3463 midnight and 5 a.m. is performed by a massage therapist acting  
 3464 under the prescription of a physician, autonomous physician  
 3465 assistant, or physician assistant licensed or registered under  
 3466 chapter 458; ~~an osteopathic physician,~~ autonomous physician  
 3467 assistant, or physician assistant licensed or registered under  
 3468 chapter 459; ~~a chiropractic physician licensed under chapter~~  
 3469 ~~460;~~ ~~a podiatric physician licensed under chapter 461;~~ ~~an~~  
 3470 ~~advanced practice registered nurse licensed under part I of~~  
 3471 ~~chapter 464;~~ ~~or a dentist licensed under chapter 466; or~~

3472 Section 70. Subsection (2) of section 493.6108, Florida  
 3473 Statutes, is amended to read:

3474 493.6108 Investigation of applicants by Department of  
 3475 Agriculture and Consumer Services.—

3476 (2) In addition to subsection (1), the department shall  
 3477 make an investigation of the general physical fitness of the  
 3478 Class "G" applicant to bear a weapon or firearm. Determination  
 3479 of physical fitness shall be certified by a physician,  
 3480 autonomous physician assistant, or physician assistant currently  
 3481 licensed or registered under ~~pursuant to~~ chapter 458, chapter  
 3482 459, or any similar law of another state or authorized to act as  
 3483 a licensed physician by a federal agency or department or by an  
 3484 advanced practice registered nurse currently licensed pursuant



3485 to chapter 464. Such certification shall be submitted on a form  
 3486 provided by the department.

3487 Section 71. Subsection (1) of section 626.9707, Florida  
 3488 Statutes, is amended to read:

3489 626.9707 Disability insurance; discrimination on basis of  
 3490 sickle-cell trait prohibited.—

3491 (1) An ~~No~~ insurer authorized to transact insurance in this  
 3492 state may not shall refuse to issue and deliver in this state  
 3493 any policy of disability insurance, whether such policy is  
 3494 defined as individual, group, blanket, franchise, industrial, or  
 3495 otherwise, which is currently being issued for delivery in this  
 3496 state and which affords benefits and coverage for any medical  
 3497 treatment or service authorized and permitted to be furnished by  
 3498 a hospital, a clinic, a health clinic, a neighborhood health  
 3499 clinic, a health maintenance organization, a physician, an  
 3500 autonomous physician assistant, a physician ~~physician's~~  
 3501 assistant, an advanced practice registered nurse ~~practitioner,~~  
 3502 or a medical service facility or personnel solely because the  
 3503 person to be insured has the sickle-cell trait.

3504 Section 72. Paragraph (b) of subsection (1) of section  
 3505 627.357, Florida Statutes, is amended to read:

3506 627.357 Medical malpractice self-insurance.—

3507 (1) DEFINITIONS.—As used in this section, the term:

3508 (b) "Health care provider" means any:

3509 1. Hospital licensed under chapter 395.

3510 2. Physician, autonomous physician assistant ~~licensed,~~ or

3511 physician assistant registered or licensed~~, under~~ chapter 458.  
 3512       3. Osteopathic physician, autonomous physician assistant,  
 3513 or physician assistant registered or licensed under chapter 459.  
 3514       4. Podiatric physician licensed under chapter 461.  
 3515       5. Health maintenance organization certificated under part  
 3516 I of chapter 641.  
 3517       6. Ambulatory surgical center licensed under chapter 395.  
 3518       7. Chiropractic physician licensed under chapter 460.  
 3519       8. Psychologist licensed under chapter 490.  
 3520       9. Optometrist licensed under chapter 463.  
 3521       10. Dentist licensed under chapter 466.  
 3522       11. Pharmacist licensed under chapter 465.  
 3523       12. Registered nurse, licensed practical nurse, or  
 3524 advanced practice registered nurse licensed or registered under  
 3525 part I of chapter 464.  
 3526       13. Other medical facility.  
 3527       14. Professional association, partnership, corporation,  
 3528 joint venture, or other association established by the  
 3529 individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9.,  
 3530 10., 11., and 12. for professional activity.  
 3531       Section 73. Paragraph (a) of subsection (1) of section  
 3532 627.736, Florida Statutes, is amended to read:  
 3533       627.736 Required personal injury protection benefits;  
 3534 exclusions; priority; claims.—  
 3535       (1) REQUIRED BENEFITS.—An insurance policy complying with  
 3536 the security requirements of s. 627.733 must provide personal

3537 injury protection to the named insured, relatives residing in  
 3538 the same household, persons operating the insured motor vehicle,  
 3539 passengers in the motor vehicle, and other persons struck by the  
 3540 motor vehicle and suffering bodily injury while not an occupant  
 3541 of a self-propelled vehicle, subject to subsection (2) and  
 3542 paragraph (4) (e), to a limit of \$10,000 in medical and  
 3543 disability benefits and \$5,000 in death benefits resulting from  
 3544 bodily injury, sickness, disease, or death arising out of the  
 3545 ownership, maintenance, or use of a motor vehicle as follows:

3546 (a) Medical benefits.—Eighty percent of all reasonable  
 3547 expenses for medically necessary medical, surgical, X-ray,  
 3548 dental, and rehabilitative services, including prosthetic  
 3549 devices and medically necessary ambulance, hospital, and nursing  
 3550 services if the individual receives initial services and care  
 3551 pursuant to subparagraph 1. within 14 days after the motor  
 3552 vehicle accident. The medical benefits provide reimbursement  
 3553 only for:

3554 1. Initial services and care that are lawfully provided,  
 3555 supervised, ordered, or prescribed by a physician or an  
 3556 autonomous physician assistant licensed or registered under  
 3557 chapter 458 or chapter 459, a dentist licensed under chapter  
 3558 466, ~~or~~ a chiropractic physician licensed under chapter 460, or  
 3559 an advanced practice registered nurse registered to engage in  
 3560 autonomous practice under s. 464.0123 or that are provided in a  
 3561 hospital or in a facility that owns, or is wholly owned by, a  
 3562 hospital. Initial services and care may also be provided by a

3563 person or entity licensed under part III of chapter 401 which  
3564 provides emergency transportation and treatment.

