Health & Human Services Committee

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

Meeting Packet

Jose Oliva
Speaker

Ray Rodrigues
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time: Wednesday, February 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.[1] The Board of Pharmacy (board), in conjunction with the Department of Health (DOH), regulates the practice of pharmacists pursuant to ch. 465, F.S.[2] To be licensed as a pharmacist in Florida, a person must:[3]

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;[4]
- Have completed a board-approved internship; and
- Successfully complete the board-approved examination.

A pharmacist must complete at least 30 hours of board-approved continuing education during each biennial renewal period.[5] Pharmacists who are certified to administer vaccines or epinephrine autoinjections must complete a 3-hour continuing education course on the safe and effective administration of vaccines and epinephrine injections as a part of the biennial licensure renewal.[6] Pharmacists who administer long-acting antipsychotic medications must complete an approved 8-hour continuing education course as a part of the continuing education for biennial licensure renewal.[7]

Pharmacist Scope of Practice

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

- Compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of a medicinal drug;
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations;
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy, including the review of the patient's drug therapy and communication with the patient's prescribing health care provider or other persons specifically authorized by the patient, regarding the drug therapy;
- Transmitting information from prescribers to their patients;
- Preparing prepackaged drug products in facilities holding Class III institutional facility permits;[9]
- Administering vaccines to adults;[10]
- Administering epinephrine injections;[11] and

[1] American Association of Colleges of Pharmacy, *About AACP*, available at https://www.aacp.org/about-aacp (last visited October 30, 2019).
[2] Sections 465.004 and 465.005, F.S.
[3] Section 465.007, F.S. The DOH may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[4] If the applicant has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, the applicant must demonstrate proficiency in English, pass the board-approved Foreign Pharmacy Graduate Equivalency Examination, and complete a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a DOH-licensed pharmacist
[5] Section 465.009, F.S.
[6] Section 465.009(6), F.S.
[7] Section 465.1893, F.S.
[8] Section 465.003(13), F.S.
[9] A Class III institutional pharmacy are those pharmacies affiliated with a hospital. *See* s. 465.019(2)(d), F.S.
[10] *See* s. 465.189, F.S.

- Administering antipsychotic medications by injection.[12]

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

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

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

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

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

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

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

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

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

Pharmacist Administration of Vaccines and Injections

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

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

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

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

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

Pharmacist Administration of Antipsychotic Medication by Injection

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

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

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

Diagnostic Tests for Influenza and Streptococcus

Influenza

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

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

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

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

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

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

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

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

Streptococcus Testing

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

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

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

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

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

Reporting of Diseases to DOH

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

Effect of Proposed Changes

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

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

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

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

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

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

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

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

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

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

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

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

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

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

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

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

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

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

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

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

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

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

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

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

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

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

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

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

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

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

465.1895 Testing for and treatment of influenza and

streptococcus.—

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

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

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

(c) The pharmacist uses a testing system that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Sirois offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

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

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

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

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

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

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

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

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

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

465.1865 Collaborative pharmacy practice for chronic health conditions.—

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

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

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

1. Arthritis;

2. Asthma;

3. Congestive heart failure;

4. Chronic obstructive pulmonary diseases;

5. Diabetes;

6. Emphysema;

7. Human immunodeficiency virus or acquired immunodeficiency syndrome;

8. Hypertension;

9. Obesity;

10. Renal disease; or

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

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

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

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

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

1. Performance of patient assessments.

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

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

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

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

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

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

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

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

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

2. Each chronic disease to be collaboratively managed.

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

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

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

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

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

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

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

(4) A pharmacist may not:

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

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

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

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

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

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

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

465.189 Administration of vaccines and epinephrine autoinjection.—

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

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

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

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

(b) ~~(c)~~ Immunizations or vaccines approved by the board in response to a state of emergency declared by the Governor pursuant to s. 252.36.

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

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

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

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

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

465.1893 Administration of antipsychotic medication by injection.—

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

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

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

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

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

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

2. A statewide association of pharmacists.

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

465.1895 Testing or screening for and treatment of minor, nonchronic health conditions.—

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

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

(a) Influenza.

(b) Streptococcus.

(c) Lice.

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

(e) Minor, uncomplicated infections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. 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.

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

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

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

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

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

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

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

and conditions of such agreement to be appropriate to the training of the pharmacist and the scope of practice of the physician; requiring notification to the board upon practicing under a collaborative pharmacy practice agreement; requiring pharmacists to submit a copy of the signed collaborative practice agreement to the Board of Pharmacy; providing for the maintenance of patient records for a certain period of time; providing for renewal of such agreement; requiring a pharmacist and the collaborating physician to maintain on file and make available the collaborative pharmacy practice agreement; prohibiting certain actions relating to the collaborative pharmacy practice agreement; requiring specified continuing education for a pharmacist who practices under a collaborative pharmacy practice agreement; requiring the Board of Pharmacy to adopt rules; amending s. 465.189, F.S.; revising the recommended immunizations or vaccines a pharmacist, or a registered intern under certain conditions, may administer; authorizing a certified pharmacist to administer the influenza vaccine to specified individuals; amending s. 465.1893, F.S.; authorizing pharmacists who meet certain requirements to administer certain extended release medications; creating s. 465.1895, F.S.; requiring the board to identify minor, nonchronic health conditions that a pharmacist may test or screen for and treat; providing requirements for a pharmacist to test or screen for and treat minor, nonchronic health conditions; requiring the

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

HB 563

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.[1] Transplantable tissue include skin used as a temporary dressing for burns, serious abrasions and other exposed areas; heart valves used to replace defective valves; tendons used to repair torn ligaments on knees or other joints; veins used in cardiac by-pass surgery; corneas used to restore sight; and bone used in orthopedic surgery to facilitate healing of fractures or prevent amputation.[2]

A single person can save up to eight lives through organ donation, and dozens more lives may be improved through tissue donation.[3] While most organ and tissue donations occur after the donor has died, some organs, including a kidney or part of a liver or lung, and tissues can be donated while the donor is alive.[4] There are about as many living donors every year as there are deceased donors.[5]

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

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

[1] Donate Life Florida, *Frequently Asked Questions,* https://www.donatelifeflorida.org/categories/donation/ (last visited Jan. 24, 2020).
[2] Id.
[3] Id.
[4] U.S. Government Information on Organ Donation and Transplantation, U.S. Department of Health & Human Services, *How Organ Donation Works,* https://organdonor.gov/about/process.html (last visited Jan. 24, 2020).
[5] Id.
[6] Organ Procurement and Transplantation Network, U.S. Department of Health & Human Services, https://optn.transplant.hrsa.gov/ (last visited Jan. 24, 2020).
[7] Id.
[8] *Supra,* note 1.
[9] Id.
[10] U.S. Department of Health and Human Services, *Organ Procurement and Transplantation Network – About the OPTN,* https://optn.transplant.hrsa.gov/governance/about-the-optn/ (last visited Jan. 24, 2020).
[11] Id.
[12] U.S. Government Information on Organ Donation and Transplantation, U.S. Department of Health & Human Services, *The Organ Transplant Process*, https://organdonor.gov/about/process/transplant-process.html (last visited Jan. 24, 2020).
[13] Donate Life Florida, *Organ Procurement Organizations and Transplant Centers*, https://www.donatelifeflorida.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.[14] The NOTA prohibits human organs, including tissue, eyes, and corneas, from being bought or sold.[15]

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)[16] which engage in the retrieval, recovery, processing, storage, or distribution of human organs or tissues for transplantation, therapy, research, or education.[17] Currently, 155 procurement organizations are certified by AHCA, 24 of which are eye banks 127 are tissue banks, and four are OPOs.[18]

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

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.[22]

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,[23] punishable by up to 30 years in prison and/or a fine up to $10,000.[24] The interaction of these provisions with the OPO certification statute,[25] 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.[26] 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.[27]

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[14] Organ Procurement and Transplantation Network, U.S. Department of Health & Human Services, *The Basic Path of Donation*, https://optn.transplant.hrsa.gov/learn/about-donation/the-basic-path-of-donation/ (last visited Jan. 24, 2020).
[15] 42 U.S.C. 274e.
[16] Agency for Health Care Administration, Agency Analysis of 2020 SB 798, p. 2 (Jan. 21, 2020). *See also* s. 765.511, F.S.
[17] S 765.511(15), F.S.
[18] *Supra,* note 16.
[19] Id.
[20] Id.
[21] Id.
[22] 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).
[23] S. 873.01, F.S.
[24] Ss. 775.082, 775.083, and 775.084, F.S.
[25] S. 765.542, F.S.
[26] 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).
[27] 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.[28] The current annual assessment fee for eye banks is $500.[29]

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.

[28] *Supra,* note 16, at 3.
[29] 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

A bill to be entitled

An act relating to the procurement of human organs and tissue; amending s. 873.01, F.S.; prohibiting for-profit entities from procuring certain human organs and tissue, with certain exceptions; amending s. 765.542, F.S.; prohibiting for-profit entities from procuring certain human organs and tissue, with certain exceptions; providing an effective date.

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

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

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

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

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

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

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

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

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

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

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

CS/HB 607

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.

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.[1] 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).[2]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[3] and ongoing efforts to expand access.[4] 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.[5] 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.[6] It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.[7]

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.[8] In 2018, there were 277.8 physicians[9] 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.[10] The states with the highest number of

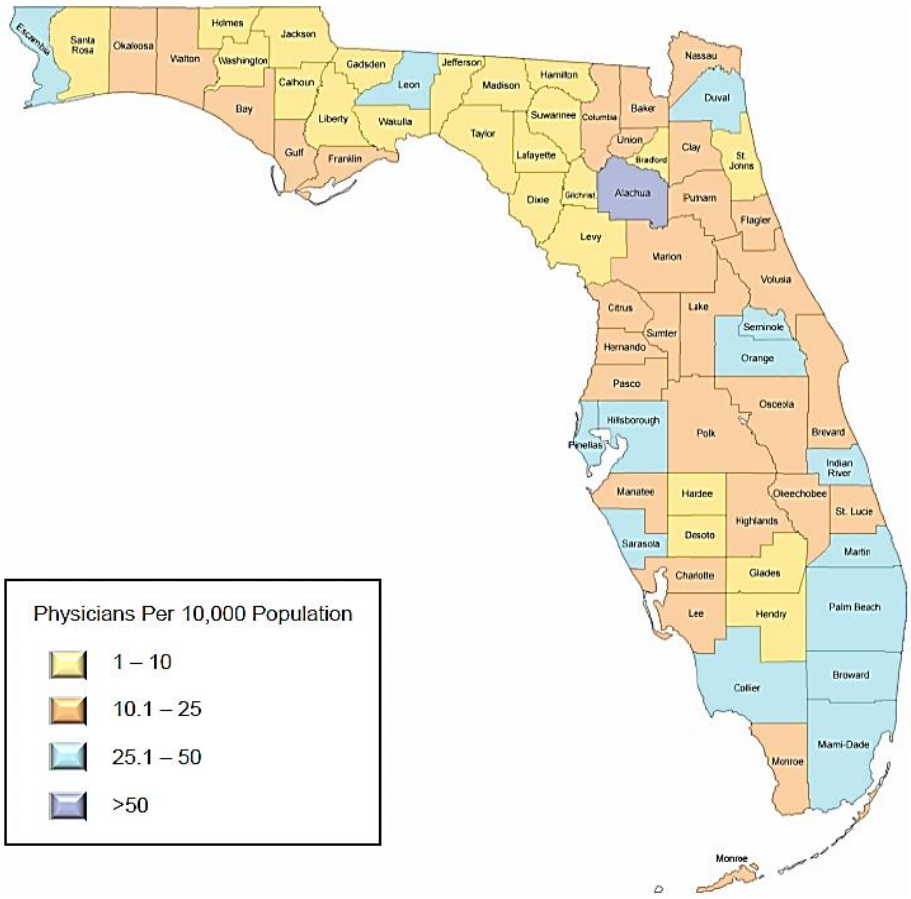
[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Dec. 31, 2019), available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited February 20, 2020). Click on "Designated HPSA Quarterly Summary" to access the report.
[2] Id.
[3] 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."
[4] 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 (last visited February 20, 2020).
[5] Id.
[6] *Supra* note 1.
[7] Id.
[8] *Supra* note 4.
[9] These totals include allopathic and osteopathic physicians.
[10] 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.[11]

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.[12] Although Florida is the third most populous state in the nation,[13] it ranks as having the 23rd highest physician to population ratio.[14] 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.[15]

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.[16] Additionally, 35 percent of practicing physicians are age 60 and older.[17]

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.[18]

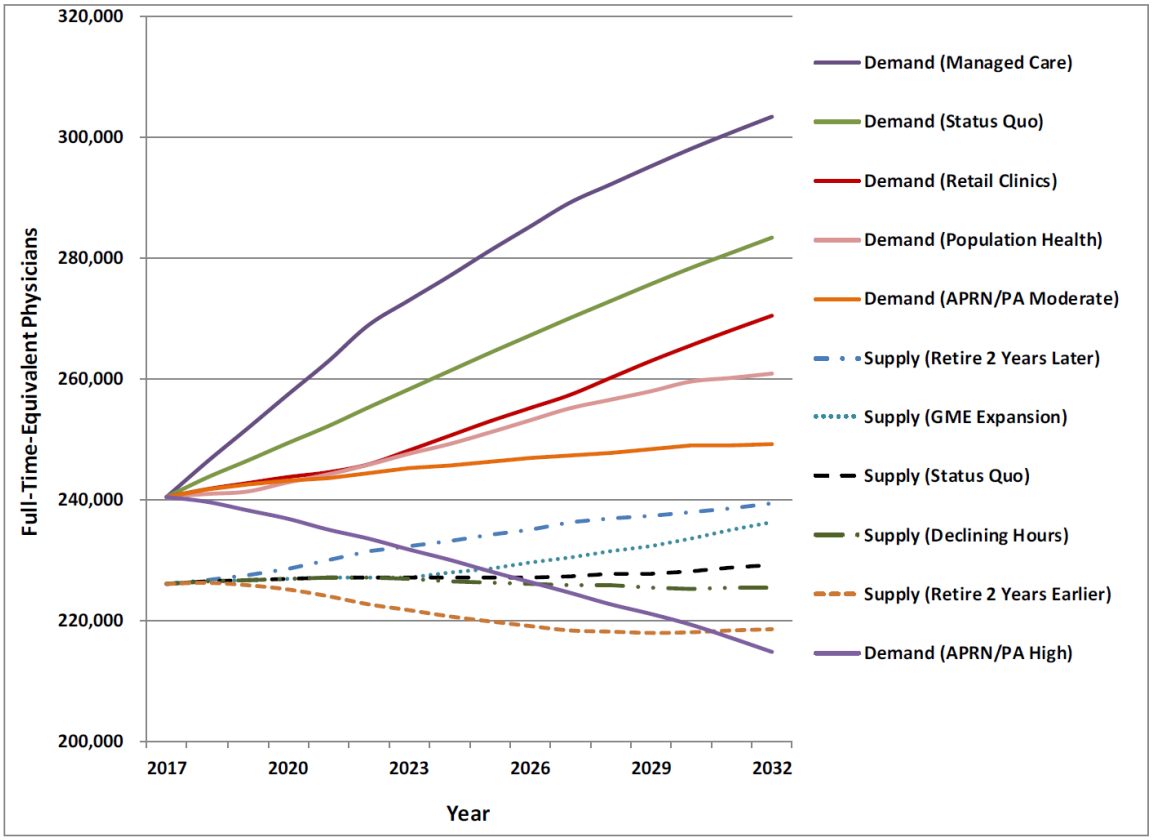


[11] Id.
[12] *Supra* note 10, at pp. 7-8
[13] As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 21,299,325 residents, behind California (39,557,045) and Texas (28,701,845). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on February 21, 2020).
[14] *Supra* note 10, at pp. 7-8.
[15] *Supra* note 10, at pp. 12-13.
[16] 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).
[17] Id. at p. 9.
[18] Id. at p. 42.

The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.[19] Currently, primary care physicians make up 28 percent of the physician workforce.[20] 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.[21] 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.[22]

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.[23]

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).[24] 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.[25]

[19] *Supra* note 4. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.
[20] Id. at p. 45.
[21] Id. at p. 46.
[22] Id at p. 18.
[23] Id.
[24] *Supra* note 16 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.
[25] Id at p. 25.

Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNPs), 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.[26] There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.[27]

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.[28] 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.[29] The Florida Center for Nursing Center) estimates that in 2016 and 2017, the number of APRNs who are actually working is 22,795,[30] and the number of RNs who are actually working is 208,870.[31] 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[32] and 39 percent of the state's APRNs[33] are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.[34]

Physician Assistant Workforce

In Florida, there are approximately 9,784 actively licensed physician assistants (PAs),[35] 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.[36] On average, a full-time PA sees 83 patients a week.[37]

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[26] 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).
[27] 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 (last visited on February 21, 2020) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.
[28] 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).
[29] 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 (last visited February 21, 2020).
[30] 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 (last visited on February 21, 2020).
[31] 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 (last visited on February 21, 2020).
[32] *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.
[33] *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.
[34] 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 (last visited on November 20, 2019).
[35] *Supra* note 28.
[36] 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.
[37] Id at p. 47.

Advanced Practice Nurses

Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)[38] 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).[39] As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.[40]

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.[41] 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.[42]

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.[43] A nursing specialty board must:[44]

- 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.[45] By comparison, physicians must establish some method of financial

[38] Section 464.003(3), F.S.
[39] 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.
[40] Email correspondence from DOH dated November 25, 2019, on file with committee staff.
[41] Section 464.012(3)-(4), F.S.
[42] Section 464.003, F.S., and s. 464.012, F.S.
[43] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.
[44] Rule 64B9-4.002(3), F.A.C.
[45] 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.[46]

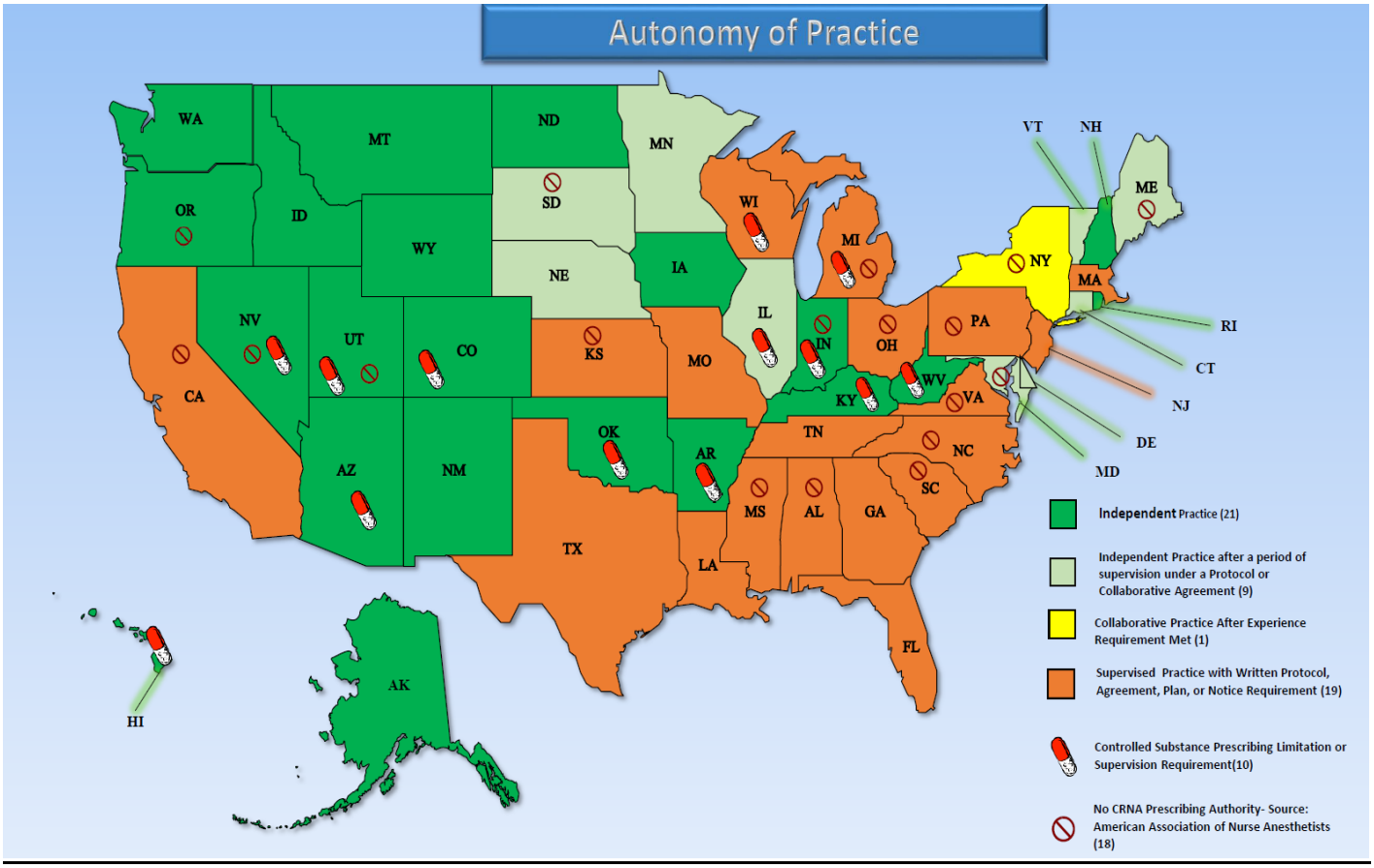
Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, HB 423 eliminated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

APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:[48]

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.