3565 2. Upon referral by a provider described in subparagraph  
3566 1., followup services and care consistent with the underlying  
3567 medical diagnosis rendered pursuant to subparagraph 1. which may  
3568 be provided, supervised, ordered, or prescribed only by a  
3569 physician or an autonomous physician assistant licensed or  
3570 registered under chapter 458 or chapter 459, a chiropractic  
3571 physician licensed under chapter 460, a dentist licensed under  
3572 chapter 466, or an advanced practice registered nurse registered  
3573 to engage in autonomous practice under s. 464.0123, or, to the  
3574 extent permitted by applicable law and under the supervision of  
3575 such physician, osteopathic physician, chiropractic physician,  
3576 or dentist, by a physician assistant licensed under chapter 458  
3577 or chapter 459 or an advanced practice registered nurse licensed  
3578 under chapter 464. Followup services and care may also be  
3579 provided by the following persons or entities:

3580 a. A hospital or ambulatory surgical center licensed under  
3581 chapter 395.

3582 b. An entity wholly owned by one or more physicians or  
3583 autonomous physician assistants licensed or registered under  
3584 chapter 458 or chapter 459, chiropractic physicians licensed  
3585 under chapter 460, advanced practice registered nurses  
3586 registered to engage in autonomous practice under s. 464.0123,  
3587 or dentists licensed under chapter 466 or by such practitioners  
3588 and the spouse, parent, child, or sibling of such practitioners.

3589 c. An entity that owns or is wholly owned, directly or  
 3590 indirectly, by a hospital or hospitals.

3591 d. A physical therapist licensed under chapter 486, based  
 3592 upon a referral by a provider described in this subparagraph.

3593 e. A health care clinic licensed under part X of chapter  
 3594 400 which is accredited by an accrediting organization whose  
 3595 standards incorporate comparable regulations required by this  
 3596 state, or

3597 (I) Has a medical director licensed under chapter 458,  
 3598 chapter 459, or chapter 460;

3599 (II) Has been continuously licensed for more than 3 years  
 3600 or is a publicly traded corporation that issues securities  
 3601 traded on an exchange registered with the United States  
 3602 Securities and Exchange Commission as a national securities  
 3603 exchange; and

3604 (III) Provides at least four of the following medical  
 3605 specialties:

3606 (A) General medicine.

3607 (B) Radiography.

3608 (C) Orthopedic medicine.

3609 (D) Physical medicine.

3610 (E) Physical therapy.

3611 (F) Physical rehabilitation.

3612 (G) Prescribing or dispensing outpatient prescription  
 3613 medication.

3614 (H) Laboratory services.

3615           3. Reimbursement for services and care provided in  
3616 subparagraph 1. or subparagraph 2. up to \$10,000 if a physician  
3617 licensed under chapter 458 or chapter 459, a dentist licensed  
3618 under chapter 466, an autonomous physician assistant or a  
3619 physician assistant registered or licensed under chapter 458 or  
3620 chapter 459, or an advanced practice registered nurse licensed  
3621 under chapter 464 has determined that the injured person had an  
3622 emergency medical condition.

3623           4. Reimbursement for services and care provided in  
3624 subparagraph 1. or subparagraph 2. is limited to \$2,500 if a  
3625 provider listed in subparagraph 1. or subparagraph 2. determines  
3626 that the injured person did not have an emergency medical  
3627 condition.

3628           5. Medical benefits do not include massage as defined in  
3629 s. 480.033 or acupuncture as defined in s. 457.102, regardless  
3630 of the person, entity, or licensee providing massage or  
3631 acupuncture, and a licensed massage therapist or licensed  
3632 acupuncturist may not be reimbursed for medical benefits under  
3633 this section.

3634           6. The Financial Services Commission shall adopt by rule  
3635 the form that must be used by an insurer and a health care  
3636 provider specified in sub-subparagraph 2.b., sub-subparagraph  
3637 2.c., or sub-subparagraph 2.e. to document that the health care  
3638 provider meets the criteria of this paragraph. Such rule must  
3639 include a requirement for a sworn statement or affidavit.

3640

3641 Only insurers writing motor vehicle liability insurance in this  
 3642 state may provide the required benefits of this section, and  
 3643 such insurer may not require the purchase of any other motor  
 3644 vehicle coverage other than the purchase of property damage  
 3645 liability coverage as required by s. 627.7275 as a condition for  
 3646 providing such benefits. Insurers may not require that property  
 3647 damage liability insurance in an amount greater than \$10,000 be  
 3648 purchased in conjunction with personal injury protection. Such  
 3649 insurers shall make benefits and required property damage  
 3650 liability insurance coverage available through normal marketing  
 3651 channels. An insurer writing motor vehicle liability insurance  
 3652 in this state who fails to comply with such availability  
 3653 requirement as a general business practice violates part IX of  
 3654 chapter 626, and such violation constitutes an unfair method of  
 3655 competition or an unfair or deceptive act or practice involving  
 3656 the business of insurance. An insurer committing such violation  
 3657 is subject to the penalties provided under that part, as well as  
 3658 those provided elsewhere in the insurance code.

3659 Section 74. Subsection (5) of section 633.412, Florida  
 3660 Statutes, is amended to read:

3661 633.412 Firefighters; qualifications for certification.—A  
 3662 person applying for certification as a firefighter must:

3663 (5) Be in good physical condition as determined by a  
 3664 medical examination given by a physician, surgeon, or autonomous  
 3665 physician assistant or physician assistant licensed or  
 3666 registered under ~~to practice in the state pursuant to~~ chapter

3667 458; an osteopathic physician, surgeon, autonomous physician  
 3668 assistant, or physician assistant licensed or registered under  
 3669 ~~to practice in the state pursuant to~~ chapter 459; or an advanced  
 3670 practice registered nurse licensed under ~~to practice in the~~  
 3671 ~~state pursuant to~~ chapter 464. Such examination may include, but  
 3672 need not be limited to, the National Fire Protection Association  
 3673 Standard 1582. A medical examination evidencing good physical  
 3674 condition shall be submitted to the division, on a form as  
 3675 provided by rule, before an individual is eligible for admission  
 3676 into a course under s. 633.408.

3677 Section 75. Subsection (8) of section 641.495, Florida  
 3678 Statutes, is amended to read:

3679 641.495 Requirements for issuance and maintenance of  
 3680 certificate.—

3681 (8) Each organization's contracts, certificates, and  
 3682 subscriber handbooks shall contain a provision, if applicable,  
 3683 disclosing that, for certain types of described medical  
 3684 procedures, services may be provided by autonomous physician  
 3685 assistants, physician assistants, advanced practice registered  
 3686 nurses ~~nurse practitioners~~, or other individuals who are not  
 3687 licensed physicians.

3688 Section 76. Subsection (1) of section 744.2006, Florida  
 3689 Statutes, is amended to read:

3690 744.2006 Office of Public and Professional Guardians;  
 3691 appointment, notification.—

3692 (1) The executive director of the Office of Public and



3693 Professional Guardians, after consultation with the chief judge  
 3694 and other circuit judges within the judicial circuit and with  
 3695 appropriate advocacy groups and individuals and organizations  
 3696 who are knowledgeable about the needs of incapacitated persons,  
 3697 may establish, within a county in the judicial circuit or within  
 3698 the judicial circuit, one or more offices of public guardian and  
 3699 if so established, shall create a list of persons best qualified  
 3700 to serve as the public guardian, who have been investigated  
 3701 pursuant to s. 744.3135. The public guardian must have knowledge  
 3702 of the legal process and knowledge of social services available  
 3703 to meet the needs of incapacitated persons. The public guardian  
 3704 shall maintain a staff or contract with professionally qualified  
 3705 individuals to carry out the guardianship functions, including  
 3706 an attorney who has experience in probate areas and another  
 3707 person who has a master's degree in social work, or a  
 3708 gerontologist, psychologist, autonomous physician assistant,  
 3709 advanced practice registered nurse, or registered nurse,~~or~~  
 3710 ~~nurse practitioner~~. A public guardian that is a nonprofit  
 3711 corporate guardian under s. 744.309(5) must receive tax-exempt  
 3712 status from the United States Internal Revenue Service.

3713 Section 77. Paragraph (a) of subsection (3) of section  
 3714 744.331, Florida Statutes, is amended to read:

3715 744.331 Procedures to determine incapacity.—

3716 (3) EXAMINING COMMITTEE.—

3717 (a) Within 5 days after a petition for determination of  
 3718 incapacity has been filed, the court shall appoint an examining

3719 | committee consisting of three members. One member must be a  
3720 | psychiatrist or other physician. The remaining members must be  
3721 | either a psychologist, a gerontologist, a ~~another~~ psychiatrist,  
3722 | a ~~or other~~ physician, an autonomous physician assistant, a  
3723 | physician assistant, an advanced practice registered nurse, a  
3724 | registered nurse, ~~nurse practitioner,~~ a licensed social worker,  
3725 | a person with an advanced degree in gerontology from an  
3726 | accredited institution of higher education, or any other person  
3727 | who by knowledge, skill, experience, training, or education may,  
3728 | in the court's discretion, advise the court in the form of an  
3729 | expert opinion. One of three members of the committee must have  
3730 | knowledge of the type of incapacity alleged in the petition.  
3731 | Unless good cause is shown, the attending or family physician  
3732 | may not be appointed to the committee. If the attending or  
3733 | family physician is available for consultation, the committee  
3734 | must consult with the physician. Members of the examining  
3735 | committee may not be related to or associated with one another,  
3736 | with the petitioner, with counsel for the petitioner or the  
3737 | proposed guardian, or with the person alleged to be totally or  
3738 | partially incapacitated. A member may not be employed by any  
3739 | private or governmental agency that has custody of, or  
3740 | furnishes, services or subsidies, directly or indirectly, to the  
3741 | person or the family of the person alleged to be incapacitated  
3742 | or for whom a guardianship is sought. A petitioner may not serve  
3743 | as a member of the examining committee. Members of the examining  
3744 | committee must be able to communicate, either directly or

3745 through an interpreter, in the language that the alleged  
 3746 incapacitated person speaks or to communicate in a medium  
 3747 understandable to the alleged incapacitated person if she or he  
 3748 is able to communicate. The clerk of the court shall send notice  
 3749 of the appointment to each person appointed no later than 3 days  
 3750 after the court's appointment.

3751 Section 78. Paragraph (b) of subsection (1) of section  
 3752 744.3675, Florida Statutes, is amended to read:

3753 744.3675 Annual guardianship plan.—Each guardian of the  
 3754 person must file with the court an annual guardianship plan  
 3755 which updates information about the condition of the ward. The  
 3756 annual plan must specify the current needs of the ward and how  
 3757 those needs are proposed to be met in the coming year.

3758 (1) Each plan for an adult ward must, if applicable,  
 3759 include:

3760 (b) Information concerning the medical and mental health  
 3761 conditions and treatment and rehabilitation needs of the ward,  
 3762 including:

3763 1. A resume of any professional medical treatment given to  
 3764 the ward during the preceding year.

3765 2. The report of a physician, autonomous physician  
 3766 assistant, physician assistant, or advanced practice registered  
 3767 nurse who examined the ward no more than 90 days before the  
 3768 beginning of the applicable reporting period. The report must  
 3769 contain an evaluation of the ward's condition and a statement of  
 3770 the current level of capacity of the ward.

3771 3. The plan for providing medical, mental health, and  
 3772 rehabilitative services in the coming year.