[46] 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.
[47] Chapter 2016-224, Laws of Fla.
[48] 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.[49] 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.[50]

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,[51] in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices

[49] 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).
[50] 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).
[51] 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.[52] 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.[53]

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.[54] In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017. [55] The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,[56] as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.[57] 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.[58] 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.[59] 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;[60];
- 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

[52] Sections 458.348, and 459.025, F.S.
[53] *Id*.
[54] *Supra* note 48. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.
[55] Chapter 2016-224, Laws of Fla.
[56] 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.
[57] *Supra* note 48.
[58] 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.
[59] 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.
[60] 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.[61]

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.[62]

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APRNs provide a different quality of care than physicians,[63] 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:[64]

- 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.[65]

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.[66] 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,

[61] Sections 464.012(3),(4), and 464.003, F.S.
[62] Sections 394.463(2) and 382.008, F.S.
[63] 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).
[64] 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).
[65] 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).
[66] 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.[67]

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.[68]

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.[69] The report estimated savings of $16.1 billion in total expenditures and $8 billion in output (gross product) each year.[70] 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.[71]

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.[72] 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).[73]

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.[74] 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.[75]

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.[76] 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.[77] 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.[78]

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[67] 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 (last visited on February 21, 2020).
[68] 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%20Ultilization%20Economic%20Impact%20Report%20May%202012.pdf (last visited on February 21, 2020).
[69] Id.
[70] Id.
[71] Id.
[72] *Supra* note 67.
[73] Id.
[74] 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).
[75] Id.
[76] 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).
[77] Id.
[78] 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.[79] Two of the physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:[80]

- 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:[81]

- 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;[82]
- 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.[83] 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.[84]

[79] 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.
[80] Id,
[81] Sections 458.347(7) and 459.022(7), F.S.
[82] Section 456.0135, F.S.
[83] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[84] 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.[85] Many programs require students to have health care experience as a condition for admission.[86] PA students receive classroom training in:[87]

- 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.[88] A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.[89]

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.[90] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[91] 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.[92]

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.[93]

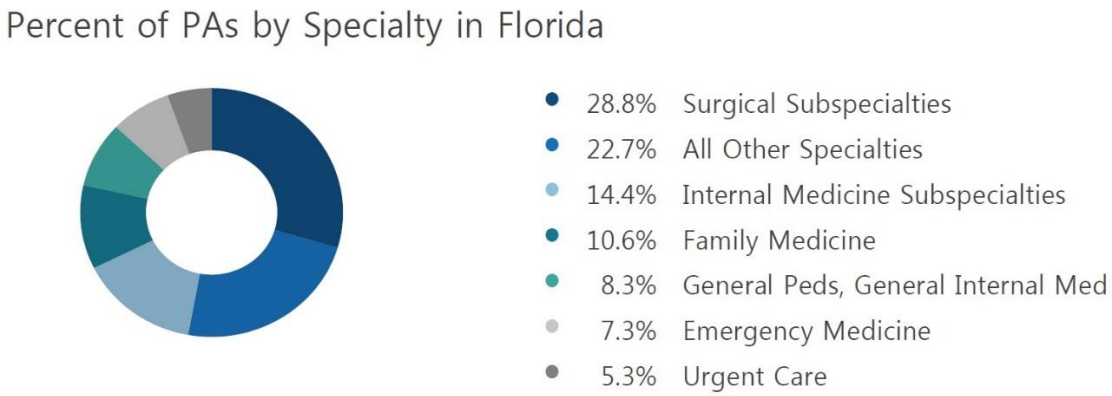
[85] American Academy of PAs, *Become a PA*, available at https://www.aapa.org/career-central/become-a-pa/ (last visited February 21, 2020).
[86] Id.
[87] Id.
[88] Id.
[89] Id.
[90] Sections 458.347(2)(f) and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[91] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[92] Sections 458.347(15) and 459.022(15), F.S.
[93] 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.[94] 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;[95]
- 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.;[96] 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.[97]

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.[98] Approximately 19 percent of Florida-licensed PAs practice primary care, but may also practice in other disciplines of medical practice:[99]



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.[100] DOH must review each report to determine if discipline against the PA's license is warranted.[101]

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:[102]

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[94] "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.
[95] 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.
[96] 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.
[97] Sections 458.347(4) and 459.022(e), F.S.
[98] *Supra* note 36.
[99] American Academy of PAs, *Florida Practice Profile*, available at https://www.aapa.org/wp-content/uploads/2016/12/PAs_In_Florida.pdf (last visited March 14, 2019).
[100] Sections 458.351 and 459.026, F.S.
[101] Sections 458.351(5) and 459.026(5), F.S.
[102] 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.[103] 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.[104] Additionally, the study noted that PAs provided more health education services than primary care physicians.[105]

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.[106]

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.[107]

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.

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[103] 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/lww-medicalcare/Abstract/2017/06000/A_Comparison_of_Nurse_Practitioners,_Physician.11.aspx (last visited February 21, 2020).
[104] Id.
[105] Id.
[106] 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).
[107] *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.[108] 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.

[108] 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.;[109]
- 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.[110] 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:

[109] This includes ambulatory surgical centers, hospitals, and nursing homes.
[110] *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[111] and the Good Samaritan Act;[112]
- 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.

[111] Section 766.103, F.S.
[112] 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 Ac; 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:

Function	*FTE Request and Description*	*Salary Rate*	*Salary/Expenses/ HR Transfer*	*NR Expenses*	*Total For Function*
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
Total	**3.50**	**183,895**	**$ 219,089**	**$ 17,716**	**$ 236,805**

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.

A bill to be entitled

An act relating to health care practitioners; amending s. 456.0391, F.S.; requiring an autonomous physician assistant to submit certain information to the Department of Health; requiring the department to send a notice to autonomous physician assistants regarding the required information; requiring autonomous physician assistants who have submitted required information to update such information in writing; providing penalties; amending s. 456.041, F.S.; requiring the department to provide a practitioner profile for an autonomous physician assistant; amending ss. 458.347 and 459.022, F.S.; defining the term "autonomous physician assistant"; authorizing third-party payors to reimburse employers for services provided by autonomous physician assistants; deleting a requirement that a physician assistant must inform a patient of a right to see a physician before prescribing or dispensing a prescription; revising the requirements for physician assistant education and training programs; authorizing the Board of Medicine to impose certain penalties upon an autonomous physician assistant; requiring the board to register a physician assistant as an autonomous physician assistant if the applicant meets certain criteria;

providing requirements; providing exceptions; requiring the department to distinguish such autonomous physician assistants' licenses; authorizing such autonomous physician assistants to perform specified acts without physician supervision or supervisory protocol; requiring biennial registration renewal; requiring the Council on Physician Assistants to establish rules; revising the membership and duties of the council; prohibiting a person who is not registered as an autonomous physician assistant from using the title; providing for the denial, suspension, or revocation of the registration of an autonomous physician assistant; requiring the board to adopt rules; requiring autonomous physician assistants to report adverse incidents to the department; amending s. 464.012, F.S.; requiring applicants for registration as an advanced practice registered nurse to apply to the Board of Nursing; authorizing an advanced practice registered nurse to sign, certify, stamp, verify, or endorse a document that requires the signature, certification, stamp, verification, affidavit, or endorsement of a physician within the framework of an established protocol; providing an exception; creating s. 464.0123, F.S.; defining the term "autonomous practice"; providing for the

registration of an advanced practice registered nurse to engage in autonomous practice; providing registration requirements; requiring the department to distinguish such advanced practice registered nurses' licenses and include the registration in their practitioner profiles; authorizing such advanced practice registered nurses to perform specified acts without physician supervision or supervisory protocol; requiring biennial registration renewal and continuing education; authorizing the Board of Nursing to establish an advisory committee to determine the medical acts that may be performed by such advanced practice registered nurses; providing for appointment and terms of committee members; requiring the board to adopt rules; creating s. 464.0155, F.S.; requiring advanced practice registered nurses registered to engage in autonomous practice to report adverse incidents to the Department of Health; providing requirements; defining the term "adverse incident"; providing for department review of such reports; authorizing the department to take disciplinary action; amending s. 464.018, F.S.; providing additional grounds for denial of a license or disciplinary action for advanced practice registered nurses registered to engage in autonomous practice;

amending s. 39.01, F.S.; revising the definition of the term "licensed health care professional" to include an autonomous physician assistant; amending s. 39.303, F.S.; authorizing a specified autonomous physician assistant to review certain cases of abuse or neglect and standards for face-to-face medical evaluations by a Child Protection Team; amending s. 39.304, F.S.; authorizing an autonomous physician assistant to perform or order an examination and diagnose a child without parental consent under certain circumstances; amending s. 110.12315, F.S.; revising requirements for reimbursement of pharmacies for specified prescription drugs and supplies under the state employees' prescription drug program; amending s. 252.515, F.S.; providing immunity from civil liability for an autonomous physician assistant under the Postdisaster Relief Assistance Act; amending ss. 310.071, 310.073, and 310.081, F.S.; authorizing an autonomous physician assistant and a physician assistant to administer the physical examination required for deputy pilot certification and state pilot licensure; authorizing an applicant for a deputy pilot certificate or a state pilot license to use controlled substances prescribed by an autonomous physician assistant; amending s. 320.0848, F.S.;

authorizing an autonomous physician assistant to certify that a person is disabled to satisfy requirements for certain permits; amending s. 381.00315, F.S.; providing for the temporary reactivation of the registration of an autonomous physician assistant in a public health emergency; amending s. 381.00593, F.S.; revising the definition of the term "health care practitioner" to include an autonomous physician assistant for purposes of the Public School Volunteer Health Care Practitioner Act; amending s. 381.026, F.S.; revising the definition of the term "health care provider" to include an advanced practice registered nurse and an autonomous physician assistant for purposes of the Florida Patient's Bill of Rights and Responsibilities; amending s. 382.008, F.S.; authorizing an autonomous physician assistant, a physician assistant, and an advanced practice registered nurse to file a certificate of death or fetal death under certain circumstances; authorizing a certified nurse midwife to provide certain information to the funeral director within a specified time period; replacing the term "primary or attending physician" with "primary or attending practitioner"; defining the term "primary or attending practitioner"; amending s. 382.011, F.S.; conforming a provision to

changes made by the act; amending s. 383.14, F.S.; authorizing the release of certain newborn tests and screening results to an autonomous physician assistant; revising the definition of the term "health care practitioner" to include an autonomous physician assistant for purposes of screening for certain disorders and risk factors; amending s. 390.0111, F.S.; authorizing a certain action by an autonomous physician assistant before an abortion procedure; amending s. 390.012, F.S.; authorizing certain actions by an autonomous physician assistant during and after an abortion procedure; amending s. 394.463, F.S.; authorizing an autonomous physician assistant, a physician assistant, and an advanced practice registered nurse to initiate an involuntary examination for mental illness under certain circumstances; authorizing a physician assistant to examine a patient; amending s. 395.0191, F.S.; providing an exception to certain onsite medical direction requirements for a specified advanced practice registered nurse; amending 395.602, F.S.; authorizing the Department of Health to use certain funds to increase the number of autonomous physician assistants in rural areas; amending s. 397.501, F.S.; prohibiting the denial of certain services to an

individual who takes medication prescribed by an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse; amending ss. 397.679 and 397.6793, F.S.; authorizing an autonomous physician assistant to execute a certificate for emergency admission of a person who is substance abuse impaired; amending s. 400.021, F.S.; revising the definition of the term "geriatric outpatient clinic" to include a site staffed by an autonomous physician assistant; amending s. 400.172, F.S.; authorizing an autonomous physician assistant and an advanced practice registered nurse to provide certain medical information to a prospective respite care resident; amending s. 400.487, F.S.; authorizing an autonomous physician assistant to establish treatment orders for certain patients under certain circumstances; amending s. 400.506, F.S.; requiring an autonomous physician assistant to comply with specified treatment plan requirements; amending ss. 400.9973, 400.9974, 400.9976, and 400.9979, F.S.; authorizing an autonomous physician assistant to prescribe client admission to a transitional living facility and care for such client, order treatment plans, supervise and record client medications, and order physical and chemical restraints, respectively; amending s.

401.445, F.S.; prohibiting recovery of damages in court against a registered autonomous physician assistant under certain circumstances; requiring an autonomous physician assistant to attempt to obtain a person's consent before providing emergency services; amending ss. 409.906 and 409.908, F.S.; authorizing the agency to reimburse an autonomous physician assistant for providing certain optional Medicaid services; amending s. 409.973, F.S.; requiring managed care plans to cover autonomous physician assistant services; amending s. 429.26, F.S.; prohibiting autonomous physician assistants from having a financial interest in the assisted living facility at which they are employed; authorizing an autonomous physician assistant to examine an assisted living facility resident before admission; amending s. 429.918, F.S.; revising the definition of the term "ADRD participant" to include a participant who has a specified diagnosis from an autonomous physician assistant; authorizing an autonomous physician assistant to provide signed documentation to an ADRD participant; amending s. 440.102, F.S.; authorizing an autonomous physician assistant to collect a specimen for a drug test for specified purposes; amending s. 456.053, F.S.; revising definitions; authorizing an

advanced practice registered nurse registered to engage in autonomous practice and an autonomous physician assistant to make referrals under certain circumstances; conforming a cross-reference; amending s. 456.072, F.S.; providing penalties for an autonomous physician assistant who prescribes or dispenses a controlled substance in a certain manner; amending s. 456.44, F.S.; revising the definition of the term "registrant" to include an autonomous physician assistant for purposes of controlled substance prescribing; providing requirements for an autonomous physician assistant who prescribes controlled substances for the treatment of chronic nonmalignant pain; amending ss. 458.3265 and 459.0137, F.S.; requiring an autonomous physician assistant to perform a physical examination of a patient at a pain-management clinic under certain circumstances; amending ss. 458.331 and 459.015, F.S.; providing grounds for denial of a license or disciplinary action against an autonomous physician assistant for certain violations; amending s. 464.003, F.S.; revising the definition of the term "practice of practical nursing" to include an autonomous physician assistant for purposes of authorizing such assistant to supervise a licensed practical nurse; amending s. 464.0205, F.S.;

authorizing an autonomous physician assistant to directly supervise a certified retired volunteer nurse; amending s. 480.0475, F.S.; authorizing the operation of a massage establishment during specified hours if the massage therapy is prescribed by an autonomous physician assistant; amending s. 493.6108, F.S.; authorizing an autonomous physician assistant to certify the physical fitness of a certain class of applicants to bear a weapon or firearm; amending s. 626.9707, F.S.; prohibiting an insurer from refusing to issue and deliver certain disability insurance that covers any medical treatment or service furnished by an autonomous physician assistant or an advanced practice registered nurse; amending s. 627.357, F.S.; revising the definition of the term "health care provider" to include an autonomous physician assistant for purposes of medical malpractice self-insurance; amending s. 627.736, F.S.; requiring personal injury protection insurance to cover a certain percentage of medical services and care provided by specified health care providers; providing for specified reimbursement of advanced practice registered nurses registered to engage in autonomous practice or autonomous physician assistants; amending s. 633.412, F.S.; authorizing an autonomous physician assistant to medically examine an

applicant for firefighter certification; amending s. 641.495, F.S.; requiring certain health maintenance organization documents to disclose that certain services may be provided by autonomous physician assistants or advanced practice registered nurses; amending s. 744.2006, F.S.; authorizing an autonomous physician assistant to carry out guardianship functions under a contract with a public guardian; conforming terminology; amending s. 744.331, F.S.; authorizing an autonomous physician assistant or a physician assistant to be an eligible member of an examining committee; conforming terminology; amending s. 744.3675, F.S.; authorizing an advanced practice registered nurse, autonomous physician assistant, or physician assistant to provide the medical report of a ward in an annual guardianship plan; amending s. 766.103, F.S.; prohibiting recovery of damages against an autonomous physician assistant under certain conditions; amending s. 766.105, F.S.; revising the definition of the term "health care provider" to include an autonomous physician assistants for purposes of the Florida Patient's Compensation Fund; amending ss. 766.1115 and 766.1116, F.S.; revising the definitions of the terms "health care provider" and "health care practitioner," respectively, to include

autonomous physician assistants for purposes of the Access to Health Care Act; amending s. 766.118, F.S.; revising the definition of the term "practitioner" to include an advanced practice registered nurse registered to engage in autonomous practice and an autonomous physician assistant; amending s. 768.135, F.S.; providing immunity from liability for an advanced practice registered nurse registered to engage in autonomous practice or an autonomous physician assistant who provides volunteer services under certain circumstances; amending s. 794.08, F.S.; providing an exception to medical procedures conducted by an autonomous physician assistant under certain circumstances; amending s. 893.02, F.S.; revising the definition of the term "practitioner" to include an autonomous physician assistant; amending s. 943.13, F.S.; authorizing an autonomous physician assistant to conduct a physical examination for a law enforcement or correctional officer to satisfy qualifications for employment or appointment; amending s. 945.603, F.S.; authorizing the Correctional Medical Authority to review and make recommendations relating to the use of autonomous physician assistants as physician extenders; amending s. 948.03, F.S.; authorizing an autonomous physician assistant to prescribe drugs or

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

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

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

456.0391, Florida Statutes, are amended to read:

456.0391 Advanced practice registered nurses and autonomous physician assistants; information required for licensure or registration.—

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

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

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

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

4. Any certification or designation that the applicant has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

456.041 Practitioner profile; creation.—

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

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

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

458.347 Physician assistants.—

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

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

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

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

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

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

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

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

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

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

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

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) PROGRAM APPROVAL.—

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

(7) PHYSICIAN ASSISTANT LICENSURE.—

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

1. Is at least 18 years of age.

2. Has satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Physician Assistants. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants and has not actively

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

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

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

b. Acknowledgment of any prior felony convictions.

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

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

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

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

(8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

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

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

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

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

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

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

apply to:

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

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

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

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

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

(c) An autonomous physician assistant may:

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The council shall:

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

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

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

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

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

1. Refuse to certify the applicant for licensure;

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

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

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

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

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

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

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

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

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

459.022 Physician assistants.—

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

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

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

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

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

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

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

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

on Certification of Physician Assistants.

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

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

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

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

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

1. A physician assistant must clearly identify to the

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

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

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

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

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

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

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

(6) PROGRAM APPROVAL.—

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

(7) PHYSICIAN ASSISTANT LICENSURE.—

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

1. Is at least 18 years of age.

2. Has satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on

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

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

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

b. Acknowledgment of any prior felony convictions.

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

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

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

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

(8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

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

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

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

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

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

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

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

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

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

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

(b) The department shall conspicuously distinguish an

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

(c) An autonomous physician assistant may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

serve more than two consecutive terms. The council shall annually elect a chairperson from among its members.

(c) The council shall:

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

2. Develop all rules regulating the primary care practice of autonomous physician assistants and the use of physician assistants by physicians under chapter 458 and this chapter, except for rules relating to the formulary developed under s. 458.347. The council shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council may not be adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all

matters relating to autonomous physician assistants and physician assistants.

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

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

1. Refuse to certify the applicant for licensure;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Initiate appropriate therapies for certain conditions.

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

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

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

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

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

464.0123 Autonomous practice by an advanced practice

registered nurse.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

liability coverage requirements of paragraph (a).

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

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

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

1. Admit the patient to the facility.

2. Manage the care received by the patient in the facility.

3. Discharge the patient from the facility, unless prohibited by federal law or rule.

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

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

licensure.

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

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

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

this section.

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

464.0155 Reports of adverse incidents by advanced practice registered nurses.—

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

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

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

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

(b) Permanent physical injury to the patient.

(c) Death of the patient.

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

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

464.018 Disciplinary actions.—

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

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

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

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

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

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

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

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

6. Exercising influence on the patient to exploit the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1)

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

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

110.12315, Florida Statutes, is amended to read:

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

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

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

Section 13. Paragraph (a) of subsection (3) of section 252.515, Florida Statutes, is amended to read:

252.515 Postdisaster Relief Assistance Act; immunity from civil liability.—

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

(a) "Emergency first responder" means:

1. A physician licensed under chapter 458.

2. An osteopathic physician licensed under chapter 459.

3. A chiropractic physician licensed under chapter 460.

4. A podiatric physician licensed under chapter 461.

5. A dentist licensed under chapter 466.

6. An advanced practice registered nurse licensed under s. 464.012.

7. An autonomous physician assistant or a physician assistant registered or licensed under chapter 458 ~~s. 458.347~~ or chapter 459 ~~s. 459.022~~.

8. A worker employed by a public or private hospital in the state.

9. A paramedic as defined in s. 401.23(17).

10. An emergency medical technician as defined in s. 401.23(11).

11. A firefighter as defined in s. 633.102.

12. A law enforcement officer as defined in s. 943.10.

13. A member of the Florida National Guard.

14. Any other personnel designated as emergency personnel

by the Governor pursuant to a declared emergency.

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

310.071 Deputy pilot certification.—

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

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

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

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

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

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

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

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

310.081 Department to examine and license state pilots and certificate deputy pilots; vacancies.—

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

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

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

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

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

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

(1)

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

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

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

b. The need to permanently use a wheelchair.

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

d. Use of portable oxygen.

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

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

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

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

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

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

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

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

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

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

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

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

4. Ordering an individual to be examined, tested, vaccinated, treated, isolated, or quarantined for communicable

diseases that have significant morbidity or mortality and present a severe danger to public health. Individuals who are unable or unwilling to be examined, tested, vaccinated, or treated for reasons of health, religion, or conscience may be subjected to isolation or quarantine.

a. Examination, testing, vaccination, or treatment may be performed by any qualified person authorized by the State Health Officer.

b. If the individual poses a danger to the public health, the State Health Officer may subject the individual to isolation or quarantine. If there is no practical method to isolate or quarantine the individual, the State Health Officer may use any means necessary to vaccinate or treat the individual.

Any order of the State Health Officer given to effectuate this paragraph shall be immediately enforceable by a law enforcement officer under s. 381.0012.

Section 19. Subsection (3) of section 381.00593, Florida Statutes, is amended to read:

381.00593 Public school volunteer health care practitioner program.—

(3) For purposes of this section, the term "health care practitioner" means a physician or autonomous physician assistant licensed or registered under chapter 458; an osteopathic physician or autonomous physician assistant licensed

or registered under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; an optometrist licensed under chapter 463; an advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a pharmacist licensed under chapter 465; a dentist or dental hygienist licensed under chapter 466; a midwife licensed under chapter 467; a speech-language pathologist or audiologist licensed under part I of chapter 468; a dietitian/nutritionist licensed under part X of chapter 468; or a physical therapist licensed under chapter 486.

Section 20. Paragraph (c) of subsection (2) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(2) DEFINITIONS.—As used in this section and s. 381.0261, the term:

(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, ~~or~~ a podiatric physician licensed under chapter 461, an autonomous physician assistant registered under s. 458.347(8), or an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123.

Section 21. Paragraph (a) of subsection (2) and subsections (3), (4), and (5) of section 382.008, Florida

Statutes, are amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, certified nurse midwife, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made

available to the funeral director by the decedent's primary or attending practitioner ~~physician~~ or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending practitioner ~~physician~~ or the medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief. As used in this section, the term "primary or attending practitioner ~~physician~~" means a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department may grant the funeral director an extension of time upon a good and sufficient showing of any of the following conditions:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

(b) If the decedent's primary or attending practitioner ~~physician~~ or the district medical examiner of the county in which the death occurred or the body was found indicates that he or she will sign and complete the medical certification of cause of death but will not be available until after the 5-day

registration deadline, the local registrar may grant an extension of 5 days. If a further extension is required, the funeral director must provide written justification to the registrar.