3773 Section 79. Subsection (3) of section 766.103, Florida  
 3774 Statutes, is amended to read:

3775 766.103 Florida Medical Consent Law.—

3776 (3) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in  
 3777 this state against any physician licensed under chapter 458,  
 3778 osteopathic physician licensed under chapter 459, chiropractic  
 3779 physician licensed under chapter 460, podiatric physician  
 3780 licensed under chapter 461, dentist licensed under chapter 466,  
 3781 advanced practice registered nurse licensed under s. 464.012,  
 3782 autonomous physician assistant registered under chapter 458 or  
 3783 chapter 459, or physician assistant licensed under s. 458.347 or  
 3784 s. 459.022 in an action brought for treating, examining, or  
 3785 operating on a patient without his or her informed consent when:

3786 (a)1. The action of the physician, osteopathic physician,  
 3787 chiropractic physician, podiatric physician, dentist, advanced  
 3788 practice registered nurse, autonomous physician assistant, or  
 3789 physician assistant in obtaining the consent of the patient or  
 3790 another person authorized to give consent for the patient was in  
 3791 accordance with an accepted standard of medical practice among  
 3792 members of the medical profession with similar training and  
 3793 experience in the same or similar medical community as that of  
 3794 the person treating, examining, or operating on the patient for  
 3795 whom the consent is obtained; and

3796 2. A reasonable individual, from the information provided

3797 by the physician, osteopathic physician, chiropractic physician,  
 3798 podiatric physician, dentist, advanced practice registered  
 3799 nurse, autonomous physician assistant, or physician assistant,  
 3800 under the circumstances, would have a general understanding of  
 3801 the procedure, the medically acceptable alternative procedures  
 3802 or treatments, and the substantial risks and hazards inherent in  
 3803 the proposed treatment or procedures, which are recognized among  
 3804 other physicians, osteopathic physicians, chiropractic  
 3805 physicians, podiatric physicians, or dentists in the same or  
 3806 similar community who perform similar treatments or procedures;  
 3807 or

3808 (b) The patient would reasonably, under all the  
 3809 surrounding circumstances, have undergone such treatment or  
 3810 procedure had he or she been advised by the physician,  
 3811 osteopathic physician, chiropractic physician, podiatric  
 3812 physician, dentist, advanced practice registered nurse,  
 3813 autonomous physician assistant, or physician assistant in  
 3814 accordance with ~~the provisions of~~ paragraph (a).

3815 Section 80. Paragraph (b) of subsection (1) and paragraph  
 3816 (e) of subsection (2) of section 766.105, Florida Statutes, are  
 3817 amended to read:

3818 766.105 Florida Patient's Compensation Fund.—

3819 (1) DEFINITIONS.—The following definitions apply in the  
 3820 interpretation and enforcement of this section:

3821 (b) The term "health care provider" means any:

3822 1. Hospital licensed under chapter 395.

3823           2. Physician, autonomous physician assistant, or physician  
3824 assistant licensed or registered under chapter 458.

3825           3. Osteopathic physician, autonomous physician assistant,  
3826 or physician assistant licensed or registered under chapter 459.

3827           4. Podiatric physician licensed under chapter 461.

3828           5. Health maintenance organization certificated under part  
3829 I of chapter 641.

3830           6. Ambulatory surgical center licensed under chapter 395.

3831           7. "Other medical facility" as defined in paragraph (c).

3832           8. Professional association, partnership, corporation,  
3833 joint venture, or other association by the individuals set forth  
3834 in subparagraphs 2., 3., and 4. for professional activity.

3835           (2) COVERAGE.—

3836           (e) The coverage afforded by the fund for a participating  
3837 hospital or ambulatory surgical center shall apply to the  
3838 officers, trustees, volunteer workers, trainees, committee  
3839 members (including physicians, osteopathic physicians, podiatric  
3840 physicians, and dentists), and employees of the hospital or  
3841 ambulatory surgical center, other than employed physicians  
3842 licensed under chapter 458, autonomous physician assistants or  
3843 physician assistants registered or licensed under chapter 458 or  
3844 chapter 459, osteopathic physicians licensed under chapter 459,  
3845 dentists licensed under chapter 466, and podiatric physicians  
3846 licensed under chapter 461. However, the coverage afforded by  
3847 the fund for a participating hospital shall apply to house  
3848 physicians, interns, employed physician residents in a resident

3849 training program, or physicians performing purely administrative  
 3850 duties for the participating hospitals other than the treatment  
 3851 of patients. This coverage shall apply to the hospital or  
 3852 ambulatory surgical center and those included in this subsection  
 3853 as one health care provider.

3854 Section 81. Paragraph (d) of subsection (3) of section  
 3855 766.1115, Florida Statutes, is amended to read:

3856 766.1115 Health care providers; creation of agency  
 3857 relationship with governmental contractors.—

3858 (3) DEFINITIONS.—As used in this section, the term:

3859 (d) "Health care provider" or "provider" means:

- 3860 1. A birth center licensed under chapter 383.
- 3861 2. An ambulatory surgical center licensed under chapter  
 3862 395.
- 3863 3. A hospital licensed under chapter 395.
- 3864 4. A physician, autonomous physician assistant, or  
 3865 physician assistant licensed or registered under chapter 458.
- 3866 5. An osteopathic physician, autonomous physician  
 3867 assistant, or ~~osteopathic~~ physician assistant licensed or  
 3868 registered under chapter 459.
- 3869 6. A chiropractic physician licensed under chapter 460.
- 3870 7. A podiatric physician licensed under chapter 461.
- 3871 8. A registered nurse, nurse midwife, licensed practical  
 3872 nurse, or advanced practice registered nurse licensed or  
 3873 registered under part I of chapter 464 or any facility which  
 3874 employs nurses licensed or registered under part I of chapter

3875 464 to supply all or part of the care delivered under this  
 3876 section.

3877 9. A midwife licensed under chapter 467.

3878 10. A health maintenance organization certificated under  
 3879 part I of chapter 641.

3880 11. A health care professional association and its  
 3881 employees or a corporate medical group and its employees.

3882 12. Any other medical facility the primary purpose of  
 3883 which is to deliver human medical diagnostic services or which  
 3884 delivers nonsurgical human medical treatment, and which includes  
 3885 an office maintained by a provider.

3886 13. A dentist or dental hygienist licensed under chapter  
 3887 466.

3888 14. A free clinic that delivers only medical diagnostic  
 3889 services or nonsurgical medical treatment free of charge to all  
 3890 low-income recipients.

3891 15. Any other health care professional, practitioner,  
 3892 provider, or facility under contract with a governmental  
 3893 contractor, including a student enrolled in an accredited  
 3894 program that prepares the student for licensure as any one of  
 3895 the professionals listed in subparagraphs 4.-9.

3896  
 3897 The term includes any nonprofit corporation qualified as exempt  
 3898 from federal income taxation under s. 501(a) of the Internal  
 3899 Revenue Code, and described in s. 501(c) of the Internal Revenue  
 3900 Code, which delivers health care services provided by licensed



3901 professionals listed in this paragraph, any federally funded  
 3902 community health center, and any volunteer corporation or  
 3903 volunteer health care provider that delivers health care  
 3904 services.