(4) If the department or local registrar grants an extension of time to provide the medical certification of cause of death, the funeral director shall file a temporary certificate of death or fetal death which shall contain all available information, including the fact that the cause of death is pending. The decedent's primary or attending practitioner ~~physician~~ or the district medical examiner of the county in which the death occurred or the body was found shall provide an estimated date for completion of the permanent certificate.

(5) A permanent certificate of death or fetal death, containing the cause of death and any other information that was previously unavailable, shall be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or district medical examiner of the county in which the death occurred or the body was found, as appropriate.

Section 22. Subsection (1) of section 382.011, Florida

Statutes, is amended to read:

382.011 Medical examiner determination of cause of death.—

(1) In the case of any death or fetal death due to causes or conditions listed in s. 406.11, any death that occurred more than 12 months after the decedent was last treated by a primary or attending physician ~~as defined in s. 382.008(3)~~, or any death for which there is reason to believe that the death may have been due to an unlawful act or neglect, the funeral director or other person to whose attention the death may come shall refer the case to the district medical examiner of the county in which the death occurred or the body was found for investigation and determination of the cause of death.

Section 23. Paragraph (c) of subsection (1) of section 383.14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. The department shall also promote the identification and screening of all newborns in this state and their families for environmental risk

factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin before ~~prior to~~ and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county health departments, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.

(c) Release of screening results.—Notwithstanding any law to the contrary, the State Public Health Laboratory may release, directly or through the Children's Medical Services program, the results of a newborn's hearing and metabolic tests or screenings to the newborn's health care practitioner, the newborn's parent or legal guardian, the newborn's personal representative, or a person designated by the newborn's parent or legal guardian. As used in this paragraph, the term "health care practitioner" means a physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458; an osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459; an

advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a midwife licensed under chapter 467; a speech-language pathologist or audiologist licensed under part I of chapter 468; or a dietician or nutritionist licensed under part X of chapter 468.

Section 24. Paragraph (a) of subsection (3) of section 390.0111, Florida Statutes, is amended to read:

390.0111 Termination of pregnancies.—

(3) CONSENTS REQUIRED.—A termination of pregnancy may not be performed or induced except with the voluntary and informed written consent of the pregnant woman or, in the case of a mental incompetent, the voluntary and informed written consent of her court-appointed guardian.

(a) Except in the case of a medical emergency, consent to a termination of pregnancy is voluntary and informed only if:

1. The physician who is to perform the procedure, or the referring physician, has, at a minimum, orally, while physically present in the same room, and at least 24 hours before the procedure, informed the woman of:

a. The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.

b. The probable gestational age of the fetus, verified by

an ultrasound, at the time the termination of pregnancy is to be performed.

(I) The ultrasound must be performed by the physician who is to perform the abortion or by a person having documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed by rule and who is working in conjunction with the physician.

(II) The person performing the ultrasound must offer the woman the opportunity to view the live ultrasound images and hear an explanation of them. If the woman accepts the opportunity to view the images and hear the explanation, a physician or a registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant working in conjunction with the physician must contemporaneously review and explain the images to the woman before the woman gives informed consent to having an abortion procedure performed.

(III) The woman has a right to decline to view and hear the explanation of the live ultrasound images after she is informed of her right and offered an opportunity to view the images and hear the explanation. If the woman declines, the woman shall complete a form acknowledging that she was offered an opportunity to view and hear the explanation of the images but that she declined that opportunity. The form must also indicate that the woman's decision was not based on any undue

influence from any person to discourage her from viewing the images or hearing the explanation and that she declined of her own free will.

(IV) Unless requested by the woman, the person performing the ultrasound may not offer the opportunity to view the images and hear the explanation and the explanation may not be given if, at the time the woman schedules or arrives for her appointment to obtain an abortion, a copy of a restraining order, police report, medical record, or other court order or documentation is presented which provides evidence that the woman is obtaining the abortion because the woman is a victim of rape, incest, domestic violence, or human trafficking or that the woman has been diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and irreversible impairment of a major bodily function if the woman delayed terminating her pregnancy.

c. The medical risks to the woman and fetus of carrying the pregnancy to term.

The physician may provide the information required in this subparagraph within 24 hours before the procedure if requested by the woman at the time she schedules or arrives for her appointment to obtain an abortion and if she presents to the physician a copy of a restraining order, police report, medical

record, or other court order or documentation evidencing that she is obtaining the abortion because she is a victim of rape, incest, domestic violence, or human trafficking.

2. Printed materials prepared and provided by the department have been provided to the pregnant woman, if she chooses to view these materials, including:

a. A description of the fetus, including a description of the various stages of development.

b. A list of entities that offer alternatives to terminating the pregnancy.

c. Detailed information on the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care.

3. The woman acknowledges in writing, before the termination of pregnancy, that the information required to be provided under this subsection has been provided.

Nothing in this paragraph is intended to prohibit a physician from providing any additional information which the physician deems material to the woman's informed decision to terminate her pregnancy.

Section 25. Paragraphs (c), (e), and (f) of subsection (3) of section 390.012, Florida Statutes, are amended to read:

390.012 Powers of agency; rules; disposal of fetal remains.—

(3) For clinics that perform or claim to perform abortions after the first trimester of pregnancy, the agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter, including the following:

(c) Rules relating to abortion clinic personnel. At a minimum, these rules shall require that:

1. The abortion clinic designate a medical director who is licensed to practice medicine in this state, and all physicians who perform abortions in the clinic have admitting privileges at a hospital within reasonable proximity to the clinic, unless the clinic has a written patient transfer agreement with a hospital within reasonable proximity to the clinic which includes the transfer of the patient's medical records held by both the clinic and the treating physician.

2. If a physician is not present after an abortion is performed, a registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant be present and remain at the clinic to provide postoperative monitoring and care until the patient is discharged.

3. Surgical assistants receive training in counseling, patient advocacy, and the specific responsibilities associated with the services the surgical assistants provide.

4. Volunteers receive training in the specific responsibilities associated with the services the volunteers

provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

(e) Rules relating to the abortion procedure. At a minimum, these rules shall require:

1. That a physician, registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant is available to all patients throughout the abortion procedure.

2. Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule.

3. Appropriate use of general and local anesthesia, analgesia, and sedation if ordered by the physician.

4. Appropriate precautions, such as the establishment of intravenous access at least for patients undergoing post-first trimester abortions.

5. Appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

(f) Rules that prescribe minimum recovery room standards. At a minimum, these rules must require that:

1. Postprocedure recovery rooms be supervised and staffed

to meet the patients' needs.

2. Immediate postprocedure care consist of observation in a supervised recovery room for as long as the patient's condition warrants.

3. A registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remain on the premises of the abortion clinic until all patients are discharged.

4. A physician sign the discharge order and be readily accessible and available until the last patient is discharged to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary.

5. A physician discuss Rho(D) immune globulin with each patient for whom it is indicated and ensure that it is offered to the patient in the immediate postoperative period or will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses the Rho(D) immune globulin, she and a witness must sign a refusal form approved by the agency which must be included in the medical record.

6. Written instructions with regard to postabortion coitus, signs of possible problems, and general aftercare which are specific to the patient be given to each patient. The

instructions must include information regarding access to medical care for complications, including a telephone number for use in the event of a medical emergency.

7. A minimum length of time be specified, by type of abortion procedure and duration of gestation, during which a patient must remain in the recovery room.

8. The physician ensure that, with the patient's consent, a registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant from the abortion clinic makes a good faith effort to contact the patient by telephone within 24 hours after surgery to assess the patient's recovery.

9. Equipment and services be readily accessible to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

Section 26. Paragraphs (a) and (f) of subsection (2) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which

that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a ~~no~~ time limit is not specified in the order, the order is ~~shall be~~ valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the

circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, autonomous physician assistant, physician assistant, clinical psychologist, psychiatric nurse, advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(f) A patient shall be examined by a physician, physician assistant, or ~~a~~ clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist

unless the release is approved by the initiating psychiatrist.

Section 27. Paragraph (b) of subsection (2) of section 395.0191, Florida Statutes, is amended to read:

395.0191 Staff membership and clinical privileges.—

(2)

(b) An advanced practice registered nurse who is certified as a registered nurse anesthetist licensed under part I of chapter 464 shall administer anesthesia under the onsite medical direction of a professional licensed under chapter 458, chapter 459, or chapter 466, and in accordance with an established protocol approved by the medical staff. The medical direction shall specifically address the needs of the individual patient. This paragraph does not apply to a certified registered nurse anesthetist registered to engage in autonomous practice under s. 464.0123.

Section 28. Subsection (3) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(3) USE OF FUNDS.—It is the intent of the Legislature that funds as appropriated shall be utilized by the department for the purpose of increasing the number of primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses in rural areas, either through the Medical Education Reimbursement and Loan Repayment Program as defined by s. 1009.65 or through a federal

loan repayment program which requires state matching funds. The department may use funds appropriated for the Medical Education Reimbursement and Loan Repayment Program as matching funds for federal loan repayment programs for health care personnel, such as that authorized in Pub. L. No. 100-177, s. 203. If the department receives federal matching funds, the department shall only implement the federal program. Reimbursement through either program shall be limited to:

(a) Primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(b) Primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural area health education centers, as defined in this section. These personnel shall practice:

1. In a county with a population density of no greater than 100 persons per square mile; or

2. Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

If the department administers a federal loan repayment program, priority shall be given to obligating state and federal matching

funds pursuant to paragraphs (a) and (b). The department may use federal matching funds in other health workforce shortage areas and medically underserved areas in the state for loan repayment programs for primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses who are employed by publicly financed health care programs that serve medically indigent persons.

Section 29. Paragraph (a) of subsection (2) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(2) RIGHT TO NONDISCRIMINATORY SERVICES.—

(a) Service providers may not deny an individual access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny an individual who takes medication prescribed by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse access to substance abuse services solely on that basis. Service providers who receive

state funds to provide substance abuse services may not, if space and sufficient state resources are available, deny access to services based solely on inability to pay.

Section 30. Section 397.679, Florida Statutes, is amended to read:

397.679 Emergency admission; circumstances justifying.—A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of a certificate by a physician, an autonomous physician assistant, an advanced practice registered nurse, a psychiatric nurse, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician assistant working under the scope of practice of the supervising physician, or a master's-level-certified addictions professional for substance abuse services, if the certificate is specific to substance abuse impairment, and the completion of an application for emergency admission.

Section 31. Subsection (1) of section 397.6793, Florida Statutes, is amended to read:

397.6793 Professional's certificate for emergency admission.—

(1) A physician, a clinical psychologist, an autonomous

physician assistant, a physician assistant working under the scope of practice of the supervising physician, a psychiatric nurse, an advanced practice registered nurse, a mental health counselor, a marriage and family therapist, a master's-level-certified addictions professional for substance abuse services, or a clinical social worker may execute a professional's certificate for emergency admission. The professional's certificate must include the name of the person to be admitted, the relationship between the person and the professional executing the certificate, the relationship between the applicant and the professional, any relationship between the professional and the licensed service provider, a statement that the person has been examined and assessed within the preceding 5 days after the application date, and factual allegations with respect to the need for emergency admission, including:

(a) The reason for the belief that the person is substance abuse impaired;

(b) The reason for the belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and

(c)1. The reason for the belief that, without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may

be avoided through the help of willing family members or friends or the provision of other services, or there is substantial likelihood that the person has inflicted or, unless admitted, is likely to inflict, physical harm on himself, herself, or another; or

2. The reason for the belief that the person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.

Section 32. Subsection (8) of section 400.021, Florida Statutes, is amended to read:

400.021 Definitions.—When used in this part, unless the context otherwise requires, the term:

(8) "Geriatric outpatient clinic" means a site for providing outpatient health care to persons 60 years of age or older, which is staffed by a registered nurse, a physician assistant, or a licensed practical nurse under the direct supervision of a registered nurse, advanced practice registered nurse, physician assistant, autonomous physician assistant, or physician.

Section 33. Subsection (3) of section 400.172, Florida Statutes, is amended to read:

400.172 Respite care provided in nursing home facilities.—

(3) A prospective respite care resident must provide

medical information from a physician, autonomous physician assistant, physician assistant, or nurse practitioner and any other information provided by the primary caregiver required by the facility before or when the person is admitted to receive respite care. The medical information must include a physician's order for respite care and proof of a physical examination by a licensed physician, autonomous physician assistant, physician assistant, or nurse practitioner. The physician's order and physical examination may be used to provide intermittent respite care for up to 12 months after the date the order is written.

Section 34. Subsection (2) of section 400.487, Florida Statutes, is amended to read:

400.487 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.—

(2) When required by ~~the provisions of~~ chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, acting within his or her respective scope of practice, shall establish treatment orders for a patient who is to receive skilled care. The treatment orders must be signed by the physician, autonomous physician assistant, physician assistant, or advanced practice

registered nurse before a claim for payment for the skilled services is submitted by the home health agency. If the claim is submitted to a managed care organization, the treatment orders must be signed within the time allowed under the provider agreement. The treatment orders shall be reviewed, as frequently as the patient's illness requires, by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse in consultation with the home health agency.

Section 35. Paragraph (a) of subsection (13) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(13) All persons referred for contract in private residences by a nurse registry must comply with the following requirements for a plan of treatment:

(a) When, in accordance with the privileges and restrictions imposed upon a nurse under part I of chapter 464, the delivery of care to a patient is under the direction or supervision of a physician or when a physician is responsible for the medical care of the patient, a medical plan of treatment must be established for each patient receiving care or treatment provided by a licensed nurse in the home. The original medical plan of treatment must be timely signed by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, acting within his or her respective

scope of practice, and reviewed in consultation with the licensed nurse at least every 2 months. Any additional order or change in orders must be obtained from the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and reduced to writing and timely signed by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse. The delivery of care under a medical plan of treatment must be substantiated by the appropriate nursing notes or documentation made by the nurse in compliance with nursing practices established under part I of chapter 464.

Section 36. Subsection (5) and paragraph (b) of subsection (7) of section 400.9973, Florida Statutes, are amended to read:

400.9973 Client admission, transfer, and discharge.—

(5) A client admitted to a transitional living facility must be admitted upon prescription by a licensed physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and must remain under the care of a licensed physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse for the duration of the client's stay in the facility.

(7) A person may not be admitted to a transitional living facility if the person:

(b) Is a danger to himself or herself or others as determined by a physician, autonomous physician assistant,

physician assistant, advanced practice registered nurse, or ~~a~~ mental health practitioner licensed under chapter 490 or chapter 491, unless the facility provides adequate staffing and support to ensure patient safety;

Section 37. Paragraphs (a) and (b) of subsection (2) of section 400.9974, Florida Statutes, are amended to read:

400.9974 Client comprehensive treatment plans; client services.—

(2) The comprehensive treatment plan must include:

(a) Orders obtained from the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and the client's diagnosis, medical history, physical examination, and rehabilitative or restorative needs.

(b) A preliminary nursing evaluation, including orders for immediate care provided by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, which shall be completed when the client is admitted.

Section 38. Section 400.9976, Florida Statutes, is amended to read:

400.9976 Administration of medication.—

(1) An individual medication administration record must be maintained for each client. A dose of medication, including a self-administered dose, shall be properly recorded in the client's record. A client who self-administers medication shall be given a pill organizer. Medication must be placed in the pill

organizer by a nurse. A nurse shall document the date and time that medication is placed into each client's pill organizer. All medications must be administered in compliance with orders of a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse.

(2) If an interdisciplinary team determines that self-administration of medication is an appropriate objective, and if the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse does not specify otherwise, the client must be instructed by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse to self-administer his or her medication without the assistance of a staff person. All forms of self-administration of medication, including administration orally, by injection, and by suppository, shall be included in the training. The client's physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse must be informed of the interdisciplinary team's decision that self-administration of medication is an objective for the client. A client may not self-administer medication until he or she demonstrates the competency to take the correct medication in the correct dosage at the correct time, to respond to missed doses, and to contact the appropriate person with questions.

(3) Medication administration discrepancies and adverse

drug reactions must be recorded and reported immediately to a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse.

Section 39. Subsections (2) through (5) of section 400.9979, Florida Statutes, are amended to read:

400.9979 Restraint and seclusion; client safety.—

(2) The use of physical restraints must be ordered and documented by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and must be consistent with the policies and procedures adopted by the facility. The client or, if applicable, the client's representative shall be informed of the facility's physical restraint policies and procedures when the client is admitted.

(3) The use of chemical restraints shall be limited to prescribed dosages of medications as ordered by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and must be consistent with the client's diagnosis and the policies and procedures adopted by the facility. The client and, if applicable, the client's representative shall be informed of the facility's chemical restraint policies and procedures when the client is admitted.

(4) Based on the assessment by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, if a client exhibits symptoms that present an immediate risk of injury or death to himself or herself or

others, a physician, physician assistant, or advanced practice registered nurse may issue an emergency treatment order to immediately administer rapid-response psychotropic medications or other chemical restraints. Each emergency treatment order must be documented and maintained in the client's record.

(a) An emergency treatment order is not effective for more than 24 hours.

(b) Whenever a client is medicated under this subsection, the client's representative or a responsible party and the client's physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse shall be notified as soon as practicable.

(5) A client who is prescribed and receives a medication that can serve as a chemical restraint for a purpose other than an emergency treatment order must be evaluated by his or her physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse at least monthly to assess:

(a) The continued need for the medication.

(b) The level of the medication in the client's blood.

(c) The need for adjustments to the prescription.

Section 40. Subsections (1) and (2) of section 401.445, Florida Statutes, are amended to read:

401.445 Emergency examination and treatment of incapacitated persons.—

(1) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced practice registered nurse licensed under s. 464.012, or any autonomous physician assistant or physician assistant registered or licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably

necessary to alleviate the emergency medical condition or to stabilize the patient.

(2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant, or any person acting under the direct medical supervision of a physician, shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.

Section 41. Subsection (18) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or

prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for all services provided to a recipient by an autonomous physician assistant or a physician assistant registered or licensed under s. 458.347 or s. 459.022. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

Section 42. Paragraph (m) of subsection (3) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in

policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(3) Subject to any limitations or directions provided for

in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, or negotiated fees.

(m) Autonomous physician assistant and physician assistant services.

Section 43. Paragraphs (c) through (cc) of subsection (1) of section 409.973, Florida Statutes, are redesignated as paragraphs (d) through (dd), respectively, and a new paragraph (c) is added to that subsection to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(c) Autonomous physician assistant services.

Section 44. Subsections (2), (4), and (5) of section 429.26, Florida Statutes, are amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(2) A physician, autonomous physician assistant, physician

assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.

(4) If possible, each resident shall have been examined by a licensed physician, an autonomous physician assistant, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, a registered autonomous physician assistant, a licensed physician assistant, or a licensed nurse practitioner shall examine the resident and complete a medical examination form

provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.

Section 45. Paragraph (a) of subsection (2) and paragraph (a) of subsection (7) of section 429.918, Florida Statutes, are amended to read:

429.918 Licensure designation as a specialized Alzheimer's services adult day care center.—

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

(a) "ADRD participant" means a participant who has a documented diagnosis of Alzheimer's disease or a dementia-related disorder (ADRD) from a licensed physician, a registered autonomous physician assistant, a licensed physician assistant, or a licensed advanced practice registered nurse.

(7)(a) An ADRD participant admitted to an adult day care center having a license designated under this section, or the caregiver when applicable, must:

1. Require ongoing supervision to maintain the highest level of medical or custodial functioning and have a demonstrated need for a responsible party to oversee his or her care.

2. Not actively demonstrate aggressive behavior that

places himself, herself, or others at risk of harm.

3. Provide the following medical documentation signed by a licensed physician, a registered autonomous physician assistant, a licensed physician assistant, or a licensed advanced practice registered nurse:

a. Any physical, health, or emotional conditions that require medical care.

b. A listing of the ADRD participant's current prescribed and over-the-counter medications and dosages, diet restrictions, mobility restrictions, and other physical limitations.

4. Provide documentation signed by a health care provider licensed in this state which indicates that the ADRD participant is free of the communicable form of tuberculosis and free of signs and symptoms of other communicable diseases.

Section 46. Paragraph (e) of subsection (5) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(e) A specimen for a drug test may be taken or collected by any of the following persons:

1. A physician, an autonomous physician assistant, a physician assistant, a registered professional nurse, a licensed practical nurse, or a nurse practitioner or a certified paramedic who is present at the scene of an accident for the purpose of rendering emergency medical service or treatment.

2. A qualified person employed by a licensed or certified laboratory as described in subsection (9).

Section 47. Paragraphs (a), (i), (o), and (r) of subsection (3) and paragraph (g) of subsection (5) of section 456.053, Florida Statutes, are amended to read:

456.053 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(a) "Board" means any of the following boards relating to the respective professions: the Board of Medicine as created in s. 458.307; the Board of Osteopathic Medicine as created in s. 459.004; the Board of Chiropractic Medicine as created in s. 460.404; the Board of Podiatric Medicine as created in s. 461.004; the Board of Optometry as created in s. 463.003; the Board of Nursing as created in s. 464.004; the Board of Pharmacy as created in s. 465.004; and the Board of Dentistry as created in s. 466.004.

(i) "Health care provider" means a ~~any~~ physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461; an

autonomous physician assistant registered under chapter 458 or chapter 459; an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123;~~,~~ or any health care provider licensed under chapter 463 or chapter 466.

(o) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, ~~that effective July 1, 1999,~~ a health care provider ~~physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461~~ may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring health care provider does not have an ~~physician has no~~ investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside

referrals, excluding radiation therapy services.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a urologist for lithotripsy services.

i. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

j. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

k. By a nephrologist for renal dialysis services and supplies, except laboratory services.

l. By a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

m. By a health care provider for sleep-related testing.

(r) "Sole provider" means one health care provider licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or registered under s. 464.0123, who maintains a separate

medical office and a medical practice separate from any other health care provider and who bills for his or her services separately from the services provided by any other health care provider. A sole provider shall not share overhead expenses or professional income with any other person or group practice.

(5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as provided in this section:

(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to be taken by the applicable board pursuant to s. 458.331(2), s. 459.015(2), s. 460.413(2), s. 461.013(2), s. 463.016(2), s. 464.018, or s. 466.028(2). Any hospital licensed under chapter 395 found in violation of this section shall be subject to s. 395.0185(2).

Section 48. Subsection (7) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) Notwithstanding subsection (2), upon a finding that a physician or autonomous physician assistant has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s. 466.028(1)(p) or (x), or that an advanced practice registered nurse has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in

a manner that violates the standard of practice set forth in s. 464.018(1)(n) or (p)6., the physician, autonomous physician assistant, or advanced practice registered nurse shall be suspended for a period of not less than 6 months and pay a fine of not less than $10,000 per count. Repeated violations shall result in increased penalties.

Section 49. Paragraph (h) of subsection (1) and subsection (2) of section 456.44, Florida Statutes, are amended to read:

456.44 Controlled substance prescribing.—

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

(h) "Registrant" means a physician, an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse who meets the requirements of subsection (2).

(2) REGISTRATION.—A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under part I of chapter 464 who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her practitioner profile.

(b) Comply with the requirements of this section and

applicable board rules.

Section 50. Paragraph (c) of subsection (3) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(3) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(c) A physician, an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse must perform a physical examination of a patient on the same day that the physician prescribes a controlled substance to a patient at a pain-management clinic. If the physician prescribes more than a 72-hour dose of controlled substances for the treatment of chronic nonmalignant pain, the physician must document in the patient's record the reason for prescribing that quantity.

Section 51. Paragraph (ii) of subsection (1) and subsection (10) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

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

(ii) Failing to report to the department any licensee

under this chapter or under chapter 459 who the physician, autonomous physician assistant, or physician assistant knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the physician, autonomous physician assistant, or physician assistant also provides services.

(10) A probable cause panel convened to consider disciplinary action against an autonomous physician assistant or a physician assistant alleged to have violated s. 456.072 or this section must include one physician assistant. The physician assistant must hold a valid license to practice as a physician assistant in this state and be appointed to the panel by the Council of Physician Assistants. The physician assistant may hear only cases involving disciplinary actions against a physician assistant. If the appointed physician assistant is not present at the disciplinary hearing, the panel may consider the matter and vote on the case in the absence of the physician assistant. The training requirements set forth in s. 458.307(4) do not apply to the appointed physician assistant. Rules need not be adopted to implement this subsection.

Section 52. Paragraph (c) of subsection (3) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(3) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(c) An osteopathic physician, an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse must perform a physical examination of a patient on the same day that the physician prescribes a controlled substance to a patient at a pain-management clinic. If the osteopathic physician prescribes more than a 72-hour dose of controlled substances for the treatment of chronic nonmalignant pain, the osteopathic physician must document in the patient's record the reason for prescribing that quantity.

Section 53. Paragraph (ll) of subsection (1) and subsection (10) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

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

(ll) Failing to report to the department any licensee under chapter 458 or under this chapter who the osteopathic physician, autonomous physician assistant, or physician assistant knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who

provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the osteopathic physician, autonomous physician assistant, or physician assistant also provides services.

(10) A probable cause panel convened to consider disciplinary action against an autonomous physician assistant or a physician assistant alleged to have violated s. 456.072 or this section must include one physician assistant. The physician assistant must hold a valid license to practice as a physician assistant in this state and be appointed to the panel by the Council of Physician Assistants. The physician assistant may hear only cases involving disciplinary actions against a physician assistant. If the appointed physician assistant is not present at the disciplinary hearing, the panel may consider the matter and vote on the case in the absence of the physician assistant. The training requirements set forth in s. 458.307(4) do not apply to the appointed physician assistant. Rules need not be adopted to implement this subsection.

Section 54. Subsection (17) of section 464.003, Florida Statutes, is amended to read:

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

(17) "Practice of practical nursing" means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the

promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, a registered autonomous physician assistant, or a licensed dentist; and the teaching of general principles of health and wellness to the public and to students other than nursing students. A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

Section 55. Paragraph (a) of subsection (4) of section 464.0205, Florida Statutes, is amended to read:

464.0205 Retired volunteer nurse certificate.—

(4) A retired volunteer nurse receiving certification from the board shall:

(a) Work under the direct supervision of the director of a county health department, a physician working under a limited license issued pursuant to s. 458.317 or s. 459.0075, a physician or an autonomous physician assistant licensed or registered under chapter 458 or chapter 459, an advanced practice registered nurse licensed under s. 464.012, or a registered nurse licensed under s. 464.008 or s. 464.009.

Section 56. Paragraph (b) of subsection (1) of section 480.0475, Florida Statutes, is amended to read:

480.0475 Massage establishments; prohibited practices.—

(1) A person may not operate a massage establishment

between the hours of midnight and 5 a.m. This subsection does not apply to a massage establishment:

(b) In which every massage performed between the hours of midnight and 5 a.m. is performed by a massage therapist acting under the prescription of a physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458; ~~,~~ an osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459; ~~,~~ a chiropractic physician licensed under chapter 460; ~~,~~ a podiatric physician licensed under chapter 461; ~~,~~ an advanced practice registered nurse licensed under part I of chapter 464; ~~,~~ or a dentist licensed under chapter 466; or

Section 57. Subsection (2) of section 493.6108, Florida Statutes, is amended to read:

493.6108 Investigation of applicants by Department of Agriculture and Consumer Services.—

(2) In addition to subsection (1), the department shall make an investigation of the general physical fitness of the Class "G" applicant to bear a weapon or firearm. Determination of physical fitness shall be certified by a physician, autonomous physician assistant, or physician assistant currently licensed or registered under ~~pursuant to~~ chapter 458, chapter 459, or any similar law of another state or authorized to act as a licensed physician by a federal agency or department or by an advanced practice registered nurse currently licensed pursuant

to chapter 464. Such certification shall be submitted on a form provided by the department.

Section 58. Subsection (1) of section 626.9707, Florida Statutes, is amended to read:

626.9707 Disability insurance; discrimination on basis of sickle-cell trait prohibited.—

(1) An ~~No~~ insurer authorized to transact insurance in this state may not ~~shall~~ refuse to issue and deliver in this state any policy of disability insurance, whether such policy is defined as individual, group, blanket, franchise, industrial, or otherwise, which is currently being issued for delivery in this state and which affords benefits and coverage for any medical treatment or service authorized and permitted to be furnished by a hospital, a clinic, a health clinic, a neighborhood health clinic, a health maintenance organization, a physician, an autonomous physician assistant, a physician ~~physician's~~ assistant, an advanced practice registered nurse ~~practitioner~~, or a medical service facility or personnel solely because the person to be insured has the sickle-cell trait.

Section 59. Paragraph (b) of subsection (1) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.—

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

(b) "Health care provider" means any:

1. Hospital licensed under chapter 395.

2. Physician, autonomous physician assistant ~~licensed~~, or physician assistant registered or licensed~~,~~ under chapter 458.

3. Osteopathic physician, autonomous physician assistant, or physician assistant registered or licensed under chapter 459.

4. Podiatric physician licensed under chapter 461.

5. Health maintenance organization certificated under part I of chapter 641.

6. Ambulatory surgical center licensed under chapter 395.

7. Chiropractic physician licensed under chapter 460.

8. Psychologist licensed under chapter 490.

9. Optometrist licensed under chapter 463.

10. Dentist licensed under chapter 466.

11. Pharmacist licensed under chapter 465.

12. Registered nurse, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464.

13. Other medical facility.

14. Professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9., 10., 11., and 12. for professional activity.

Section 60. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician or an autonomous physician assistant licensed or registered under chapter 458 or chapter 459, a dentist licensed under chapter 466, ~~or~~ a chiropractic physician licensed under chapter 460, or an advanced practice registered nurse registered to engage in

autonomous practice under s. 464.0123 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician or an autonomous physician assistant licensed or registered under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians or autonomous physician assistants licensed or registered under chapter 458 or chapter 459, chiropractic physicians licensed

under chapter 460, advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule

the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 61. Subsection (5) of section 633.412, Florida

Statutes, is amended to read:

633.412 Firefighters; qualifications for certification.—A person applying for certification as a firefighter must:

(5) Be in good physical condition as determined by a medical examination given by a physician, surgeon, or autonomous physician assistant or physician assistant licensed or registered under ~~to practice in the state pursuant to~~ chapter 458; an osteopathic physician, surgeon, autonomous physician assistant, or physician assistant licensed or registered under ~~to practice in the state pursuant to~~ chapter 459; or an advanced practice registered nurse licensed under ~~to practice in the state pursuant to~~ chapter 464. Such examination may include, but need not be limited to, the National Fire Protection Association Standard 1582. A medical examination evidencing good physical condition shall be submitted to the division, on a form as provided by rule, before an individual is eligible for admission into a course under s. 633.408.

Section 62. Subsection (8) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(8) Each organization's contracts, certificates, and subscriber handbooks shall contain a provision, if applicable, disclosing that, for certain types of described medical procedures, services may be provided by autonomous physician

assistants, physician assistants, advanced practice registered nurses ~~nurse practitioners~~, or other individuals who are not licensed physicians.

Section 63. Subsection (1) of section 744.2006, Florida Statutes, is amended to read:

744.2006 Office of Public and Professional Guardians; appointment, notification.—

(1) The executive director of the Office of Public and Professional Guardians, after consultation with the chief judge and other circuit judges within the judicial circuit and with appropriate advocacy groups and individuals and organizations who are knowledgeable about the needs of incapacitated persons, may establish, within a county in the judicial circuit or within the judicial circuit, one or more offices of public guardian and if so established, shall create a list of persons best qualified to serve as the public guardian, who have been investigated pursuant to s. 744.3135. The public guardian must have knowledge of the legal process and knowledge of social services available to meet the needs of incapacitated persons. The public guardian shall maintain a staff or contract with professionally qualified individuals to carry out the guardianship functions, including an attorney who has experience in probate areas and another person who has a master's degree in social work, or a gerontologist, psychologist, autonomous physician assistant, advanced practice registered nurse, or registered nurse~~, or~~

~~nurse practitioner~~. A public guardian that is a nonprofit corporate guardian under s. 744.309(5) must receive tax-exempt status from the United States Internal Revenue Service.

Section 64. Paragraph (a) of subsection (3) of section 744.331, Florida Statutes, is amended to read:

744.331 Procedures to determine incapacity.—

(3) EXAMINING COMMITTEE.—

(a) Within 5 days after a petition for determination of incapacity has been filed, the court shall appoint an examining committee consisting of three members. One member must be a psychiatrist or other physician. The remaining members must be either a psychologist, a gerontologist, a ~~another~~ psychiatrist, a ~~or other~~ physician, an autonomous physician assistant, a physician assistant, an advanced practice registered nurse, a registered nurse, ~~nurse practitioner,~~ a licensed social worker, a person with an advanced degree in gerontology from an accredited institution of higher education, or any other person who by knowledge, skill, experience, training, or education may, in the court's discretion, advise the court in the form of an expert opinion. One of three members of the committee must have knowledge of the type of incapacity alleged in the petition. Unless good cause is shown, the attending or family physician may not be appointed to the committee. If the attending or family physician is available for consultation, the committee must consult with the physician. Members of the examining

committee may not be related to or associated with one another, with the petitioner, with counsel for the petitioner or the proposed guardian, or with the person alleged to be totally or partially incapacitated. A member may not be employed by any private or governmental agency that has custody of, or furnishes, services or subsidies, directly or indirectly, to the person or the family of the person alleged to be incapacitated or for whom a guardianship is sought. A petitioner may not serve as a member of the examining committee. Members of the examining committee must be able to communicate, either directly or through an interpreter, in the language that the alleged incapacitated person speaks or to communicate in a medium understandable to the alleged incapacitated person if she or he is able to communicate. The clerk of the court shall send notice of the appointment to each person appointed no later than 3 days after the court's appointment.

Section 65. Paragraph (b) of subsection (1) of section 744.3675, Florida Statutes, is amended to read:

744.3675 Annual guardianship plan.—Each guardian of the person must file with the court an annual guardianship plan which updates information about the condition of the ward. The annual plan must specify the current needs of the ward and how those needs are proposed to be met in the coming year.

(1) Each plan for an adult ward must, if applicable, include:

(b) Information concerning the medical and mental health conditions and treatment and rehabilitation needs of the ward, including:

1. A resume of any professional medical treatment given to the ward during the preceding year.

2. The report of a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse who examined the ward no more than 90 days before the beginning of the applicable reporting period. The report must contain an evaluation of the ward's condition and a statement of the current level of capacity of the ward.

3. The plan for providing medical, mental health, and rehabilitative services in the coming year.

Section 66. Subsection (3) of section 766.103, Florida Statutes, is amended to read:

766.103 Florida Medical Consent Law.—

(3) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced practice registered nurse licensed under s. 464.012, autonomous physician assistant registered under chapter 458 or chapter 459, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or

operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced practice registered nurse, autonomous physician assistant, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced practice registered nurse, autonomous physician assistant, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or

procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced practice registered nurse, autonomous physician assistant, or physician assistant in accordance with ~~the provisions of~~ paragraph (a).

Section 67. Paragraph (b) of subsection (1) and paragraph (e) of subsection (2) of section 766.105, Florida Statutes, are amended to read:

766.105 Florida Patient's Compensation Fund.—

(1) DEFINITIONS.—The following definitions apply in the interpretation and enforcement of this section:

(b) The term "health care provider" means any:

1. Hospital licensed under chapter 395.

2. Physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458.

3. Osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459.

4. Podiatric physician licensed under chapter 461.

5. Health maintenance organization certificated under part I of chapter 641.

6. Ambulatory surgical center licensed under chapter 395.

7. "Other medical facility" as defined in paragraph (c).

8. Professional association, partnership, corporation, joint venture, or other association by the individuals set forth in subparagraphs 2., 3., and 4. for professional activity.

(2) COVERAGE.—

(e) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, trainees, committee members (including physicians, osteopathic physicians, podiatric physicians, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, autonomous physician assistants or physician assistants registered or licensed under chapter 458 or chapter 459, osteopathic physicians licensed under chapter 459, dentists licensed under chapter 466, and podiatric physicians licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to house physicians, interns, employed physician residents in a resident training program, or physicians performing purely administrative duties for the participating hospitals other than the treatment of patients. This coverage shall apply to the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

Section 68. Paragraph (d) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:

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

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

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458.

5. An osteopathic physician, autonomous physician assistant, or ~~osteopathic~~ physician assistant licensed or registered under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes

an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

Section 69. Subsection (1) of section 766.1116, Florida Statutes, is amended to read:

766.1116 Health care practitioner; waiver of license renewal fees and continuing education requirements.—

(1) As used in this section, the term "health care

practitioner" means a physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458; an osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; an advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a dentist or dental hygienist licensed under chapter 466; or a midwife licensed under chapter 467, who participates as a health care provider under s. 766.1115.

Section 70. Paragraph (c) of subsection (1) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

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

(c) "Practitioner" means any person licensed or registered under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 486, ~~or~~ s. 464.012, or s. 464.0123. "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "practitioner" includes any person or entity for whom a

practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner.

Section 71. Subsection (3) of section 768.135, Florida Statutes, is amended to read:

768.135 Volunteer team physicians; immunity.—

(3) A practitioner licensed or registered under chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 who gratuitously and in good faith conducts an evaluation pursuant to s. 1006.20(2)(c) is not liable for any civil damages arising from that evaluation unless the evaluation was conducted in a wrongful manner.

Section 72. Subsection (5) of section 794.08, Florida Statutes, is amended to read:

794.08 Female genital mutilation.—

(5) This section does not apply to procedures performed by or under the direction of a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a registered nurse licensed under part I of chapter 464, a practical nurse licensed under part I of chapter 464, an advanced practice registered nurse licensed under part I of chapter 464, a midwife licensed under chapter 467, or an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459 when necessary to preserve the physical health of a female person.

This section also does not apply to any autopsy or limited dissection conducted pursuant to chapter 406.

Section 73. Subsection (23) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(23) "Practitioner" means a physician licensed under chapter 458, a dentist licensed under chapter 466, a veterinarian licensed under chapter 474, an osteopathic physician licensed under chapter 459, an advanced practice registered nurse licensed under chapter 464, a naturopath licensed under chapter 462, a certified optometrist licensed under chapter 463, a psychiatric nurse as defined in s. 394.455, a podiatric physician licensed under chapter 461, an autonomous physician assistant registered under chapter 458 or chapter 459, or a physician assistant licensed under chapter 458 or chapter 459, provided such practitioner holds a valid federal controlled substance registry number.

Section 74. Subsection (6) of section 943.13, Florida Statutes, is amended to read:

943.13 Officers' minimum qualifications for employment or appointment.—On or after October 1, 1984, any person employed or appointed as a full-time, part-time, or auxiliary law enforcement officer or correctional officer; on or after October

1, 1986, any person employed as a full-time, part-time, or auxiliary correctional probation officer; and on or after October 1, 1986, any person employed as a full-time, part-time, or auxiliary correctional officer by a private entity under contract to the Department of Corrections, to a county commission, or to the Department of Management Services shall:

(6) Have passed a physical examination by a licensed physician, registered autonomous physician assistant, licensed physician assistant, or licensed advanced practice registered nurse, based on specifications established by the commission. In order to be eligible for the presumption set forth in s. 112.18 while employed with an employing agency, a law enforcement officer, correctional officer, or correctional probation officer must have successfully passed the physical examination required by this subsection upon entering into service as a law enforcement officer, correctional officer, or correctional probation officer with the employing agency, which examination must have failed to reveal any evidence of tuberculosis, heart disease, or hypertension. A law enforcement officer, correctional officer, or correctional probation officer may not use a physical examination from a former employing agency for purposes of claiming the presumption set forth in s. 112.18 against the current employing agency.

Section 75. Subsection (2) of section 945.603, Florida Statutes, is amended to read:

945.603 Powers and duties of authority.—The purpose of the authority is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions. For this purpose, the authority has the authority to:

(2) Review and make recommendations regarding health care for the delivery of health care services including, but not limited to, acute hospital-based services and facilities, primary and tertiary care services, ancillary and clinical services, dental services, mental health services, intake and screening services, medical transportation services, and the use of nurse practitioner, autonomous physician assistant, and physician assistant personnel to act as physician extenders as these relate to inmates in the Department of Corrections.

Section 76. Paragraph (n) of subsection (1) of section 948.03, Florida Statutes, is amended to read:

948.03 Terms and conditions of probation.—

(1) The court shall determine the terms and conditions of

probation. Conditions specified in this section do not require oral pronouncement at the time of sentencing and may be considered standard conditions of probation. These conditions may include among them the following, that the probationer or offender in community control shall:

(n) Be prohibited from using intoxicants to excess or possessing any drugs or narcotics unless prescribed by a physician, an advanced practice registered nurse, an autonomous physician assistant, or a physician assistant. The probationer or community controllee may not knowingly visit places where intoxicants, drugs, or other dangerous substances are unlawfully sold, dispensed, or used.

Section 77. Subsection (34) of section 984.03, Florida Statutes, is amended to read:

984.03 Definitions.—When used in this chapter, the term:

(34) "Licensed health care professional" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a nurse licensed under part I of chapter 464, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or a dentist licensed under chapter 466.

Section 78. Subsection (30) of section 985.03, Florida Statutes, is amended to read:

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

(30) "Licensed health care professional" means a physician

licensed under chapter 458, an osteopathic physician licensed under chapter 459, a nurse licensed under part I of chapter 464, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or a dentist licensed under chapter 466.

Section 79. Paragraph (i) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(i) Epinephrine use and supply.—

1. A student who has experienced or is at risk for life-threatening allergic reactions may carry an epinephrine auto-injector and self-administer epinephrine by auto-injector while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities if the school has been provided with parental and physician authorization. The State Board of Education, in cooperation with the Department of Health, shall adopt rules for such use of epinephrine auto-injectors that shall include provisions to protect the safety of all students from the misuse or abuse of

auto-injectors. A school district, county health department, public-private partner, and their employees and volunteers shall be indemnified by the parent of a student authorized to carry an epinephrine auto-injector for any and all liability with respect to the student's use of an epinephrine auto-injector pursuant to this paragraph.

2. A public school may purchase a supply of epinephrine auto-injectors from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as defined in s. 499.003 for the epinephrine auto-injectors at fair-market, free, or reduced prices for use in the event a student has an anaphylactic reaction. The epinephrine auto-injectors must be maintained in a secure location on the public school's premises. The participating school district shall adopt a protocol developed by a licensed physician for the administration by school personnel who are trained to recognize an anaphylactic reaction and to administer an epinephrine auto-injection. The supply of epinephrine auto-injectors may be provided to and used by a student authorized to self-administer epinephrine by auto-injector under subparagraph 1. or trained school personnel.

3. The school district and its employees, agents, and the physician who provides the standing protocol for school epinephrine auto-injectors are not liable for any injury arising from the use of an epinephrine auto-injector administered by

trained school personnel who follow the adopted protocol and whose professional opinion is that the student is having an anaphylactic reaction:

a. Unless the trained school personnel's action is willful and wanton;

b. Notwithstanding that the parents or guardians of the student to whom the epinephrine is administered have not been provided notice or have not signed a statement acknowledging that the school district is not liable; and

c. Regardless of whether authorization has been given by the student's parents or guardians or by the student's physician, autonomous physician assistant, physician ~~physician's~~ assistant, or advanced practice registered nurse.

Section 80. Paragraph (b) of subsection (17) of section 1002.42, Florida Statutes, is amended to read:

1002.42 Private schools.—

(17) EPINEPHRINE SUPPLY.—

(b) The private school and its employees, agents, and the physician who provides the standing protocol for school epinephrine auto-injectors are not liable for any injury arising from the use of an epinephrine auto-injector administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is having an anaphylactic reaction:

1. Unless the trained school personnel's action is willful

and wanton;

2. Notwithstanding that the parents or guardians of the student to whom the epinephrine is administered have not been provided notice or have not signed a statement acknowledging that the school district is not liable; and

3. Regardless of whether authorization has been given by the student's parents or guardians or by the student's physician, autonomous physician assistant, physician ~~physician's~~ assistant, or advanced practice registered nurse.

Section 81. Paragraph (a) of subsection (1) and subsections (4) and (5) of section 1006.062, Florida Statutes, are amended to read:

1006.062 Administration of medication and provision of medical services by district school board personnel.—

(1) Notwithstanding the provisions of the Nurse Practice Act, part I of chapter 464, district school board personnel may assist students in the administration of prescription medication when the following conditions have been met:

(a) Each district school board shall include in its approved school health services plan a procedure to provide training, by a registered nurse, a licensed practical nurse, or an advanced practice registered nurse licensed under chapter 464 or by a physician, autonomous physician assistant, or physician assistant licensed or registered under ~~pursuant to~~ chapter 458 or chapter 459~~, or a physician assistant licensed pursuant to~~

~~chapter 458 or chapter 459~~, to the school personnel designated by the school principal to assist students in the administration of prescribed medication. Such training may be provided in collaboration with other school districts, through contract with an education consortium, or by any other arrangement consistent with the intent of this subsection.