3905 Section 82. Subsection (1) of section 766.1116, Florida  
 3906 Statutes, is amended to read:

3907 766.1116 Health care practitioner; waiver of license  
 3908 renewal fees and continuing education requirements.—

3909 (1) As used in this section, the term "health care  
 3910 practitioner" means a physician, autonomous physician assistant,  
 3911 or physician assistant licensed or registered under chapter 458;  
 3912 an osteopathic physician, autonomous physician assistant, or  
 3913 physician assistant licensed or registered under chapter 459; a  
 3914 chiropractic physician licensed under chapter 460; a podiatric  
 3915 physician licensed under chapter 461; an advanced practice  
 3916 registered nurse, registered nurse, or licensed practical nurse  
 3917 licensed under part I of chapter 464; a dentist or dental  
 3918 hygienist licensed under chapter 466; or a midwife licensed  
 3919 under chapter 467, who participates as a health care provider  
 3920 under s. 766.1115.

3921 Section 83. Paragraph (c) of subsection (1) of section  
 3922 766.118, Florida Statutes, is amended to read:

3923 766.118 Determination of noneconomic damages.—

3924 (1) DEFINITIONS.—As used in this section, the term:

3925 (c) "Practitioner" means any person licensed or registered  
 3926 under chapter 458, chapter 459, chapter 460, chapter 461,

3927 chapter 462, chapter 463, chapter 466, chapter 467, chapter 486,  
 3928 ~~or~~ s. 464.012, or s. 464.0123. "Practitioner" also means any  
 3929 association, corporation, firm, partnership, or other business  
 3930 entity under which such practitioner practices or any employee  
 3931 of such practitioner or entity acting in the scope of his or her  
 3932 employment. For the purpose of determining the limitations on  
 3933 noneconomic damages set forth in this section, the term  
 3934 "practitioner" includes any person or entity for whom a  
 3935 practitioner is vicariously liable and any person or entity  
 3936 whose liability is based solely on such person or entity being  
 3937 vicariously liable for the actions of a practitioner.

3938 Section 84. Subsection (3) of section 768.135, Florida  
 3939 Statutes, is amended to read:

3940 768.135 Volunteer team physicians; immunity.—

3941 (3) A practitioner licensed or registered under chapter  
 3942 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 who  
 3943 gratuitously and in good faith conducts an evaluation pursuant  
 3944 to s. 1006.20(2)(c) is not liable for any civil damages arising  
 3945 from that evaluation unless the evaluation was conducted in a  
 3946 wrongful manner.

3947 Section 85. Subsection (5) of section 794.08, Florida  
 3948 Statutes, is amended to read:

3949 794.08 Female genital mutilation.—

3950 (5) This section does not apply to procedures performed by  
 3951 or under the direction of a physician licensed under chapter  
 3952 458, an osteopathic physician licensed under chapter 459, a

3953 registered nurse licensed under part I of chapter 464, a  
 3954 practical nurse licensed under part I of chapter 464, an  
 3955 advanced practice registered nurse licensed under part I of  
 3956 chapter 464, a midwife licensed under chapter 467, or an  
 3957 autonomous physician assistant or a physician assistant  
 3958 registered or licensed under chapter 458 or chapter 459 when  
 3959 necessary to preserve the physical health of a female person.  
 3960 This section also does not apply to any autopsy or limited  
 3961 dissection conducted pursuant to chapter 406.

3962 Section 86. Subsection (23) of section 893.02, Florida  
 3963 Statutes, is amended to read:

3964 893.02 Definitions.—The following words and phrases as  
 3965 used in this chapter shall have the following meanings, unless  
 3966 the context otherwise requires:

3967 (23) "Practitioner" means a physician licensed under  
 3968 chapter 458, a dentist licensed under chapter 466, a  
 3969 veterinarian licensed under chapter 474, an osteopathic  
 3970 physician licensed under chapter 459, an advanced practice  
 3971 registered nurse licensed under chapter 464, a naturopath  
 3972 licensed under chapter 462, a certified optometrist licensed  
 3973 under chapter 463, a psychiatric nurse as defined in s. 394.455,  
 3974 a podiatric physician licensed under chapter 461, an autonomous  
 3975 physician assistant registered under chapter 458 or chapter 459,  
 3976 or a physician assistant licensed under chapter 458 or chapter  
 3977 459, provided such practitioner holds a valid federal controlled  
 3978 substance registry number.

3979 Section 87. Subsection (6) of section 943.13, Florida  
 3980 Statutes, is amended to read:

3981 943.13 Officers' minimum qualifications for employment or  
 3982 appointment.—On or after October 1, 1984, any person employed or  
 3983 appointed as a full-time, part-time, or auxiliary law  
 3984 enforcement officer or correctional officer; on or after October  
 3985 1, 1986, any person employed as a full-time, part-time, or  
 3986 auxiliary correctional probation officer; and on or after  
 3987 October 1, 1986, any person employed as a full-time, part-time,  
 3988 or auxiliary correctional officer by a private entity under  
 3989 contract to the Department of Corrections, to a county  
 3990 commission, or to the Department of Management Services shall:

3991 (6) Have passed a physical examination by a licensed  
 3992 physician, registered autonomous physician assistant, licensed  
 3993 physician assistant, or licensed advanced practice registered  
 3994 nurse, based on specifications established by the commission. In  
 3995 order to be eligible for the presumption set forth in s. 112.18  
 3996 while employed with an employing agency, a law enforcement  
 3997 officer, correctional officer, or correctional probation officer  
 3998 must have successfully passed the physical examination required  
 3999 by this subsection upon entering into service as a law  
 4000 enforcement officer, correctional officer, or correctional  
 4001 probation officer with the employing agency, which examination  
 4002 must have failed to reveal any evidence of tuberculosis, heart  
 4003 disease, or hypertension. A law enforcement officer,  
 4004 correctional officer, or correctional probation officer may not

4005 use a physical examination from a former employing agency for  
 4006 purposes of claiming the presumption set forth in s. 112.18  
 4007 against the current employing agency.

4008 Section 88. Subsection (2) of section 945.603, Florida  
 4009 Statutes, is amended to read:

4010 945.603 Powers and duties of authority.—The purpose of the  
 4011 authority is to assist in the delivery of health care services  
 4012 for inmates in the Department of Corrections by advising the  
 4013 Secretary of Corrections on the professional conduct of primary,  
 4014 convalescent, dental, and mental health care and the management  
 4015 of costs consistent with quality care, by advising the Governor  
 4016 and the Legislature on the status of the Department of  
 4017 Corrections' health care delivery system, and by assuring that  
 4018 adequate standards of physical and mental health care for  
 4019 inmates are maintained at all Department of Corrections  
 4020 institutions. For this purpose, the authority has the authority  
 4021 to:

4022 (2) Review and make recommendations regarding health care  
 4023 for the delivery of health care services including, but not  
 4024 limited to, acute hospital-based services and facilities,  
 4025 primary and tertiary care services, ancillary and clinical  
 4026 services, dental services, mental health services, intake and  
 4027 screening services, medical transportation services, and the use  
 4028 of nurse practitioner, autonomous physician assistant, and  
 4029 physician assistant personnel to act as physician extenders as  
 4030 these relate to inmates in the Department of Corrections.

4031 Section 89. Paragraph (n) of subsection (1) of section  
 4032 948.03, Florida Statutes, is amended to read:

4033 948.03 Terms and conditions of probation.—

4034 (1) The court shall determine the terms and conditions of  
 4035 probation. Conditions specified in this section do not require  
 4036 oral pronouncement at the time of sentencing and may be  
 4037 considered standard conditions of probation. These conditions  
 4038 may include among them the following, that the probationer or  
 4039 offender in community control shall:

4040 (n) Be prohibited from using intoxicants to excess or  
 4041 possessing any drugs or narcotics unless prescribed by a  
 4042 physician, an advanced practice registered nurse, an autonomous  
 4043 physician assistant, or a physician assistant. The probationer  
 4044 or community controllee may not knowingly visit places where  
 4045 intoxicants, drugs, or other dangerous substances are unlawfully  
 4046 sold, dispensed, or used.

4047 Section 90. Subsection (34) of section 984.03, Florida  
 4048 Statutes, is amended to read:

4049 984.03 Definitions.—When used in this chapter, the term:

4050 (34) "Licensed health care professional" means a physician  
 4051 licensed under chapter 458, an osteopathic physician licensed  
 4052 under chapter 459, a nurse licensed under part I of chapter 464,  
 4053 an autonomous physician assistant or a physician assistant  
 4054 registered or licensed under chapter 458 or chapter 459, or a  
 4055 dentist licensed under chapter 466.

4056 Section 91. Subsection (30) of section 985.03, Florida

4057 Statutes, is amended to read:

4058 985.03 Definitions.—As used in this chapter, the term:

4059 (30) "Licensed health care professional" means a physician  
 4060 licensed under chapter 458, an osteopathic physician licensed  
 4061 under chapter 459, a nurse licensed under part I of chapter 464,  
 4062 an autonomous physician assistant or a physician assistant  
 4063 registered or licensed under chapter 458 or chapter 459, or a  
 4064 dentist licensed under chapter 466.

4065 Section 92. Paragraph (i) of subsection (3) of section  
 4066 1002.20, Florida Statutes, is amended to read:

4067 1002.20 K-12 student and parent rights.—Parents of public  
 4068 school students must receive accurate and timely information  
 4069 regarding their child's academic progress and must be informed  
 4070 of ways they can help their child to succeed in school. K-12  
 4071 students and their parents are afforded numerous statutory  
 4072 rights including, but not limited to, the following:

4073 (3) HEALTH ISSUES.—

4074 (i) Epinephrine use and supply.—

4075 1. A student who has experienced or is at risk for life-  
 4076 threatening allergic reactions may carry an epinephrine auto-  
 4077 injector and self-administer epinephrine by auto-injector while  
 4078 in school, participating in school-sponsored activities, or in  
 4079 transit to or from school or school-sponsored activities if the  
 4080 school has been provided with parental and physician  
 4081 authorization. The State Board of Education, in cooperation with  
 4082 the Department of Health, shall adopt rules for such use of

4083 epinephrine auto-injectors that shall include provisions to  
 4084 protect the safety of all students from the misuse or abuse of  
 4085 auto-injectors. A school district, county health department,  
 4086 public-private partner, and their employees and volunteers shall  
 4087 be indemnified by the parent of a student authorized to carry an  
 4088 epinephrine auto-injector for any and all liability with respect  
 4089 to the student's use of an epinephrine auto-injector pursuant to  
 4090 this paragraph.

4091         2. A public school may purchase a supply of epinephrine  
 4092 auto-injectors from a wholesale distributor as defined in s.  
 4093 499.003 or may enter into an arrangement with a wholesale  
 4094 distributor or manufacturer as defined in s. 499.003 for the  
 4095 epinephrine auto-injectors at fair-market, free, or reduced  
 4096 prices for use in the event a student has an anaphylactic  
 4097 reaction. The epinephrine auto-injectors must be maintained in a  
 4098 secure location on the public school's premises. The  
 4099 participating school district shall adopt a protocol developed  
 4100 by a licensed physician for the administration by school  
 4101 personnel who are trained to recognize an anaphylactic reaction  
 4102 and to administer an epinephrine auto-injection. The supply of  
 4103 epinephrine auto-injectors may be provided to and used by a  
 4104 student authorized to self-administer epinephrine by auto-  
 4105 injector under subparagraph 1. or trained school personnel.

4106         3. The school district and its employees, agents, and the  
 4107 physician who provides the standing protocol for school  
 4108 epinephrine auto-injectors are not liable for any injury arising



4109 from the use of an epinephrine auto-injector administered by  
 4110 trained school personnel who follow the adopted protocol and  
 4111 whose professional opinion is that the student is having an  
 4112 anaphylactic reaction:

4113 a. Unless the trained school personnel's action is willful  
 4114 and wanton;

4115 b. Notwithstanding that the parents or guardians of the  
 4116 student to whom the epinephrine is administered have not been  
 4117 provided notice or have not signed a statement acknowledging  
 4118 that the school district is not liable; and

4119 c. Regardless of whether authorization has been given by  
 4120 the student's parents or guardians or by the student's  
 4121 physician, autonomous physician assistant, physician ~~physician's~~  
 4122 assistant, or advanced practice registered nurse.