(4) Nonmedical assistive personnel shall be allowed to perform health-related services upon successful completion of child-specific training by a registered nurse or advanced practice registered nurse licensed under chapter 464 or~~,~~ a physician, autonomous physician assistant, or physician assistant licensed or registered under ~~pursuant to~~ chapter 458 or chapter 459~~, or a physician assistant licensed pursuant to chapter 458 or chapter 459~~. All procedures shall be monitored periodically by a nurse, advanced practice registered nurse, autonomous physician assistant, physician assistant, or physician, including, but not limited to:

(a) Intermittent clean catheterization.

(b) Gastrostomy tube feeding.

(c) Monitoring blood glucose.

(d) Administering emergency injectable medication.

(5) For all other invasive medical services not listed in this subsection, a registered nurse or advanced practice registered nurse licensed under chapter 464 or~~,~~ a physician, autonomous physician assistant, or physician assistant licensed

or registered under ~~pursuant to~~ chapter 458 or chapter 459~~, or a physician assistant licensed pursuant to chapter 458 or chapter 459~~ shall determine if nonmedical district school board personnel shall be allowed to perform such service.

Section 82. Paragraph (c) of subsection (2) of section 1006.20, Florida Statutes, is amended to read:

1006.20 Athletics in public K-12 schools.—

(2) ADOPTION OF BYLAWS, POLICIES, OR GUIDELINES.—

(c) The FHSAA shall adopt bylaws that require all students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year before ~~prior to~~ participating in interscholastic athletic competition or engaging in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team. Such medical evaluation may be administered only by a practitioner licensed or registered under chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 and in good standing with the practitioner's regulatory board. The bylaws shall establish requirements for eliciting a student's medical history and performing the medical evaluation required under this paragraph, which shall include a physical assessment of the student's physical capabilities to participate in interscholastic athletic competition as contained in a uniform preparticipation physical evaluation and history form.

The evaluation form shall incorporate the recommendations of the American Heart Association for participation cardiovascular screening and shall provide a place for the signature of the practitioner performing the evaluation with an attestation that each examination procedure listed on the form was performed by the practitioner or by someone under the direct supervision of the practitioner. The form shall also contain a place for the practitioner to indicate if a referral to another practitioner was made in lieu of completion of a certain examination procedure. The form shall provide a place for the practitioner to whom the student was referred to complete the remaining sections and attest to that portion of the examination. The preparticipation physical evaluation form shall advise students to complete a cardiovascular assessment and shall include information concerning alternative cardiovascular evaluation and diagnostic tests. Results of such medical evaluation must be provided to the school. A student is not eligible to participate, as provided in s. 1006.15(3), in any interscholastic athletic competition or engage in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team until the results of the medical evaluation have been received and approved by the school.

Section 83. Subsection (1) of section 1009.65, Florida Statutes, is amended to read:

1009.65 Medical Education Reimbursement and Loan Repayment Program.—

(1) To encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, there is established the Medical Education Reimbursement and Loan Repayment Program. The function of the program is to make payments that offset loans and educational expenses incurred by students for studies leading to a medical or nursing degree, medical or nursing licensure, ~~or~~ advanced practice registered nurse licensure, autonomous physician assistant registration, or physician assistant licensure. The following licensed or certified health care professionals are eligible to participate in this program: medical doctors with primary care specialties, doctors of osteopathic medicine with primary care specialties, autonomous physician assistants, physician ~~physician's~~ assistants, licensed practical nurses and registered nurses, and advanced practice registered nurses with primary care specialties such as certified nurse midwives. Primary care medical specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties which may be identified by the Department of Health.

Section 84. For the 2020-2021 fiscal year, 3.5 full-time equivalent positions with associated salary rate of 183,895 are authorized and the sums of $219,089 in recurring funds and

$17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health for the purpose of implementing this act.

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	_____	

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

Amendment

Remove lines 640-644 and insert:

States, at least 2,000 clinical practice hours within the 5 years immediately preceding the submission of the registration request while practicing as a physician assistant under the supervision of an allopathic or osteopathic physician who held an active, unencumbered license issued by any state, the

Remove line 943 and insert:

States, at least 2,000 clinical practice hours within the 5

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

Amendment

Remove line 1197 and insert:

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.[1] 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[2] 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.[3] 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.[4]

[1] Agency for Health Care Administration, *Health Quality Assurance*, 2017, available at http://ahca.myflorida.com/MCHQ/ (last visited January 31, 2020).
[2] "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.
[3] S. 408.802, F.S.
[4] 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.[5] 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. [6]

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[7] at five and ten minutes;
- Newborn deaths; and
- Stillborn/Fetal deaths. [8]

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.[9]

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.

[5] S. 383.302(2), F.S. Section 383.302(8), F.S.
[6] Section 383.309, F.S.; The minimum standards for birth centers are contained in Chapter 59A-11, F.A.C.
[7] The AGPAR 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).
[8] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Apr. 2019).
[9] 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.[10] 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[11], to be deposited into the Public Medical Assistance Trust Fund (PMATF). These assessments were ruled unconstitutional in 2002, and are no longer collected.[12]

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.[13]

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

[10] Ch. 2019-136, L.O.F.
[11] 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.
[12] *Agency for Health Care Administration v. Hameroff,* 816 So. 2d 1145, 1149-1150 (Fla. 1st DCA 2002).
[13] 42 C.F.R. §. 488.308(a).

deficiency[14], has been cited for two or more class II deficiencies[15] 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

[14] 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.

[15] 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.[16]

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.[17]

[16] Id.
[17] 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.[18]

Home Health Agencies

Current Situation

A "home health agency" is an organization that provides home health services and staffing services.[19] 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.[20]

Home health services are health and medical services and supplies furnished by an organization[21] 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.[22]

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.[23]

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.[24]

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.

[18] Supra FN 9.
[19] S. 400.462(12), F.S.
[20] Id.
[21] 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.
[22] S. 400.462(14), F.S.
[23] Supra FN 9.
[24] 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.[25] 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.[26] 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.[27]

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.[28] 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[29] 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.[30] 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.[31] A health care clinic may voluntarily apply for a certificate of exemption for a fee of $100.[32] Certificates of exemption are valid for up to two years.[33] Among many other exemptions, certain federally certified entities are exempt from licensure under the Act, including:

[25] Supra FN 9
[26] Id.
[27] Id.
[28] 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.
[29] S. 408.8065, F.S., and s. 408.810, F.S.
[30] Supra FN 9.
[31] S. 400.9905(4), F.S.
[32] S. 400.9935(6), F.S.
[33] 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[34], portable x-ray providers[35], or rural health care clinics[36].

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.[37]

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[38], 225-236, and 368[39] 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.

[34] 42 C.F.R. §§. 485.900-485.920.
[35] 42 C.F.R. §§. 486.100-486.110.
[36] 42 C.F.R. §§. 491.1-491.12.
[37] Supra FN 9.
[38] 2019, HB 5001, General Appropriations Act, Funds in specific appropriation 208 are for the inclusion of freestanding dialysis clinics in the Medicaid Program.
[39] 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.[40]

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.[41]

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.[42]

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

[40] "Applied Behavioral Analysis", *Psychology Today*, available at https://www.psychologytoday.com/us/therapy-types/applied-behavior-analysis (last accessed January 31, 2020).
[41] Supra FN 9.
[42] Id.

clinic, in a scanned document that can be emailed upon request, or in posted signage of an undetermined size.[43]

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.[44]

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.[45] 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.[46] 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.[47] AHCA publishes the electronic prescribing data online[48], 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.

[43] Supra FN 9.
[44] 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).
[45] S. 408.0611(2)(a), F.S.
[46] Ch. 2007-156, Laws of Fla.
[47] S. 408.0611(4), F.S.
[48] 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[49], 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.[50]

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

[49] 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).
[50] 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.[51]

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[52] 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.[53] 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.[54]

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.[55]

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.[56]

[51] Id.
[52] Ch. 2002-389, Laws of Fla.
[53] S. 409.909(3), F.S.
[54] Supra FN 9.
[55] Id.
[56] 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.[57]

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.[58] 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.[59] Further, DCF would no longer be required to disseminate the list to their contracted service providers.

[57] Supra FN 9.
[58] Id.
[59] 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.[60] 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 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.[61]

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

[60] Ch. 2014-84, Laws of Fla.
[61] 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.[62]

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.[63] 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.[64] 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.[65] 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.[66]

Since 2011, AHCA has imposed only six fines against multiphasic health testing centers, and received only 10 complaints, with none substantiated.[67]

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.[68] 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.[69]

A provisional license is issued to an applicant for licensure renewal when a proceeding is pending to deny or revoke their license.[70] A provisional license may also be issued to an applicant applying for a

[62] S. 483.288(2), F.S.
[63] 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 (last accessed January 31, 2020).
[64] 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)
[65] Id.
[66] Supra FN 9.
[67] Id.
[68] S. 408.808(1), F.S.
[69] S. 408.808(3), F.S.
[70] 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.[71] 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.[72] 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.[73]

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;

[71] Supra FN 9.
[72] S. 429.41(1)(b), F.S.
[73] 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.[74]

MPI also conducts provider audits based on probable cause through the Alien Audit Program, which was created in 2010[75]. 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.[76] 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.[77]

Federal regulations require AHCA to have a post-payment review process for all Medicaid services.[78] 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.[79]

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.[80] 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.

[74] Id.
[75] Ch. 2009-223 Laws of Fla.
[76] *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).
[77] Supra FN 9.
[78] 42 C.F.R. § 456.23.
[79] 42 C.F.R. § 455.12.
[80] 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.[81]

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.

[81] 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.[82]

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.[83] AHCA expects 28,291 providers to qualify for the exemption.[84] 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.[85] 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.[86]

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.[87] 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.[88]

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

[82] Supra FN 9.
[83] 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 (last accessed January 31, 2020).
[84] Supra FN 9.
[85] Id.
[86] HB 5001, specific appropriations 229 and 230.
[87] Id.
[88] 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.

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring birth centers to report certain deaths and stillbirths to the Agency for Health Care Administration; removing a requirement that a certain report be submitted annually to the agency; authorizing the agency to prescribe by rule the frequency at which such report is submitted; amending s. 395.003, F.S.; removing a requirement that specified information be listed on licenses for certain facilities; repealing s. 395.7015, F.S., relating to an annual assessment on health care entities; amending s. 395.7016, F.S.; conforming a provision to changes made by the act; amending s. 400.19, F.S.; revising provisions requiring the agency to conduct licensure inspections of nursing homes; requiring the agency to conduct additional licensure surveys under certain circumstances; revising a provision requiring the agency to assess a specified fine for such surveys; amending s. 400.462, F.S.; revising definitions; amending ss. 400.464, 400.471, 400.492, 400.506, and 400.509, F.S.; revising provisions relating to licensure requirements for home health agencies to conform to changes made by the act; exempting certain

persons and entities from such licensure requirements; amending s. 400.605, F.S.; removing a requirement that the agency conduct specified inspections of certain licensees; amending s. 400.60501, F.S.; removing an obsolete date and a requirement that the agency develop a specified annual report; amending s. 400.9905, F.S.; revising the definition of the term "clinic"; amending s. 400.991, F.S.; conforming provisions to changes made by the act; removing the option for health care clinics to file a surety bond under certain circumstances; amending s. 400.9935, F.S.; requiring certain clinics to publish and post a schedule of charges; amending s. 408.033, F.S.; conforming a provision to changes made by the act; amending s. 408.061, F.S.; revising provisions requiring health care facilities to submit specified data to the agency; amending s. 408.0611, F.S.; requiring the agency to annually publish a report on the progress of implementation of electronic prescribing on its Internet website; amending s. 408.062, F.S.; requiring the agency to annually publish certain information on its Internet website; removing a requirement that the agency submit certain annual reports to the Governor and Legislature; amending s. 408.063, F.S.; removing a requirement that

the agency annually publish certain reports; amending ss. 408.802, 408.820, 408.831, and 408.832, F.S.; conforming provisions to changes made by the act; amending s. 408.803, F.S.; conforming a provision to changes made by the act; providing a definition of the term "low-risk provider"; amending s. 408.806, F.S.; exempting certain low-risk providers from a specified inspection; amending s. 408.808, F.S.; authorizing the issuance of a provisional license to certain applicants; amending s. 408.809, F.S.; revising provisions relating to background screening requirements for certain licensure applicants; removing an obsolete date and provisions relating to certain rescreening requirements; amending s. 408.811, F.S.; authorizing the agency to exempt certain low-risk providers from inspections and conduct unannounced licensure inspections of such providers under certain circumstances; authorizing the agency to adopt rules to waive routine inspections and grant extended time periods between relicensure inspections under certain conditions; amending s. 408.821, F.S.; revising provisions requiring licensees to have a specified plan; providing requirements for the submission of such plan; amending s. 408.909, F.S.; removing a requirement that the agency and Office of

Insurance Regulation evaluate a specified program; amending s. 408.9091, F.S.; removing a requirement that the agency and office jointly submit a specified annual report to the Governor and Legislature; amending s. 409.905, F.S.; providing construction for a provision that requires the agency to discontinue its hospital retrospective review program under certain circumstances; providing legislative intent; amending s. 409.907, F.S.; requiring that a specified background screening be conducted through the agency on certain persons and entities; amending s. 409.913, F.S.; revising a requirement that the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs submit a specified report to the Legislature; authorizing the agency to recover specified costs associated with an audit, investigation, or enforcement action relating to provider fraud under the Medicaid program; amending ss. 409.967 and 409.973, F.S.; revising the length of managed care plan and Medicaid prepaid dental health program contracts, respectively, procured by the agency beginning during a specified timeframe; requiring the agency to extend the term of certain existing contracts until a specified date; amending s. 429.11, F.S.; removing an authorization for the issuance of a

provisional license to certain facilities; amending s. 429.19, F.S.; removing requirements that the agency develop and disseminate a specified list and the Department of Children and Families disseminate such list to certain providers; amending ss. 429.35, 429.905, and 429.929, F.S.; revising provisions requiring a biennial inspection cycle for specified facilities and centers, respectively; repealing part I of chapter 483, F.S., relating to The Florida Multiphasic Health Testing Center Law; providing effective dates.

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

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner and the agency.

(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency at which it is submitted shall be prescribed by rule of the agency.

Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed on the face of the license. ~~All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds.~~ A licensed facility shall not operate a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

Section 3. Section 395.7015, Florida Statutes, is repealed.

Section 4. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015, and~~ the reduction by chapter 2000-256, Laws of Florida, in the assessment on hospitals under s. 395.701~~,~~ and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as state match for the state's Medicaid program.

Section 5. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall conduct periodic, ~~every 15 months conduct at least one~~ unannounced licensure inspections ~~inspection~~ to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under ~~the provisions of~~ those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. ~~The survey shall be conducted every 6 months for the next 2-year period~~ If the facility has been cited for a class I deficiency or~~,~~ has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, the agency shall conduct an additional licensure survey ~~or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency~~. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the additional licensure survey ~~6-month survey cycle~~. The fine for the additional licensure survey ~~2-year period~~ shall be $3,000 ~~$6,000, one-half to be paid at the completion of each survey~~. The agency may adjust such ~~this~~ fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through

subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to ~~the provisions of~~ chapter 110.

Section 6. Subsections (23) through (30) of section 400.462, Florida Statutes, are renumbered as subsections (22) through (29), respectively, and subsections (12), (14), (17), and (21) and present subsection (22) of that section are amended to read:

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

(12) "Home health agency" means a person or entity ~~an organization~~ that provides one or more home health services ~~and staffing services~~.

(14) "Home health services" means health and medical services and medical supplies furnished ~~by an organization~~ to an individual in the individual's home or place of residence. The term includes ~~organizations that provide one or more of~~ the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(17) "Home infusion therapy provider" means a person or entity ~~an organization~~ that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(21) "Nurse registry" means a ~~any~~ person or entity that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395, this chapter, or chapter 429 or other business entities.

~~(22) "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.~~

Section 7. Subsections (1), (4), and (5) of section 400.464, Florida Statutes, are amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and persons or entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license or registration issued by the agency is required in order to operate a home health agency in this state. A license or registration issued on or after July 1, 2018, must specify the home health services the licensee or registrant ~~organization~~ is authorized to perform and indicate whether such specified services are considered skilled care. The

provision or advertising of services that require licensure or registration pursuant to this part without such services being specified on the face of the license or registration issued on or after July 1, 2018, constitutes unlicensed activity as prohibited under s. 408.812.

(4)(a) A licensee or registrant ~~An organization~~ that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the licensee or registrant ~~organization~~ by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant that ~~who~~ fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500. The holder of a license or registration issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license or registration other than the one it has been issued.

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such

violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

(c) A person or entity that ~~who~~ violates paragraph (a) is subject to an injunctive proceeding under s. 408.816. A violation of paragraph (a) or s. 408.812 is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(d) A person or entity that ~~who~~ violates ~~the provisions of~~ paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any person or entity that ~~who~~ commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(e) A ~~Any~~ person or entity that ~~who~~ owns, operates, or maintains an unlicensed home health agency and ~~who~~, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(f) A ~~Any~~ home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812.

(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding ~~the provisions of~~ this act.

5. The Department of Children and Families.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part I of chapter 429, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part IV of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services for which the adult family-care home is licensed under part II of chapter 429, to serve the residents in its facility.

(o) A person or entity that provides skilled care by health care professionals licensed solely under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486.

(p) A person or entity that provides services using only volunteers or individuals related by blood or marriage to the patient or client.

Section 8. Paragraph (g) of subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care services must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(g) In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. A home health agency that does not provide skilled care is exempt from this paragraph. Notwithstanding s. 408.806, the ~~an initial~~ applicant must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is

recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for licensure. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes release of, and the agency receives the report of, the accrediting organization.

Section 9. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.—Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall

describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other health care providers ~~organizations~~ subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be

continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 10. Subsection (4) and paragraph (a) of subsection (5) of section 400.506, Florida Statutes, are amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(4) A licensee ~~person~~ that provides, offers, or advertises to the public any service for which licensure is required under this section must include in such advertisement the license number issued to it by the Agency for Health Care Administration. The agency shall assess a fine of not less than $100 against a ~~any~~ licensee that ~~who~~ fails to include the license number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500.

(5)(a) In addition to the requirements of s. 408.812, a ~~any~~ person or entity that ~~who~~ owns, operates, or maintains an unlicensed nurse registry and ~~who~~, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

Section 11. Subsections (1), (2), (4), and (5) of section 400.509, Florida Statutes, are amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) A person or entity ~~Any organization~~ that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, a person or entity ~~any organization~~ that provides companion services or homemaker services must register with the agency. A person or entity ~~An organization~~ under contract with the Agency for Persons with Disabilities that ~~which~~ provides companion services only for persons with a developmental disability, as defined in s. 393.063, is exempt from registration.

(2) The requirements of part II of chapter 408 apply to the provision of services that require registration or licensure pursuant to this section and part II of chapter 408 and entities registered by or applying for such registration from the Agency for Health Care Administration pursuant to this section. Each applicant for registration and each registrant must comply with all provisions of part II of chapter 408. Registration or a license issued by the agency is required for the operation of a person or entity ~~an organization~~ that provides companion services or homemaker services.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person or entity ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's or contractor's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(5) A person or entity that offers or advertises to the public a service for which registration is required must include in its advertisement the registration number issued by the Agency for Health Care Administration.

Section 12. Subsection (3) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—

(3) In accordance with s. 408.811, the agency shall conduct ~~annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The agency shall conduct~~ such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules.

Section 13. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting~~; annual report~~.—

(1) ~~No later than December 31, 2019,~~ The agency shall adopt the national hospice outcome measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state.

(2) The agency shall~~:~~

~~(a)~~ 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.

~~(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.~~

Section 14. Paragraphs (a), (b), (c), and (d) of subsection (4) of section 400.9905, Florida Statutes, are amended, and paragraphs (o), (p), and (q) are added to that subsection, to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B,

~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective

certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective

certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the

scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(o) Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a mutual insurance holding company, as defined in s. 628.703, with an entity licensed or certified under chapter 627 or chapter 641 which has $1 billion or more in total annual sales in this state.

(p) Entities that are owned by an entity that is a behavioral health care service provider in at least five other states; that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services; and wherein one or more of the

persons responsible for the operations of the entity is a health care practitioner who is licensed in this state, who is responsible for supervising the business activities of the entity, and who is responsible for the entity's compliance with state law for purposes of this part.

(q) Medicaid providers.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 15. Paragraph (c) of subsection (3) of section 400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.—

(3) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under ss. 408.8065(1) and ~~s.~~ 408.810(8). ~~As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic,~~

~~payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.~~

Section 16. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous place in the reception area of any clinic that is considered an ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must include, but is not limited to, the 50 services most frequently provided by the clinic. ~~The schedule may group services by three price levels, listing services in each price level.~~ The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is considered an urgent care center, to publish and post a schedule of charges as required by this section shall result in

a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 17. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and health care clinics~~, and multiphasic testing centers~~ and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 18. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

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

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

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

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

Section 19. Subsection (4) of section 408.0611, Florida Statutes, is amended to read:

408.0611 Electronic prescribing clearinghouse.—

(4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. ~~By January 31 of each year,~~ The agency shall annually publish a report on the progress of implementation of electronic prescribing on its Internet website ~~to the Governor and the Legislature~~. Information reported pursuant to this subsection shall include 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 transmitted.

Section 20. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(i) The use of emergency department services by patient acuity level ~~and the implication of increasing hospital cost by providing nonurgent care in emergency departments~~. The agency shall annually publish information ~~submit an annual report~~ based on this monitoring and assessment on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific

medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall annually publish information regarding ~~submit an annual status report on~~ the collection of data and publication of health care quality measures on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

Section 21. Subsection (5) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.—

~~(5) The agency shall publish annually a comprehensive report of state health expenditures. The report shall identify:~~

~~(a) The contribution of health care dollars made by all payors.~~

~~(b) The dollars expended by type of health care service in Florida.~~

Section 22. Section 408.802, Florida Statutes, is amended to read:

408.802 Applicability.~~The provisions of~~ This part applies ~~apply~~ to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102.

(2) Birth centers, as provided under chapter 383.

(3) Abortion clinics, as provided under chapter 390.

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394.

(6) Residential treatment facilities, as provided under part IV of chapter 394.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.

(8) Hospitals, as provided under part I of chapter 395.

(9) Ambulatory surgical centers, as provided under part I of chapter 395.

(10) Nursing homes, as provided under part II of chapter 400.

(11) Assisted living facilities, as provided under part I of chapter 429.

(12) Home health agencies, as provided under part III of chapter 400.

(13) Nurse registries, as provided under part III of chapter 400.

(14) Companion services or homemaker services providers, as provided under part III of chapter 400.

(15) Adult day care centers, as provided under part III of chapter 429.

(16) Hospices, as provided under part IV of chapter 400.

(17) Adult family-care homes, as provided under part II of chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.

~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 23. Subsections (10) through (14) of section 408.803, Florida Statutes, are renumbered as subsections (11) through (15), respectively, subsection (3) is amended, and a new subsection (10) is added to that section, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765.

(10) "Low-risk provider" means a nonresidential provider, including a nurse registry, a home medical equipment provider, or a health care clinic.

Section 24. Paragraph (b) of subsection (7) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(7)

(b) An initial inspection is not required for companion services or homemaker services providers~~,~~ as provided under part III of chapter 400, ~~or~~ for health care services pools~~,~~ as provided under part IX of chapter 400, or for low-risk providers as provided in s. 408.811(1)(c).

Section 25. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(2) PROVISIONAL LICENSE.—An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant making initial application for licensure or making application ~~applying~~ for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

Section 26. Subsections (6) through (9) of section 408.809, Florida Statutes, are renumbered as subsections (5) through (8), respectively, and subsections (2) and (4) and present subsection (5) of that section are amended to read:

408.809 Background screening; prohibited offenses.—

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print

arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. ~~Until a specified agency is fully implemented in the clearinghouse created under s. 435.12,~~ The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of ~~the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or~~ the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;

(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and

(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

If, upon rescreening, a person who is currently employed or contracted with a licensee ~~as of June 30, 2014,~~ and was screened and qualified under s. ~~ss. 435.03 and~~ 435.04~~,~~ has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.

~~(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the~~

~~appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:~~

~~(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.~~

~~(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.~~

~~(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.~~

Section 27. Subsection (1) of section 408.811, Florida Statutes, is amended to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.—

(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has

reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(a) All inspections shall be unannounced, except as specified in s. 408.806.

(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from a licensure inspection if the provider or a controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory actions as defined in agency rule. The agency must conduct unannounced licensure inspections on at least 10 percent of the exempt low-risk providers to verify regulatory compliance.

(d) The agency may adopt rules to waive any inspection, including a relicensure inspection, or grant an extended time period between relicensure inspections based upon:

1. An excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory measures.

2. Outcome measures that demonstrate quality performance.

3. Successful participation in a recognized, quality program.

4. Accreditation status.

5. Other measures reflective of quality and safety.

6. The length of time between inspections.

The agency shall continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for an exemption or extended period between relicensure inspections. The agency may conduct an inspection of any provider at any time to verify regulatory compliance.

Section 28. Subsection (24) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

~~(24) Multiphasic health testing centers, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 29. Subsections (1) and (2) of section 408.821, Florida Statutes, are amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(1) A licensee required by authorizing statutes and agency rule to have a comprehensive ~~an~~ emergency management ~~operations~~ plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:

(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.

(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.

(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.

(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management ~~operations~~ plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate

care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

Section 30. Subsection (3) of section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to those chapters.

Section 31. Section 408.832, Florida Statutes, is amended to read:

408.832 Conflicts.—In case of conflict between ~~the provisions of~~ this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this part shall prevail.

Section 32. Subsection (9) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

~~(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 15, 2016, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 33. Paragraph (d) of subsection (10) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(10) PROGRAM EVALUATION.—The agency and the office shall:

~~(d) Jointly submit by March 1, annually, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.~~

Section 34. Effective upon becoming a law, paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the

state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall 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.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization

for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; 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.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However, this subparagraph may not be construed to prevent the agency from

conducting retrospective reviews under s. 409.913, including reviews in which overpayment is suspected due to improper claiming, mistake, or any other reason that does not rise to the level of fraud or abuse.

Section 35. It is the intent of the Legislature that s. 409.905(5)(a), Florida Statutes, as amended by this act, confirm and clarify existing law.

Section 36. Subsection (8) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(8)(a) A level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following:

1. The ~~Each~~ provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity~~, seeking to participate in the Medicaid program~~

~~must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check~~.

2. Principals of the provider, who include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury,

to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

3. Any person who participates or seeks to participate in the Medicaid program by way of rendering services to Medicaid recipients or having 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. This subparagraph does not impose additional screening requirements on any providers licensed under part II of chapter 408.

(b) Notwithstanding paragraph (a) ~~the above~~, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(c) ~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:

1. A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2. Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(d) ~~(b)~~ Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

Section 37. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 ~~1~~, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a ~~joint~~ report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal

claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards,

benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

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

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance

with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track

Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud,

misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review

organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-

related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11) The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13) The agency shall terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2). If the agency determines that the provider did not participate or acquiesce in the offense, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action.

(14) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in

effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, or ordered or authorized the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time ranging from more than 1 year to 20 years. Termination precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid

provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that remain in effect for up to 3 years and that are monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted

in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history

of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the

case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note

was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

(23)(a) In an audit, ~~or~~ investigation, or enforcement action for ~~of~~ a violation committed by a provider which is conducted or taken pursuant to this section, the agency or contractor is entitled to recover any and all investigative and~~,~~ legal costs incurred as a result of such audit, investigation, or enforcement action. Such costs may include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on the case, and any other expenses incurred by the agency or contractor that are associated with the case, including any~~, and~~ expert witness costs and attorney fees incurred on behalf of the agency or contractor if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another

state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must

be made within 30 days after the date of the final order, which is not subject to further appeal.

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(26) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(28) Venue for all Medicaid program integrity cases lies in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within

30 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold reimbursement payments for Medicaid services until the amount due is paid in full.

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection

shall include only records specifically related to that provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency's efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of explanations of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation, information on how to report criminal Medicaid fraud to the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 38. Subsection (1) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year ~~5-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

Section 39. Paragraph (b) of subsection (5) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act

and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process. Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 ~~5~~ years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.

Section 40. Subsection (6) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application~~

~~for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 41. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

~~(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly 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 Care Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.~~

Section 42. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of an ~~the biennial~~ inspection conducted ~~visit required~~ under s. 408.811 or within 30 days after the date of an ~~any~~ interim visit, the agency shall forward the results of the inspection to the local ombudsman council in the district where the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

Section 43. Subsection (2) of section 429.905, Florida Statutes, is amended to read:

429.905 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.—

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection ~~and at least biennially~~ to ensure adequate space and

sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule. For the purpose of this subsection, the term "day" means any portion of a 24-hour day.

Section 44. Subsection (2) of section 429.929, Florida Statutes, is amended to read:

429.929 Rules establishing standards.—

~~(2) Pursuant to this part, s. 408.811, and applicable rules, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of provider groups. These standards shall be included in rules adopted by the agency.~~

Section 45. Part I of chapter 483, Florida Statutes, is repealed.

Section 46. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1,

2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Perez offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner and the agency.

(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency at which it is submitted shall be prescribed by rule of the agency.

Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed on the face of the license. ~~All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds.~~ A licensed facility shall not operate a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

Section 3. Subsection (18) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) The establishment of two hospital program licensure levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

(b)1. For a hospital seeking a Level I program, demonstration that, for the most recent 12-month period as

reported to the agency, the hospital has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes.

2.a. A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program is not required to meet the diagnostic cardiac catheterization volume and ischemic heart disease diagnosis volume requirements in subparagraph 1. if the hospital demonstrates that it has, for the most recent 12-month period as reported to the agency, provided a minimum of 100 adult inpatient and outpatient diagnostic cardiac catheterizations or that, for the most recent 12-month period, it has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease.

b. A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program does not need to meet the 60-minute transfer time protocol requirement in subparagraph 1. if the hospital demonstrates that it has a formalized, written transfer agreement with a hospital that has a Level II program. The agreement must include written transport

protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather conditions, and viability of ground and air ambulance service to transfer the patient.

3. At a minimum, the rules for adult cardiovascular services must require nursing and technical staff to have demonstrated experience in handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:

a. Had an annual volume of 500 or more percutaneous cardiac intervention procedures.

b. Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures.

c. Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures.

d. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational

atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

(c) For a hospital seeking a Level II program, demonstration that, for the most recent 12-month period as reported to the agency, the hospital has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

(d) Compliance with the most recent guidelines of the American College of Cardiology and the American Heart Association guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria, to ensure patient quality and safety.

(e) The establishment of appropriate hours of operation and protocols to ensure availability and timely referral in the event of emergencies.

(f) The demonstration of a plan to provide services to Medicaid and charity care patients.

(g) Hospitals licensed for adult diagnostic cardiac catheterization, Level I or Level II adult cardiovascular services must participate in the American College of Cardiology – National Cardiovascular Data Registry or the American Heart Association Get with the Guidelines – Coronary Artery Disease

Data Registry and document an ongoing quality improvement plan to ensure these licensed programs meet or exceed national quality and outcome benchmarks reported by the registry in which they participate. Hospitals licensed for Level II adult cardiovascular services must also participate in the clinical outcome reporting systems operated by the Society for Thoracic Surgeons.

Section 4. Paragraph (b) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

(b) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a

rural hospital from the date of designation through June 30, 2025~~2021~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 5. Section 395.7015, Florida Statutes, is repealed.

Section 6. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015, and~~ the reduction by chapter 2000-256, Laws of Florida, in the assessment on hospitals under s. 395.701~~,~~ and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as state match for the state's Medicaid program.

Section 7. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall conduct periodic, ~~every 15 months conduct at least one~~ unannounced licensure inspections ~~inspection~~ to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under ~~the~~

~~provisions of~~ those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. ~~The survey shall be conducted every 6 months for the next 2-year period~~ If the facility has been cited for a class I deficiency or~~,~~ has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency, the agency shall conduct biannual licensure surveys until the facility has two consecutive licensure surveys without a citation for a Class I or a Class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine of ~~for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be~~ $6,000 for the biannual licensure surveys~~, one-half to be paid at the completion of each survey~~. The agency may adjust such ~~this~~ fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which

provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to ~~the provisions of~~ chapter 110.

Section 8. Subsections (23) through (30) of section 400.462, Florida Statutes, are renumbered as subsections (22) through (29), respectively, and subsections (12), (14), (17), and (21) and present subsection (22) of that section are amended to read:

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

(12) "Home health agency" means a person ~~an organization~~ that provides one or more home health services ~~and staffing services~~.

(14) "Home health services" means health and medical services and medical supplies furnished ~~by an organization~~ to an individual in the individual's home or place of residence. The term includes ~~organizations that provide one or more of~~ the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(17) "Home infusion therapy provider" means a person ~~an organization~~ that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(21) "Nurse registry" means any person that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395, this chapter, or chapter 429 or other business entities.

~~(22) "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.~~

Section 9. Subsections (1), (4), and (5) of section 400.464, Florida Statutes, are amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and persons or entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license or registration issued by the agency is required in order to operate a home health agency in this state. A license or registration issued on or after July 1, 2018, must specify the home health services the licensee or registrant ~~organization~~ is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services that require licensure or registration pursuant to this part without such services being specified on the face of the license or registration issued on or after July 1, 2018, constitutes unlicensed activity as prohibited under s. 408.812.

(4)(a) A licensee or registrant ~~An organization~~ that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the licensee or registrant ~~organization~~ by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant that ~~who~~ fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500. The holder of a license or registration issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license or registration other than the one it has been issued.

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

(c) A person who violates paragraph (a) is subject to an injunctive proceeding under s. 408.816. A violation of paragraph (a) or s. 408.812 is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(d) A person who violates the provisions of paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any person who commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(e) Any person who owns, operates, or maintains an unlicensed home health agency and who, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(f) A ~~Any~~ home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812.

(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding ~~the provisions of~~ this act.

5. The Department of Children and Families.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the

scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part I of chapter 429, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part IV of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services for which the adult family-care home is licensed under part II of chapter 429, to serve the residents in its facility.

(o) A person that provides skilled care by health care professionals licensed solely under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486. This exemption does not entitle an individual to perform home health services without the required professional license.

(p) A person that provides services using only volunteers or individuals related by blood or marriage to the patient or client.

Section 10. Paragraph (g) of subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care

services must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(g) In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. A home health agency that does not provide skilled care is exempt from this paragraph. Notwithstanding s. 408.806, the ~~an initial~~ applicant must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for licensure. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home

health agency authorizes release of, and the agency receives the report of, the accrediting organization.

Section 11. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.—Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other health care providers ~~organizations~~ subject to written agreement; and

prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 12. Subsection (4) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(4) A licensee ~~person~~ that provides, offers, or advertises to the public any service for which licensure is required under this section must include in such advertisement the license number issued to it by the Agency for Health Care Administration. The agency shall assess a fine of not less than $100 against a ~~any~~ licensee that ~~who~~ fails to include the license number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500.

Section 13. Subsections (1), (2), (3), (4), and (5) of section 400.509, Florida Statutes, are amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) Any person ~~organization~~ that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any person ~~organization~~ that provides companion services or homemaker services must register with the agency. A person ~~An~~ organization under contract with the Agency for Persons with Disabilities which provides companion services only for persons with a developmental disability, as defined in s. 393.063, is exempt from registration.

(2) The requirements of part II of chapter 408 apply to the provision of services that require registration or licensure

pursuant to this section and part II of chapter 408 and entities registered by or applying for such registration from the Agency for Health Care Administration pursuant to this section. Each applicant for registration and each registrant must comply with all provisions of part II of chapter 408. Registration or a license issued by the agency is required for a person to provide ~~the operation of an organization that provides~~ companion services or homemaker services.

(3) In accordance with s. 408.805, applicants and registrants shall pay fees for all registrations issued under this part, part II of chapter 408, and applicable rules. The amount of the fee shall be $50 per biennium.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's or contractor's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

Section 14. Subsection (3) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—

(3) In accordance with s. 408.811, the agency shall conduct ~~annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The agency shall conduct~~ such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules.

Section 15. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting~~; annual report~~.—

(1) ~~No later than December 31, 2019,~~ The agency shall adopt the national hospice outcome measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state.

(2) The agency shall~~:~~

~~(a)~~ 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.

~~(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.~~

Section 16. Paragraphs (a), (b), (c), and (d) of subsection (4) of section 400.9905, Florida Statutes, are amended, and paragraphs (o), (p), and (q) are added to that subsection, to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and

providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or

registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an

entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common

ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(o) Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a

mutual insurance holding company, as defined in s. 628.703, with an entity licensed or certified under chapter 627 or chapter 641 which has $1 billion or more in total annual sales in this state.

(p) Entities that are owned by an entity that is a behavioral health care service provider in at least five other states; that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services; and wherein one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state, who is responsible for supervising the business activities of the entity, and who is responsible for the entity's compliance with state law for purposes of this part.

(q) Medicaid providers.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 17. Paragraph (c) of subsection (3) of section 400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.—

(3) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under ss. 408.8065(1) and ~~s.~~ 408.810(8). ~~As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.~~

Section 18. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous

place in the reception area of any clinic that is considered an ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must include, but is not limited to, the 50 services most frequently provided by the clinic. ~~The schedule may group services by three price levels, listing services in each price level.~~ The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is considered an urgent care center, to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 19. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and health care clinics~~, and multiphasic testing centers~~ and by assessments on organizations subject to certification by the

agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 20. Effective January 1, 2021, subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Transparency.—

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

(l) By July 1 of each year, publish a report identifying the health care services with the most significant price variation both statewide and regionally.

Section 21. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

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

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall

be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to, ~~:~~ case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, including patient- ~~with patient~~ and provider-specific identifiers ~~included~~, actual charge data by diagnostic groups or other bundled groupings as specified by rule, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents including ~~such~~

~~as~~, but not limited to, ~~:~~ leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. ~~Reported~~ Data elements shall be reported electronically in accordance with rules adopted by the agency ~~rule 59E-7.012, Florida Administrative Code~~. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 22. Subsection (4) of section 408.0611, Florida Statutes, is amended to read:

408.0611 Electronic prescribing clearinghouse.—

(4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. ~~By January 31 of each year,~~ The agency shall annually publish a report on the progress of implementation of electronic prescribing on its Internet website ~~to the Governor and the Legislature~~. Information reported pursuant to this subsection shall include 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 transmitted.

Section 23. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(i) The use of emergency department services by patient acuity level ~~and the implication of increasing hospital cost by providing nonurgent care in emergency departments~~. The agency shall annually publish information ~~submit an annual report~~ based on this monitoring and assessment on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of

admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall annually publish information regarding ~~submit an annual status report on~~ the collection of data and publication of health care quality measures on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

Section 24. Subsection (5) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.—

~~(5) The agency shall publish annually a comprehensive report of state health expenditures. The report shall identify:~~

~~(a) The contribution of health care dollars made by all payors.~~

~~(b) The dollars expended by type of health care service in Florida.~~

Section 25. Section 408.802, Florida Statutes, is amended to read:

408.802 Applicability.~~The provisions of~~ This part applies ~~apply~~ to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102.

(2) Birth centers, as provided under chapter 383.

(3) Abortion clinics, as provided under chapter 390.

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394.

(6) Residential treatment facilities, as provided under part IV of chapter 394.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.

(8) Hospitals, as provided under part I of chapter 395.

(9) Ambulatory surgical centers, as provided under part I of chapter 395.

(10) Nursing homes, as provided under part II of chapter 400.

(11) Assisted living facilities, as provided under part I of chapter 429.

(12) Home health agencies, as provided under part III of chapter 400.

(13) Nurse registries, as provided under part III of chapter 400.

(14) Companion services or homemaker services providers, as provided under part III of chapter 400.

(15) Adult day care centers, as provided under part III of chapter 429.

(16) Hospices, as provided under part IV of chapter 400.

(17) Adult family-care homes, as provided under part II of chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.

~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 26. Subsections (10) through (14) of section 408.803, Florida Statutes, are renumbered as subsections (11) through (15), respectively, subsection (3) is amended, and a new subsection (10) is added to that section, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765.

(10) "Low-risk provider" means a nonresidential provider, including a nurse registry, a home medical equipment provider, or a health care clinic.

Section 27. Paragraph (b) of subsection (7) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(7)

(b) An initial inspection is not required for companion services or homemaker services providers~~,~~ as provided under part III of chapter 400, ~~or~~ for health care services pools~~,~~ as provided under part IX of chapter 400, or for low-risk providers as provided in s. 408.811(1)(c).

Section 28. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(2) PROVISIONAL LICENSE.—An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant making initial application for licensure or making application ~~applying~~ for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

Section 29. Subsections (6) through (9) of section 408.809, Florida Statutes, are renumbered as subsections (5) through (8), respectively, and subsections (2) and (4) and present subsection (5) of that section are amended to read:

408.809 Background screening; prohibited offenses.—

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. ~~Until a specified agency is fully implemented in~~

~~the clearinghouse created under s. 435.12,~~ The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of ~~the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or~~ the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;

(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and

(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo

contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

If, upon rescreening, a person who is currently employed or contracted with a licensee ~~as of June 30, 2014,~~ and was screened and qualified under s. ~~ss. 435.03 and~~ 435.04~~,~~ has a

disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.

~~(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after~~

~~receipt of the rescreening results by the person. The rescreening schedule shall be:~~

~~(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.~~

~~(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.~~

~~(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.~~

Section 30. Subsection (1) of section 408.811, Florida Statutes, is amended to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.—

(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a

license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(a) All inspections shall be unannounced, except as specified in s. 408.806.

(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from a licensure inspection if the provider or a controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory actions as defined in agency rule. The agency must conduct unannounced licensure inspections on at least 10 percent of the exempt low-risk providers to verify regulatory compliance.

(d) The agency may adopt rules to waive any inspection, including a relicensure inspection, or grant an extended time period between relicensure inspections based upon:

1. An excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory measures.

2. Outcome measures that demonstrate quality performance.

3. Successful participation in a recognized, quality program.

4. Accreditation status.

5. Other measures reflective of quality and safety.

6. The length of time between inspections.

The agency shall continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for an exemption or extended period between relicensure inspections. The agency may conduct an inspection of any provider at any time to verify regulatory compliance.

Section 31. Subsection (24) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

~~(24) Multiphasic health testing centers, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 32. Subsections (1) and (2) of section 408.821, Florida Statutes, are amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(1) A licensee required by authorizing statutes and agency rule to have a comprehensive ~~an~~ emergency management ~~operations~~ plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency

management agency, county health department, or Department of Health as follows:

(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.

(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.

(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.

(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management ~~operations~~ plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

Section 33. Subsection (3) of section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to those chapters.

Section 34. Section 408.832, Florida Statutes, is amended to read:

408.832 Conflicts.—In case of conflict between ~~the~~ ~~provisions of~~ this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this part shall prevail.

Section 35. Subsection (9) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

~~(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall~~

~~use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 15, 2016, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 36. Paragraph (d) of subsection (10) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(10) PROGRAM EVALUATION.—The agency and the office shall:

~~(d) Jointly submit by March 1, annually, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.~~

Section 37. Effective upon becoming a law, paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to

Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall 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.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; 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.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However, this subparagraph may not be construed to prevent the agency from conducting retrospective reviews under s. 409.913, including, but not limited to, reviews in which an overpayment is suspected due to a mistake or submission of an improper claim or for other reasons that do not rise to the level of fraud or abuse.

Section 38. It is the intent of the Legislature that s. 409.905(5)(a), Florida Statutes, as amended by this act,

confirms and clarifies existing law. This section shall take effect upon becoming a law.

Section 39. Subsection (8) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(8)(a) A level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following:

1. The ~~Each~~ provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity~~, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check~~.

2. Principals of the provider, who include any officer, director, billing agent, managing employee, or affiliated

person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

3. Any person who participates or seeks to participate in the Medicaid program by way of rendering services to Medicaid recipients or having 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. This subparagraph does not impose additional screening requirements on any providers licensed under part II of chapter 408.

4. Non-emergency transportation drivers that are employed or contracted with transportation network companies or transportation brokers are not subject to level 2 screening, and must comply with level 1 background screening pursuant to chapter 435 or an equivalent as authorized in s. 381.87.