4123 Section 93. Paragraph (b) of subsection (17) of section  
 4124 1002.42, Florida Statutes, is amended to read:

4125 1002.42 Private schools.—

4126 (17) EPINEPHRINE SUPPLY.—

4127 (b) The private school and its employees, agents, and the  
 4128 physician who provides the standing protocol for school  
 4129 epinephrine auto-injectors are not liable for any injury arising  
 4130 from the use of an epinephrine auto-injector administered by  
 4131 trained school personnel who follow the adopted protocol and  
 4132 whose professional opinion is that the student is having an  
 4133 anaphylactic reaction:

4134 1. Unless the trained school personnel's action is willful

4135 and wanton;

4136 2. Notwithstanding that the parents or guardians of the  
 4137 student to whom the epinephrine is administered have not been  
 4138 provided notice or have not signed a statement acknowledging  
 4139 that the school district is not liable; and

4140 3. Regardless of whether authorization has been given by  
 4141 the student's parents or guardians or by the student's  
 4142 physician, autonomous physician assistant, physician ~~physician's~~  
 4143 assistant, or advanced practice registered nurse.

4144 Section 94. Paragraph (a) of subsection (1) and  
 4145 subsections (4) and (5) of section 1006.062, Florida Statutes,  
 4146 are amended to read:

4147 1006.062 Administration of medication and provision of  
 4148 medical services by district school board personnel.—

4149 (1) Notwithstanding the provisions of the Nurse Practice  
 4150 Act, part I of chapter 464, district school board personnel may  
 4151 assist students in the administration of prescription medication  
 4152 when the following conditions have been met:

4153 (a) Each district school board shall include in its  
 4154 approved school health services plan a procedure to provide  
 4155 training, by a registered nurse, a licensed practical nurse, or  
 4156 an advanced practice registered nurse licensed under chapter 464  
 4157 or by a physician, autonomous physician assistant, or physician  
 4158 assistant licensed or registered under ~~pursuant to~~ chapter 458  
 4159 or chapter 459, ~~or a physician assistant licensed pursuant to~~  
 4160 ~~chapter 458 or chapter 459~~, to the school personnel designated

4161 by the school principal to assist students in the administration  
 4162 of prescribed medication. Such training may be provided in  
 4163 collaboration with other school districts, through contract with  
 4164 an education consortium, or by any other arrangement consistent  
 4165 with the intent of this subsection.

4166 (4) Nonmedical assistive personnel shall be allowed to  
 4167 perform health-related services upon successful completion of  
 4168 child-specific training by a registered nurse or advanced  
 4169 practice registered nurse licensed under chapter 464 or a  
 4170 physician, autonomous physician assistant, or physician  
 4171 assistant licensed or registered under pursuant to chapter 458  
 4172 or chapter 459, or a physician assistant licensed pursuant to  
 4173 chapter 458 or chapter 459. All procedures shall be monitored  
 4174 periodically by a nurse, advanced practice registered nurse,  
 4175 autonomous physician assistant, physician assistant, or  
 4176 physician, including, but not limited to:

- 4177 (a) Intermittent clean catheterization.
- 4178 (b) Gastrostomy tube feeding.
- 4179 (c) Monitoring blood glucose.
- 4180 (d) Administering emergency injectable medication.

4181 (5) For all other invasive medical services not listed in  
 4182 this subsection, a registered nurse or advanced practice  
 4183 registered nurse licensed under chapter 464 or a physician,  
 4184 autonomous physician assistant, or physician assistant licensed  
 4185 or registered under pursuant to chapter 458 or chapter 459, ~~or a~~  
 4186 ~~physician assistant licensed pursuant to chapter 458 or chapter~~

4187 | ~~459~~ shall determine if nonmedical district school board  
 4188 | personnel shall be allowed to perform such service.

4189 | Section 95. Paragraph (c) of subsection (2) of section  
 4190 | 1006.20, Florida Statutes, is amended to read:

4191 | 1006.20 Athletics in public K-12 schools.—

4192 | (2) ADOPTION OF BYLAWS, POLICIES, OR GUIDELINES.—

4193 | (c) The FHSAA shall adopt bylaws that require all students  
 4194 | participating in interscholastic athletic competition or who are  
 4195 | candidates for an interscholastic athletic team to  
 4196 | satisfactorily pass a medical evaluation each year before ~~prior~~  
 4197 | ~~to~~ participating in interscholastic athletic competition or  
 4198 | engaging in any practice, tryout, workout, or other physical  
 4199 | activity associated with the student's candidacy for an  
 4200 | interscholastic athletic team. Such medical evaluation may be  
 4201 | administered only by a practitioner licensed or registered under  
 4202 | chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s.  
 4203 | 464.0123 and in good standing with the practitioner's regulatory  
 4204 | board. The bylaws shall establish requirements for eliciting a  
 4205 | student's medical history and performing the medical evaluation  
 4206 | required under this paragraph, which shall include a physical  
 4207 | assessment of the student's physical capabilities to participate  
 4208 | in interscholastic athletic competition as contained in a  
 4209 | uniform preparticipation physical evaluation and history form.  
 4210 | The evaluation form shall incorporate the recommendations of the  
 4211 | American Heart Association for participation cardiovascular  
 4212 | screening and shall provide a place for the signature of the

4213 practitioner performing the evaluation with an attestation that  
4214 each examination procedure listed on the form was performed by  
4215 the practitioner or by someone under the direct supervision of  
4216 the practitioner. The form shall also contain a place for the  
4217 practitioner to indicate if a referral to another practitioner  
4218 was made in lieu of completion of a certain examination  
4219 procedure. The form shall provide a place for the practitioner  
4220 to whom the student was referred to complete the remaining  
4221 sections and attest to that portion of the examination. The  
4222 preparticipation physical evaluation form shall advise students  
4223 to complete a cardiovascular assessment and shall include  
4224 information concerning alternative cardiovascular evaluation and  
4225 diagnostic tests. Results of such medical evaluation must be  
4226 provided to the school. A student is not eligible to  
4227 participate, as provided in s. 1006.15(3), in any  
4228 interscholastic athletic competition or engage in any practice,  
4229 tryout, workout, or other physical activity associated with the  
4230 student's candidacy for an interscholastic athletic team until  
4231 the results of the medical evaluation have been received and  
4232 approved by the school.