(b) Notwithstanding paragraph (a) ~~the above~~, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(c)~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:

1. A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2. Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(d) ~~(b)~~ Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

Section 40. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the

availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided in s. 409.905(5), except as otherwise provided in this subsection.

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

~~e. Class III psychiatric hospitals.~~

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year

under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.

Section 41. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 ~~1~~, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a ~~joint~~ report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the

cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the

Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

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

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program

and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by

the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to

increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician

or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal

business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11) The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13) The agency shall terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2). If the agency determines that the provider did not participate or acquiesce in the offense, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action.

(14) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's

participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, or ordered or authorized the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited

to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time ranging from more than 1 year to 20 years. Termination precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional

services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that remain in effect for up to 3 years and that are monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a

specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This

limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

(23)(a) In an audit, ~~or~~ investigation, or enforcement action for ~~of~~ a violation committed by a provider which is conducted or taken pursuant to this section, the agency or contractor is entitled to recover any and all investigative and~~,~~ legal costs incurred as a result of such audit, investigation, or enforcement action. Such costs may include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on the case, and any other expenses incurred by the agency or contractor that are associated with the case, including any~~, and~~ expert witness costs and attorney fees incurred on behalf of the agency or contractor if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated

from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is not subject to further appeal.

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(26) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(28) Venue for all Medicaid program integrity cases lies in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within 30 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold reimbursement payments for Medicaid services until the amount due is paid in full.

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a

provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection shall include only records specifically related to that provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency's

efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of explanations of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation, information on how to report criminal Medicaid fraud to the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other

applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or

the Federal Government which use technology to prevent or detect health care fraud.

Section 42. Paragraph (a) of subsection (2) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(2)(a) A person may not:

1. Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the agency or its fiscal agent or a managed care plan for payment.

2. Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

3. Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit the agency or its fiscal agent for any payment received from a third-party source.

4. Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the agency to

determine a general or specific rate of payment for an item or service provided by a provider.

5. Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program. This subparagraph does not apply to any discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or regulations promulgated thereunder.

6. Knowingly submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider.

7. Knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.

Section 43. Subsection (1) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year ~~5-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

Section 44. Paragraph (b) of subsection (5) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act

and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process. Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 ~~5~~ years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.

Section 45. Subsection (6) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application~~

~~for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 46. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

~~(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly 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 Care Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.~~

Section 47. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of an ~~the biennial~~ inspection conducted ~~visit required~~ under s. 408.811 or within 30 days after the date of an ~~any~~ interim visit, the agency shall forward the results of the inspection to the local ombudsman council in the district where the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

Section 48. Subsection (2) of section 429.905, Florida Statutes, is amended to read:

429.905 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.—

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection ~~and at least biennially~~ to ensure adequate space and

sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule. For the purpose of this subsection, the term "day" means any portion of a 24-hour day.

Section 49. Subsection (2) of section 429.929, Florida Statutes, is amended to read:

429.929 Rules establishing standards.—

~~(2) Pursuant to this part, s. 408.811, and applicable rules, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of provider groups. These standards shall be included in rules adopted by the agency.~~

Section 50. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 51. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

Section 52. Effective January 1, 2021, paragraph (e) of subsection (2) and paragraph (e) of subsection (3) of section 641.31076, Florida Statutes, are amended to read:

641.31076 Shared savings incentive program.—

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

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(l).

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared

savings incentive program. A health maintenance organization that offers a shared savings incentive program must:

(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, or credit the shared savings incentive amount to the subscriber's flexible spending account, health savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent ~~such that the amount does not constitute income to the subscriber~~.

Section 53. Part I of chapter 483, Florida Statutes, is repealed, and part II and part III of that chapter are redesignated as part I and part II, respectively.

Section 54. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

20.43 Department of Health.—There is created a Department of Health.

(3) The following divisions of the Department of Health are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. Respiratory therapy, as provided under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part I ~~part II~~ of chapter 483.

23. Medical physicists, as provided under part II ~~part III~~ of chapter 483.

24. The Board of Opticianry, created under part I of chapter 484.

25. The Board of Hearing Aid Specialists, created under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

30. Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 55. Subsection (3) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or part I ~~part II~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 56. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

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

(4) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 57. Paragraphs (h) and (i) of subsection (2) of section 456.057, Florida Statutes, are amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(h) Clinical laboratory personnel licensed under part I ~~part II~~ of chapter 483.

(i) Medical physicists licensed under part II ~~part III~~ of chapter 483.

Section 58. Paragraph (j) of subsection (1) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

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

(j) "Practitioner" means a person licensed, registered, certified, or regulated by the department under part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or

an applicant for a license, registration, or certification under the same laws.

Section 59. Paragraph (b) of subsection (1) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

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

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I or part II ~~part II or part III~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multistate health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

Section 60. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2020.

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

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring birth centers to report certain deaths and stillbirths to the Agency for Health Care Administration; removing a requirement that a certain report be submitted annually to the agency; authorizing the agency to prescribe by rule the frequency at which such report is submitted; amending s. 395.003, F.S.; removing a requirement that specified information be listed on licenses for certain facilities; amending s. 395.1055, F.S.; requiring the agency to adopt specified rules related to ongoing quality improvement programs for certain cardiac programs; repealing s. 395.7015, F.S., relating to an annual assessment on health care entities; amending s. 395.7016, F.S.; conforming a provision to changes made by the act; amending s. 400.19, F.S.; revising provisions requiring the agency to conduct licensure inspections of nursing homes; requiring the agency to conduct additional licensure surveys under certain circumstances; revising a provision requiring the agency to assess a specified fine for such surveys; amending s. 400.462, F.S.; revising definitions; amending s. 400.464, F.S.; revising exemptions from licensure requirements for home health agencies; amending ss. 400.471, 400.492, 400.506, and 400.509, F.S.; revising provisions relating to licensure requirements for home health agencies to

conform to changes made by the act; exempting certain persons and entities from such licensure requirements; amending s. 400.605, F.S.; removing a requirement that the agency conduct specified inspections of certain licensees; amending s. 400.60501, F.S.; removing an obsolete date and a requirement that the agency develop a specified annual report; amending s. 400.9905, F.S.; revising the definition of the term "clinic"; amending s. 400.991, F.S.; conforming provisions to changes made by the act; removing the option for health care clinics to file a surety bond under certain circumstances; amending s. 400.9935, F.S.; requiring certain clinics to publish and post a schedule of charges; amending s. 408.033, F.S.; conforming a provision to changes made by the act; amending s. 408.05, F.S.; requiring the agency to publish by a specified date an annual report identifying certain health care services; amending s. 408.061, F.S.; revising provisions requiring health care facilities to submit specified data to the agency; amending s. 408.0611, F.S.; requiring the agency to annually publish a report on the progress of implementation of electronic prescribing on its Internet website; amending s. 408.062, F.S.; requiring the agency to annually publish certain information on its Internet website; removing a requirement that the agency submit certain annual reports to the Governor and Legislature; amending s. 408.063, F.S.; removing a requirement that the agency annually publish certain reports; amending ss. 408.802, 408.820, 408.831,

and 408.832, F.S.; conforming provisions to changes made by the act; amending s. 408.803, F.S.; conforming a provision to changes made by the act; providing a definition of the term "low-risk provider"; amending s. 408.806, F.S.; exempting certain low-risk providers from a specified inspection; amending s. 408.808, F.S.; authorizing the issuance of a provisional license to certain applicants; amending s. 408.809, F.S.; revising provisions relating to background screening requirements for certain licensure applicants; removing an obsolete date and provisions relating to certain rescreening requirements; amending s. 408.811, F.S.; authorizing the agency to exempt certain low-risk providers from inspections and conduct unannounced licensure inspections of such providers under certain circumstances; authorizing the agency to adopt rules to waive routine inspections and grant extended time periods between relicensure inspections under certain conditions; amending s. 408.821, F.S.; revising provisions requiring licensees to have a specified plan; providing requirements for the submission of such plan; amending s. 408.909, F.S.; removing a requirement that the agency and Office of Insurance Regulation evaluate a specified program; amending s. 408.9091, F.S.; removing a requirement that the agency and office jointly submit a specified annual report to the Governor and Legislature; amending s. 409.905, F.S.; providing construction for a provision that requires the agency to

discontinue its hospital retrospective review program under certain circumstances; providing legislative intent; amending s. 409.907, F.S.; requiring that a specified background screening be conducted through the agency on certain persons and entities; amending s. 409.908, F.S.; revising provisions related to the prospective payment methodology for certain Medicaid provider reimbursements; amending s. 409.913, F.S.; revising a requirement that the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs submit a specified report to the Legislature; authorizing the agency to recover specified costs associated with an audit, investigation, or enforcement action relating to provider fraud under the Medicaid program; amending s. 409.920, F.S.; revising provisions related to prohibited referral practices in the Medicaid program; amending ss. 409.967 and 409.973, F.S.; revising the length of managed care plan and Medicaid prepaid dental health program contracts, respectively, procured by the agency beginning during a specified timeframe; requiring the agency to extend the term of certain existing contracts until a specified date; amending s. 429.11, F.S.; removing an authorization for the issuance of a provisional license to certain facilities; amending s. 429.19, F.S.; removing requirements that the agency develop and disseminate a specified list and the Department of Children and Families disseminate such list to certain providers; amending ss. 429.35, 429.905, and 429.929, F.S.; revising provisions

requiring a biennial inspection cycle for specified facilities and centers, respectively; repealing part I of chapter 483, F.S., relating to The Florida Multiphasic Health Testing Center Law; amending ss. 627.6387, 627.6648, and 641.31076, F.S.; revising the definition of the term "shoppable health care service"; revising duties of certain health insurers and health maintenance organizations; amending ss. 20.43, 381.0034, 456.001, 456.057, 456.076, and 456.47, F.S.; conforming cross-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.[1]

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.[2] 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.[3] The most commonly diagnosed mental disorders in children are attention deficit hyperactivity disorder (ADHD), behavior problems, anxiety, and depression.[4] 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.[5]

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.[6] Approximately 37.7% of those children received depression care.[7] 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.[8] Seventy-six children between the ages of 2 to 17 died by suicide in Florida in 2018.[9]

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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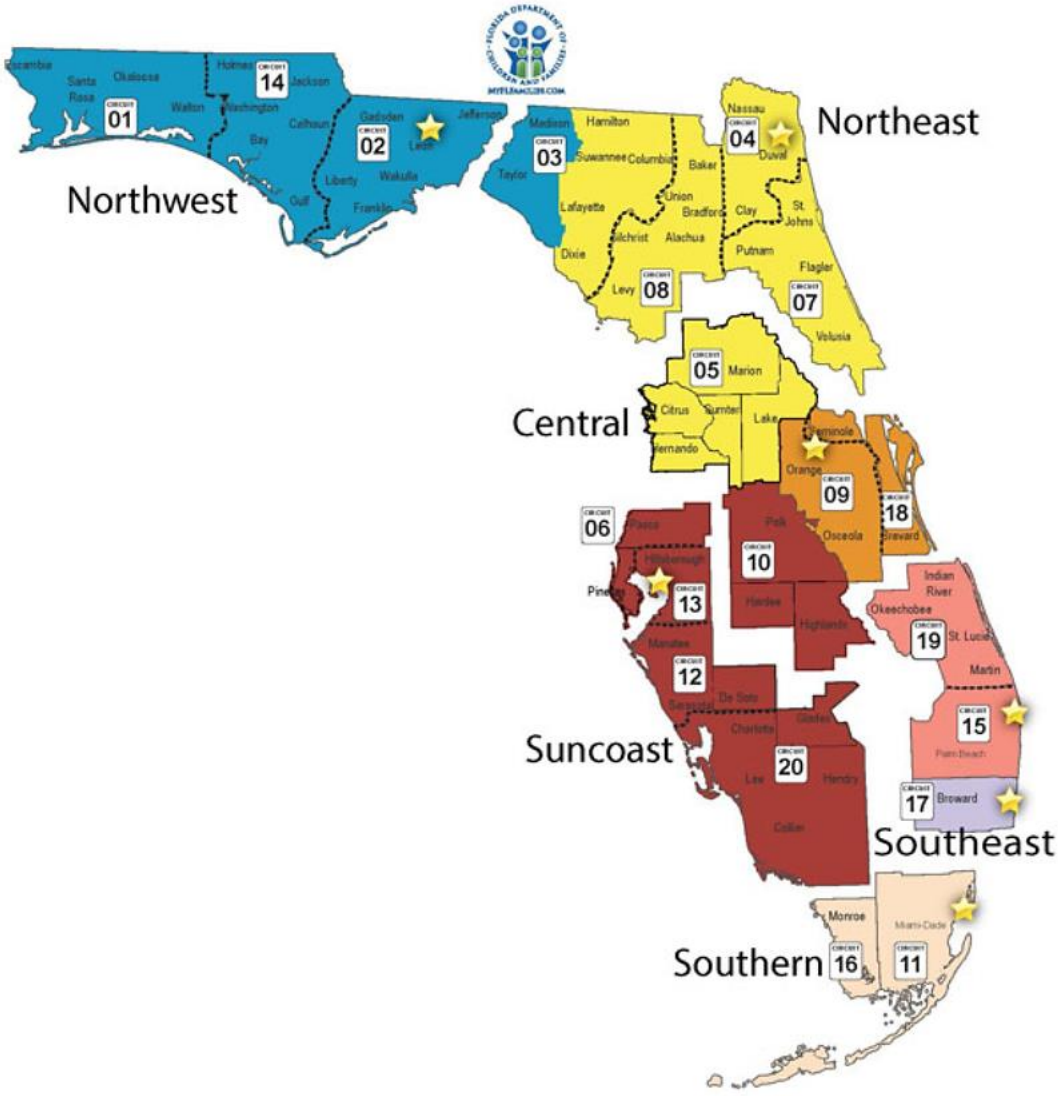
[1] Centers for Disease Control and Prevention, *Learn About Mental Health*, https://www.cdc.gov/mentalhealth/learn/ (last visited Feb. 21, 2020).
[2] Id.
[3] Centers for Disease Control and Prevention, *Data and Statistics on Children's Mental Health,* https://www.cdc.gov/childrensmentalhealth/data.html (last visited Feb. 21, 2020).
[4] Id.
[5] 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).
[6] 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).
[7] Id.
[8] 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).
[9] 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.[10] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[11] Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.[12]
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[13] for the delivery of mental health and substance abuse services:[14]



[10] Ch. 2001-191, Laws of Fla.
[11] Ch. 2008-243, Laws of Fla.
[12] *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.
[13] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[14] 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.[15]

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.[16] 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.[17] 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.[18] 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.[19] DCF must use performance-based contracts to award grants.[20]

There are several essential elements which make up a coordinated system of care, including: [21]

- 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

[15] 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).
[16] S. 394.9082(5)(d), F.S.
[17] S. 394.4573(1)(c), F.S.
[18] S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.
[19] Id.
[20] Id.
[21] 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:[22]

- 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. [23] 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.[24] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[25]

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.[26] 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.[27]

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.[28] 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

[22] S. 394.495(4), F.S.
[23] S. 394.9082(3)(c), F.S.
[24] S. 394.9082(5)(b), F.S.
[25] S. 394.75(3), F.S.
[26] Ss. 394.451-394.47892, F.S.
[27] S. 394.459, F.S.
[28] 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.[29]

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.[30] 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.[31] 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.[32]

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.[33] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[34] 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.[35] Individuals often enter the public mental health system through CSUs.[36] 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.[37]

As of September 2019, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.[38] Of the 54 public receiving facilities, 40 are CSU's.[39]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[40] 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.[41] If the patient is a minor, the examination must be initiated within 12 hours.[42]

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:[43]

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[29] S. 394.463(1), F.S.
[30] S. 394.455(39), F.S. This term does not include a county jail.
[31] S. 394.455(37), F.S
[32] Rule 65E-5.400(2), F.A.C.
[33] S. 394.875(1)(a), F.S.
[34] Id
[35] Id.
[36] 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).
[37] Id. Sections 394.65-394.9085, F.S.
[38] 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%20Faciliites.pdf (last visited Feb. 21, 2020). Hospitals can also be designated as public receiving facilities.
[39] Id.
[40] S. 394.463(2)(g), F.S.
[41] S. 394.463(2)(f), F.S.
[42] S. 394.463(2)(g), F.S.
[43] 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[44]

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

[44] 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[45] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[46]

- 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.[47]

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.[48] 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.[49] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children.[50] Children have a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%).[51] Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018, ranging from 2 to 19.[52] DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 initiations.[53] DCF's review of medical records found:[54]

- 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;

[45] Ch. 2017-151, Laws of Florida.
[46] 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).
[47] Id.
[48] Ch. 2019-134, Laws of Florida.
[49] *Supra,* note 44.
[50] Id. at 2.
[51] Id.
[52] Id.
[53] Id.
[54] 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.[55] 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.[56]

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.[57] 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.[58]

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.[59] 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.[60]

[55] *Supra,* note 46.
[56] *Supra* note 44, at 17-18.
[57] S. 1003.42(2)(n), F.S.
[58] S. 1012.01(2)(b), F.S.
[59] S. 1012.01(6), F.S.
[60] 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.[61] 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.[62]

DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.[63] 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.[64] 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.[65]

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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[61] *See* s. 1006.04(1)(a), F.S.
[62] S. 1006.04(1)(b), F.S.
[63] S. 1006.04(2), F.S.
[64] 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).
[65] 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)[66] within the Florida Department of Law Enforcement (FDLE).[67] The Commission is composed of 16 voting members and four nonvoting members.[68] 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."[69] 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.[70]

The Commission recommended:[71]

- 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.[72] Family members and caregivers of an individual experiencing a mental health crisis are often ill-

[66] 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.
[67] Ch. 2018-3, Laws of Florida.
[68] 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.
[69] 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).
[70] Id.
[71] Id.
[72] 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.[73] 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.[74] 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.[75] 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.[76] 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.[77] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring.[78] 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.[79]

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.[80] Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[81]

DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:[82]

- 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.

[73] Id.
[74] Id.
[75] Id. at 2
[76] Supra note 72.
[77] Id.
[78] Supra note 72, at 7.
[79] Id.
[80] Supra note 49.
[81] Id.
[82] Supra note 72, at 2-3.

The Florida Medicaid program covers approximately 3.8 million low-income individuals.[83]

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.[84] 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.[85]

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.[86]

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;

[83] 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 (last visited Feb. 21, 2020).
[84] S. 409.964, F.S.
[85] 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 (last visited Feb. 21, 2020).
[86] 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[87] 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:

[87] 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 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 the bill favorably as a committee substitute.

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

A bill to be entitled

An act relating to children's mental health; amending s. 394.493, F.S.; requiring the Department of Children and Families and the Agency for Health Care Administration to identify certain children and adolescents who use crisis stabilization services during specified fiscal years; requiring the department and agency to collaboratively meet the behavioral health needs of such children and adolescents and submit a quarterly report to the Legislature; amending s. 394.495, F.S.; including crisis response services provided through mobile response teams in the array of services available to children and adolescents; requiring the department to contract with managing entities for mobile response teams to provide certain services to certain children, adolescents, and young adults; providing requirements for such mobile response teams; providing requirements for managing entities when procuring mobile response teams; creating s. 394.4955, F.S.; requiring managing entities to develop a plan promoting the development of a coordinated system of care for certain services; providing requirements for the planning process; requiring each managing entity to submit such plan by a specified date; requiring the entities involved in

the planning process to implement such plan by a specified date; requiring that such plan be reviewed and updated periodically; amending s. 394.9082, F.S.; revising the duties of the department relating to priority populations that will benefit from care coordination; requiring that a managing entity's behavioral health care needs assessment include certain information regarding gaps in certain services; requiring a managing entity to promote the use of available crisis intervention services; amending s. 409.175, F.S.; revising requirements relating to preservice training for foster parents; amending s. 409.967, F.S.; requiring the Agency for Health Care Administration to conduct, or contract for, the testing of provider network databases maintained by Medicaid managed care plans for specified purposes; amending s. 409.988, F.S.; revising the duties of a lead agency relating to individuals providing care for dependent children; amending s. 985.601, F.S.; requiring the Department of Juvenile Justice to participate in the planning process for promoting a coordinated system of care for children and adolescents; amending s. 1003.02, F.S.; requiring each district school board to participate in the planning process for promoting a coordinated

system of care; amending s. 1004.44, F.S.; requiring the Louis de la Parte Florida Mental Health Institute to develop, in consultation with other entities, a model response protocol for schools; amending s. 1006.04, F.S.; requiring the educational multiagency network to participate in the planning process for promoting a coordinated system of care; amending s. 1011.62, F.S.; revising the elements of a plan required for school district funding under the mental health assistance allocation; requiring the Department of Children and Families and Agency for Health Care Administration to assess the quality of care provided in crisis stabilization units to certain children and adolescents; requiring the department and agency to review current standards of care for certain settings and make recommendations; requiring the department and agency to jointly submit a report to the Governor and Legislature by a specified date; providing an effective date.

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

Section 1. Subsection (4) is added to section 394.493, Florida Statutes, to read:

394.493 Target populations for child and adolescent mental

health services funded through the department.—

(4) Beginning with fiscal year 2020-2021 through fiscal year 2021-2022, the department and the Agency for Health Care Administration shall identify children and adolescents who are the highest utilizers of crisis stabilization services. The department and agency shall collaboratively take appropriate action within available resources to meet the behavioral health needs of such children and adolescents more effectively, and shall jointly submit to the Legislature a quarterly report listing the actions taken by both agencies to better serve such children and adolescents.

Section 2. Paragraph (q) is added to subsection (4) of section 394.495, Florida Statutes, and subsection (7) is added to that section, to read:

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

(4) The array of services may include, but is not limited to:

(q) Crisis response services provided through mobile response teams.

(7)(a) The department shall contract with managing entities for mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25, inclusive, who:

1. Have an emotional disturbance;

2. Are experiencing an acute mental or emotional crisis;

3. Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function typically within the family, living situation, or community environment; or

4. Are served by the child welfare system and are experiencing or are at high risk of placement instability.

(b) A mobile response team shall, at a minimum:

1. Respond to new requests for services within 60 minutes after such requests are made.

2. Respond to a crisis in the location where the crisis is occurring.

3. Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family.

4. Provide evidence-based practices to children, adolescents, young adults, and families to enable them to independently and effectively deescalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises.

5. Provide screening, standardized assessments, early identification, and referrals to community services.

6. Engage the child, adolescent, or young adult and his or her family as active participants in every phase of the

treatment process whenever possible.