4233 Section 96. Subsection (1) of section 1009.65, Florida  
4234 Statutes, is amended to read:

4235 1009.65 Medical Education Reimbursement and Loan Repayment  
4236 Program.—

4237 (1) To encourage qualified medical professionals to  
4238 practice in underserved locations where there are shortages of

4239 such personnel, there is established the Medical Education  
 4240 Reimbursement and Loan Repayment Program. The function of the  
 4241 program is to make payments that offset loans and educational  
 4242 expenses incurred by students for studies leading to a medical  
 4243 or nursing degree, medical or nursing licensure, ~~or~~ advanced  
 4244 practice registered nurse licensure, autonomous physician  
 4245 assistant registration, or physician assistant licensure. The  
 4246 following licensed or certified health care professionals are  
 4247 eligible to participate in this program: medical doctors with  
 4248 primary care specialties, doctors of osteopathic medicine with  
 4249 primary care specialties, autonomous physician assistants,  
 4250 physician ~~physician's~~ assistants, licensed practical nurses and  
 4251 registered nurses, and advanced practice registered nurses with  
 4252 primary care specialties such as certified nurse midwives.  
 4253 Primary care medical specialties for physicians include  
 4254 obstetrics, gynecology, general and family practice, internal  
 4255 medicine, pediatrics, and other specialties which may be  
 4256 identified by the Department of Health.

4257 Section 97. For the 2020-2021 fiscal year, four full-time  
 4258 equivalent positions with associated salary rate of 166,992 are  
 4259 authorized and the sums of \$643,659 in recurring and \$555,200 in  
 4260 nonrecurring funds from the Health Care Trust Fund are  
 4261 appropriated to the Agency for Health Care Administration for  
 4262 the purpose of implementing sections 400.52, 408.064, and  
 4263 408.822, Florida Statutes, as created by this act.

4264 Section 98. For the 2020-2021 fiscal year, 3.5 full-time

4265 equivalent positions with associated salary rate of 183,895 are  
4266 authorized and the sums of \$219,089 in recurring funds and  
4267 \$17,716 in nonrecurring funds from the Medical Quality Assurance  
4268 Trust Fund are appropriated to the Department of Health for the  
4269 purpose of implementing section 464.0123, Florida Statutes, as  
4270 created by this act.

4271 Section 99. 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                                          

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1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Yarborough offered the following:

4

5 **Amendment (with title amendment)**

6 Remove lines 559-605 and insert:

7 Home Health Program for the purpose of awarding home health  
8 agencies or nurse registries that meet the criteria specified in  
9 this section.

10 (2) (a) The agency shall adopt rules establishing criteria  
11 for the program which must include, at a minimum, meeting  
12 standards relating to:

13 1. Patient or client satisfaction.

14 2. Patients or clients requiring emergency care for wound  
15 infections.

PCS for CSHB 7053 a1

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Amendment No. 1

16 3. Patients or clients admitted or readmitted to an acute  
17 care hospital.

18 4. Patient or client improvement in the activities of  
19 daily living.

20 5. Employee satisfaction, as applicable.

21 6. Quality of employee training, as applicable.

22 7. Employee retention rates, as applicable.

23 8. High performance under federal Medicaid electronic  
24 visit verification requirements, as applicable.

25 (b) The agency must annually evaluate home health agencies  
26 and nurse registries seeking the award which apply on a form and  
27 in the manner designated by rule.

28 (3) The home health agency or nurse registry must:

29 (a) Be actively licensed and operating for at least 24  
30 months to be eligible to apply for a program award. An award  
31 under the program is not transferrable to another license,  
32 except when the existing home health agency or nurse registry is  
33 being relicensed in the name of an entity related to the current  
34 licenseholder by common control or ownership, and there will be  
35 no change in the management, operation, or programs of the home  
36 health agency or nurse registry as a result of the relicensure.

37 (b) Have had no licensure denials, revocations, or any  
38 Class I, Class II, or uncorrected Class III deficiencies within  
39 the 24 months preceding the application for the program award.

PCS for CSHB 7053 a1

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Amendment No. 1

40       (4) The award designation shall expire on the same date as  
41 the home health agency's or nurse registry's license. A home  
42 health agency or nurse registry must reapply and be approved for  
43 the award designation to continue using the award designation in  
44 the manner authorized under subsection (5).

45       (5) A home health agency or nurse registry that is awarded  
46 under the program may use the designation in advertising and  
47 marketing. A home health agency or nurse registry may not use  
48 the award designation in any advertising or marketing if the  
49 home health agency or nurse registry:

50       (a) Has not been awarded the designation;

51       (b) Fails to renew the award upon expiration of the award  
52 designation;

53       (c) Has undergone a change in ownership that does not  
54 qualify for an exception under paragraph (3) (a); or

55       (d) Has been notified that it no longer meets the criteria  
56 for the award upon reapplication after expiration of the award  
57 designation.

58  
59       -----

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

61       Remove lines 36-41 and insert:

62       annually evaluate certain home health agencies and nurse  
63       registries that apply for a program award; providing eligibility  
64       requirements; requiring an agency to reapply biennially for the

COMMITTEE/SUBCOMMITTEE AMENDMENT  
Bill No. PCS for CS/HB 7053 (2020)

Amendment No. 1

65 | award designation; authorizing an award recipient to use the  
66 | designation in advertising and marketing; prohibiting a home  
67 | health agency or nurse registry from

PCS for CSHB 7053 a1

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Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health & Human Services  
2 Committee

3 Representative Pigman offered the following:

4

5 **Amendment**

6 Remove lines 1124-1128 and insert:

7 States, at least 2,000 clinical practice hours within the 5  
8 years immediately preceding the submission of the registration  
9 request while practicing as a physician assistant under the  
10 supervision of an allopathic or osteopathic physician who held  
11 an active, unencumbered license issued by any state, the

12 Remove line 1427 and insert:

13 States, at least 2,000 clinical practice hours within the 5