7. Develop a care plan for the child, adolescent, or young adult.

8. Provide care coordination by facilitating the transition to ongoing services.

9. Ensure there is a process in place for informed consent and confidentiality compliance measures.

10. Promote information sharing and the use of innovative technology.

11. Coordinate with the managing entity within the service location and other key entities providing services and supports to the child, adolescent, or young adult and his or her family, including, but not limited to, the child, adolescent, or young adult's school, the local educational multiagency network for severely emotionally disturbed students under s. 1006.04, the child welfare system, and the juvenile justice system.

(c) When procuring mobile response teams, the managing entity must, at a minimum:

1. Collaborate with local sheriff's offices and public schools in the planning, development, evaluation, and selection processes.

2. Require that services be made available 24 hours per day, 7 days per week, with onsite response time to the location of the referred crisis within 60 minutes after the request for services is made.

3. Require the provider to establish response protocols with local law enforcement agencies, local community-based care lead agencies as defined in s. 409.986(3), the child welfare system, and the Department of Juvenile Justice. The response protocol with a school district shall be consistent with the model response protocol developed under s. 1004.44.

4. Require access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner.

5. Require mobile response teams to refer children, adolescents, or young adults and their families to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services as necessary to address the immediate crisis event.

Section 3. Section 394.4955, Florida Statutes, is created to read:

394.4955 Coordinated system of care; child and adolescent mental health treatment and support.—

(1) Pursuant to s. 394.9082(5)(d), each managing entity shall develop a plan that promotes the development and effective implementation of a coordinated system of care which integrates services provided through providers funded by the state's child-serving systems and facilitates access by children and adolescents, as resources permit, to needed mental health treatment and services at any point of entry regardless of the

time of year, intensity, or complexity of the need, and other systems with which such children and adolescents are involved, as well as treatment and services available through other systems for which they would qualify.

(2)(a) The managing entity shall lead a planning process that includes, but is not limited to, children and adolescents with behavioral health needs and their families; behavioral health service providers; law enforcement agencies; school districts or superintendents; the multiagency network for students with emotional or behavioral disabilities; the department; and representatives of the child welfare and juvenile justice systems, early learning coalitions, the Agency for Health Care Administration, Medicaid managed medical assistance plans, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and other community partners. An organization receiving state funding must participate in the planning process if requested by the managing entity.

(b) The managing entity and collaborating organizations shall take into consideration the geographical distribution of the population, needs, and resources, and create separate plans on an individual county or multi-county basis, as needed, to maximize collaboration and communication at the local level.

(c) To the extent permitted by available resources, the coordinated system of care shall include the array of services listed in s. 394.495.

(d) Each plan shall integrate with the local plan developed under s. 394.4573.

(3) By July 1, 2021, the managing entity shall complete the plans developed under this section and submit them to the department. By July 1, 2022, the entities involved in the planning process shall implement the coordinated system of care specified in each plan. The managing entity and collaborating organizations shall review and update the plans, as necessary, at least every 3 years thereafter.

(4) The managing entity and collaborating organizations shall create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and support by making referrals to specialized treatment providers, if necessary, with follow up to ensure services are received.

(5) The managing entity and collaborating organizations shall document each coordinated system of care for children and adolescents through written memoranda of understanding or other binding arrangements.

(6) The managing entity shall identify gaps in the arrays of services for children and adolescents listed in s. 394.495 available under each plan and include relevant information in its annual needs assessment required by s. 394.9082.

Section 4. Paragraph (c) of subsection (3) and paragraphs (b) and (d) of subsection (5) of section 394.9082, Florida

Statutes, are amended, and paragraph (t) is added to subsection (5) of that section, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(c) Define the priority populations that will benefit from receiving care coordination. In defining such populations, the department shall take into account the availability of resources and consider:

1. The number and duration of involuntary admissions within a specified time.

2. The degree of involvement with the criminal justice system and the risk to public safety posed by the individual.

3. Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455.

4. The degree of utilization of behavioral health services.

5. Whether the individual is a parent or caregiver who is involved with the child welfare system.

6. Whether the individual is an adolescent, as defined in s. 394.492, who requires assistance in transitioning to services provided in the adult system of care.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(b) Conduct a community behavioral health care needs assessment every 3 years in the geographic area served by the

managing entity which identifies needs by subregion. The process for conducting the needs assessment shall include an opportunity for public participation. The assessment shall include, at a minimum, the information the department needs for its annual report to the Governor and Legislature pursuant to s. 394.4573. The assessment shall also include a list and descriptions of any gaps in the arrays of services for children or adolescents identified pursuant to s. 394.4955 and recommendations for addressing such gaps. The managing entity shall provide the needs assessment to the department.

(d) Promote the development and effective implementation of a coordinated system of care pursuant to ss. 394.4573 and 394.495 ~~s. 394.4573~~.

(t) Promote the use of available crisis intervention services by requiring contracted providers to provide contact information for mobile response teams established under s. 394.495 to parents and caregivers of children, adolescents, and young adults between ages 18 and 25, inclusive, who receive safety-net behavioral health services.

Section 5. Paragraph (b) of subsection (14) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(14)

(b) As a condition of licensure, foster parents shall successfully complete preservice training. The preservice training shall be uniform statewide and shall include, but not be limited to, such areas as:

1. Orientation regarding agency purpose, objectives, resources, policies, and services;

2. Role of the foster parent as a treatment team member;

3. Transition of a child into and out of foster care, including issues of separation, loss, and attachment;

4. Management of difficult child behavior that can be intensified by placement, by prior abuse or neglect, and by prior placement disruptions;

5. Prevention of placement disruptions;

6. Care of children at various developmental levels, including appropriate discipline; ~~and~~

7. Effects of foster parenting on the family of the foster parent; and

8. Information about and contact information for the local mobile response team as a means for addressing a behavioral health crisis or preventing placement disruption.

Section 6. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care

program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the

availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 7. Paragraph (f) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(f) Shall ensure that all individuals providing care for dependent children receive:

1. Appropriate training and meet the minimum employment

standards established by the department.

2. Contact information for the local mobile response team established under s. 394.495.

Section 8. Subsection (4) of section 985.601, Florida Statutes, is amended to read:

985.601 Administering the juvenile justice continuum.—

(4) The department shall maintain continuing cooperation with the Department of Education, the Department of Children and Families, the Department of Economic Opportunity, and the Department of Corrections for the purpose of participating in agreements with respect to dropout prevention and the reduction of suspensions, expulsions, and truancy; increased access to and participation in high school equivalency diploma, vocational, and alternative education programs; and employment training and placement assistance. The cooperative agreements between the departments shall include an interdepartmental plan to cooperate in accomplishing the reduction of inappropriate transfers of children into the adult criminal justice and correctional systems. As part of its continuing cooperation, the department shall participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 9. Subsection (5) is added to section 1003.02, Florida Statutes, to read:

1003.02 District school board operation and control of

public K-12 education within the school district.—As provided in part II of chapter 1001, district school boards are constitutionally and statutorily charged with the operation and control of public K-12 education within their school district. The district school boards must establish, organize, and operate their public K-12 schools and educational programs, employees, and facilities. Their responsibilities include staff development, public K-12 school student education including education for exceptional students and students in juvenile justice programs, special programs, adult education programs, and career education programs. Additionally, district school boards must:

(5) Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 10. Subsection (4) of section 1004.44, Florida Statutes, is renumbered as subsection (5), and a new subsection (4) is added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(4) By August 1, 2020, the institute shall develop a model response protocol for schools to use mobile response teams established under s. 394.495. In developing the protocol, the institute shall, at a minimum, consult with school districts

that effectively use such teams, school districts that use such teams less often, local law enforcement agencies, the Department of Children and Families, managing entities as defined in s. 394.9082(2), and mobile response team providers.

Section 11. Paragraph (c) of subsection (1) of section 1006.04, Florida Statutes, is amended to read:

1006.04 Educational multiagency services for students with severe emotional disturbance.—

(1)

(c) The multiagency network shall:

1. Support and represent the needs of students in each school district in joint planning with fiscal agents of children's mental health funds, including the expansion of school-based mental health services, transition services, and integrated education and treatment programs.

2. Improve coordination of services for children with or at risk of emotional or behavioral disabilities and their families by assisting multi-agency collaborative initiatives to identify critical issues and barriers of mutual concern and develop local response systems that increase home and school connections and family engagement.

3. Increase parent and youth involvement and development with local systems of care.

4. Facilitate student and family access to effective services and programs for students with and at risk of emotional

or behavioral disabilities that include necessary educational, residential, and mental health treatment services, enabling these students to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living.

5. Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 12. Paragraph (b) of subsection (16) of section 1011.62, Florida Statutes, is amended to read:

1011.62 Funds for operation of schools.—If the annual allocation from the Florida Education Finance Program to each district for operation of schools is not determined in the annual appropriations act or the substantive bill implementing the annual appropriations act, it shall be determined as follows:

(16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental health assistance allocation is created to provide funding to assist school districts in establishing or expanding school-based mental health care; train educators and other school staff in detecting and responding to mental health issues; and connect children, youth, and families who may experience behavioral health issues with appropriate services. These funds shall be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district shall

receive a minimum of $100,000, with the remaining balance allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment. Charter schools that submit a plan separate from the school district are entitled to a proportionate share of district funding. The allocated funds may not supplant funds that are provided for this purpose from other operating funds and may not be used to increase salaries or provide bonuses. School districts are encouraged to maximize third-party health insurance benefits and Medicaid claiming for services, where appropriate.

(b) The plans required under paragraph (a) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plans must include the following elements:

1. Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff in order to better align with nationally recommended ratio models. These

providers include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals. The plan also must identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students, which may include the review and revision of district staffing resource allocations based on school or student mental health assistance needs.

2. An interagency agreement or memorandum of understanding with the managing entity, as defined in s. 394.9082(2), that facilitates referrals of students to community-based services and coordinates care for students served by school-based and community-based providers. Such agreement or memorandum of understanding must address the sharing of records and information as authorized under s. 1006.07(7)(d) to coordinate care and increase access to appropriate services.

3.~~2.~~ Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided

on or off the school campus and may be supplemented by telehealth.

4.~~3.~~ Policies and procedures, including contracts with service providers, which will ensure that:

a. Parents of students are provided information about behavioral health services available through the students' school or local community-based behavioral health services providers, including, but not limited to, the mobile response team as established in s. 394.495 serving their area. A school may meet this requirement by providing information about and internet addresses for web-based directories or guides of local behavioral health services as long as such directories or guides are easily navigated and understood by individuals unfamiliar with behavioral health delivery systems or services and include specific contact information for local behavioral health providers.

b. School districts use the services of the mobile response teams to the extent that such services are available. Each school district shall establish policies and procedures to carry out the model response protocol developed under s. 1004.44.

c. Students who are referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns and ensure that the assessment of students at risk for mental health

disorders occurs within 15 days of referral. School-based mental health services must be initiated within 15 days after identification and assessment, and support by community-based mental health service providers for students who are referred for community-based mental health services must be initiated within 30 days after the school or district makes a referral.

d. Referrals to behavioral health services available through other delivery systems or payors for which a student or individuals living in the household of a student receiving services under this subsection may qualify, if such services appear to be needed or enhancements in those individuals' behavioral health would contribute to the improved well-being of the student.

5.~~4.~~ Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems, depression, anxiety disorders, suicidal tendencies, or substance use disorders.

6.~~5.~~ Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders, to improve the provision of early intervention services, and to assist students in dealing with trauma and violence.

Section 13. The Department of Children and Families and the Agency for Health Care Administration shall assess the quality of care provided in crisis stabilization units to

children and adolescents who are high utilizers of crisis stabilization services. The department and agency shall review current standards of care for such settings applicable to licensure under chapters 394 and 408, Florida Statutes, and designation under s. 394.461, Florida Statutes; compare the standards to other states' standards and relevant national standards; and make recommendations for improvements to such standards. The assessment and recommendations shall address, at a minimum, efforts by each facility to gather and assess information regarding each child or adolescent, to coordinate with other providers treating the child or adolescent, and to create discharge plans that comprehensively and effectively address the needs of the child or adolescent to avoid or reduce his or her future use of crisis stabilization services. The department and agency shall 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.

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

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Silvers offered the following:

Amendment (with title amendment)

Remove lines 109-572 and insert:

(b) A mobile response team shall, at a minimum:

1. Triage new requests to determine the level of severity and prioritize new requests that meet the clinical threshold for an in-person response. To the extent permitted by available resources, teams must provide in-person responses to such calls meeting that clinical level of response within 60 minutes after prioritization.

2. Respond to a crisis in the location where the crisis is occurring.

3. Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family.

4. Provide evidence-based practices to children, adolescents, young adults, and families to enable them to deescalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises.

5. Provide screening, standardized assessments, early identification, and referrals to community services.

6. Provide care coordination by facilitating the transition to ongoing services.

7. Ensure there is a process in place for informed consent and confidentiality compliance measures.

8. Promote information sharing and the use of innovative technology.

9. Coordinate with the applicable managing entity to establish informal partnerships with key entities providing behavioral health services and supports to children, adolescents, or young adults and their families to facilitate continuity of care.

(c) When procuring mobile response teams, the managing entity must, at a minimum:

1. Collaborate with local sheriff's offices and public schools in the planning, development, evaluation, and selection processes.

2. Require that services be made available 24 hours per day, 7 days per week.

3. Require the provider to establish response protocols with local law enforcement agencies, local community-based care lead agencies as defined in s. 409.986(3), the child welfare system, and the Department of Juvenile Justice. The response protocol with a school district shall be consistent with the model response protocol developed under s. 1004.44.

4. Require access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner.

5. Require mobile response teams to refer children, adolescents, or young adults and their families to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services as necessary to address the immediate crisis event.

Section 3. Section 394.4955, Florida Statutes, is created to read:

394.4955 Coordinated system of care; child and adolescent mental health treatment and support.—

(1) Pursuant to s. 394.9082(5)(d), each managing entity shall lead the development of a plan that promotes the development and effective implementation of a coordinated system of care which integrates services provided through providers funded by the state's child-serving systems and facilitates

access by children and adolescents, as resources permit, to needed mental health treatment and services at any point of entry regardless of the time of year, intensity, or complexity of the need, and other systems with which such children and adolescents are involved, as well as treatment and services available through other systems for which they would qualify.

(2)(a) The planning process shall include, but is not limited to, children and adolescents with behavioral health needs and their families; behavioral health service providers; law enforcement agencies; school districts or superintendents; the multiagency network for students with emotional or behavioral disabilities; the department; and representatives of the child welfare and juvenile justice systems, early learning coalitions, the Agency for Health Care Administration, Medicaid managed medical assistance plans, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and other community partners. An organization receiving state funding must participate in the planning process if requested by the managining entity. State agencies shall provide reasonable staff support to the planning process if requested by the managing entity.

(b) The planning process shall take into consideration the geographical distribution of the population, needs, and resources, and create separate plans on an individual county or

multi-county basis, as needed, to maximize collaboration and communication at the local level.

(c) To the extent permitted by available resources, the coordinated system of care shall include the array of services listed in s. 394.495.

(d) Each plan shall integrate with the local plan developed under s. 394.4573.

(3) By January 1, 2022, the managing entity shall complete the plans developed under this section and submit them to the department. By January 1, 2023, the entities involved in the planning process shall implement the coordinated system of care specified in each plan. The managing entity and collaborating organizations shall review and update the plans, as necessary, at least every 3 years thereafter.

(4) The managing entity and collaborating organizations shall create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and support by making referrals to specialized treatment providers, if necessary, with follow up to ensure services are received.

(5) The managing entity and collaborating organizations shall document each coordinated system of care for children and adolescents through written memoranda of understanding or other binding arrangements.

(6) The managing entity shall identify gaps in the arrays of services for children and adolescents listed in s. 394.495 available under each plan and include relevant information in its annual needs assessment required by s. 394.9082.

Section 4. Paragraph (c) of subsection (3) and paragraphs (b) and (d) of subsection (5) of section 394.9082, Florida Statutes, are amended, and paragraph (t) is added to subsection (5) of that section, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(c) Define the priority populations that will benefit from receiving care coordination. In defining such populations, the department shall take into account the availability of resources and consider:

1. The number and duration of involuntary admissions within a specified time.

2. The degree of involvement with the criminal justice system and the risk to public safety posed by the individual.

3. Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455.

4. The degree of utilization of behavioral health services.

5. Whether the individual is a parent or caregiver who is involved with the child welfare system.

6. Whether the individual is an adolescent, as defined in s. 394.492, who requires assistance in transitioning to services provided in the adult system of care.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(b) Conduct a community behavioral health care needs assessment every 3 years in the geographic area served by the managing entity which identifies needs by subregion. The process for conducting the needs assessment shall include an opportunity for public participation. The assessment shall include, at a minimum, the information the department needs for its annual report to the Governor and Legislature pursuant to s. 394.4573. The assessment shall also include a list and descriptions of any gaps in the arrays of services for children or adolescents identified pursuant to s. 394.4955 and recommendations for addressing such gaps. The managing entity shall provide the needs assessment to the department.

(d) Promote the development and effective implementation of a coordinated system of care pursuant to ss. 394.4573 and 394.495 ~~s. 394.4573~~.

(t) Promote the use of available crisis intervention services by requiring contracted providers to provide contact information for mobile response teams established under s. 394.495 to parents and caregivers of children, adolescents, and young adults between ages 18 and 25, inclusive, who receive safety-net behavioral health services.

Section 5. Paragraph (b) of subsection (14) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(14)

(b) As a condition of licensure, foster parents shall successfully complete preservice training. The preservice training shall be uniform statewide and shall include, but not be limited to, such areas as:

1. Orientation regarding agency purpose, objectives, resources, policies, and services;

2. Role of the foster parent as a treatment team member;

3. Transition of a child into and out of foster care, including issues of separation, loss, and attachment;

4. Management of difficult child behavior that can be intensified by placement, by prior abuse or neglect, and by prior placement disruptions;

5. Prevention of placement disruptions;

6. Care of children at various developmental levels, including appropriate discipline; ~~and~~

7. Effects of foster parenting on the family of the foster parent; and

8. Information about and contact information for the local mobile response team as a means for addressing a behavioral health crisis or preventing placement disruption.

Section 6. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or

administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to

providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a

result of early and periodic screening, diagnosis, and treatment.

Section 7. Paragraph (f) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(f) Shall ensure that all individuals providing care for dependent children receive:

1. Appropriate training and meet the minimum employment standards established by the department.

2. Contact information for the local mobile response team established under s. 394.495.

Section 8. Subsection (4) of section 985.601, Florida Statutes, is amended to read:

985.601 Administering the juvenile justice continuum.—

(4) The department shall maintain continuing cooperation with the Department of Education, the Department of Children and Families, the Department of Economic Opportunity, and the Department of Corrections for the purpose of participating in agreements with respect to dropout prevention and the reduction of suspensions, expulsions, and truancy; increased access to and participation in high school equivalency diploma, vocational, and alternative education programs; and employment training and placement assistance. The cooperative agreements between the departments shall include an interdepartmental plan to cooperate

in accomplishing the reduction of inappropriate transfers of children into the adult criminal justice and correctional systems. As part of its continuing cooperation, the department shall participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 9. Subsection (5) is added to section 1003.02, Florida Statutes, to read:

1003.02 District school board operation and control of public K-12 education within the school district.—As provided in part II of chapter 1001, district school boards are constitutionally and statutorily charged with the operation and control of public K-12 education within their school district. The district school boards must establish, organize, and operate their public K-12 schools and educational programs, employees, and facilities. Their responsibilities include staff development, public K-12 school student education including education for exceptional students and students in juvenile justice programs, special programs, adult education programs, and career education programs. Additionally, district school boards must:

(5) Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 10. Subsection (4) of section 1004.44, Florida Statutes, is renumbered as subsection (5), and a new subsection (4) is added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(4) By August 1, 2020, the institute shall develop a model response protocol for schools to use mobile response teams established under s. 394.495. In developing the protocol, the institute shall, at a minimum, consult with school districts that effectively use such teams, school districts that use such teams less often, local law enforcement agencies, the Department of Children and Families, managing entities as defined in s. 394.9082(2), and mobile response team providers.

Section 11. Paragraph (c) of subsection (1) of section 1006.04, Florida Statutes, is amended to read:

1006.04 Educational multiagency services for students with severe emotional disturbance.—

(1)

(c) The multiagency network shall:

1. Support and represent the needs of students in each school district in joint planning with fiscal agents of children's mental health funds, including the expansion of school-based mental health services, transition services, and integrated education and treatment programs.

2. Improve coordination of services for children with or at risk of emotional or behavioral disabilities and their families by assisting multi-agency collaborative initiatives to identify critical issues and barriers of mutual concern and develop local response systems that increase home and school connections and family engagement.

3. Increase parent and youth involvement and development with local systems of care.

4. Facilitate student and family access to effective services and programs for students with and at risk of emotional or behavioral disabilities that include necessary educational, residential, and mental health treatment services, enabling these students to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living.

5. Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 12. Paragraph (b) of subsection (16) of section 1011.62, Florida Statutes, is amended to read:

1011.62 Funds for operation of schools.—If the annual allocation from the Florida Education Finance Program to each district for operation of schools is not determined in the annual appropriations act or the substantive bill implementing

the annual appropriations act, it shall be determined as follows:

(16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental health assistance allocation is created to provide funding to assist school districts in establishing or expanding school-based mental health care; train educators and other school staff in detecting and responding to mental health issues; and connect children, youth, and families who may experience behavioral health issues with appropriate services. These funds shall be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district shall receive a minimum of $100,000, with the remaining balance allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment. Charter schools that submit a plan separate from the school district are entitled to a proportionate share of district funding. The allocated funds may not supplant funds that are provided for this purpose from other operating funds and may not be used to increase salaries or provide bonuses. School districts are encouraged to maximize third-party health insurance benefits and Medicaid claiming for services, where appropriate.

(b) The plans required under paragraph (a) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention,

treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plans must include the following elements:

1. Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff in order to better align with nationally recommended ratio models. These providers include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals. The plan also must identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students, which may include the review and revision of district staffing resource allocations based on school or student mental health assistance needs.

2. Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group

counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided on or off the school campus and may be supplemented by telehealth.

3. Policies and procedures, including contracts with service providers, which will ensure that:

a. Parents of students are provided information about behavioral health services available through the students' school or local community-based behavioral health services providers, including, but not limited to, the mobile response team as established in s. 394.495 serving their area. A school may meet this requirement by providing information about and internet addresses for web-based directories or guides of local behavioral health services as long as such directories or guides are easily navigated and understood by individuals unfamiliar with behavioral health delivery systems or services and include specific contact information for local behavioral health providers.

b. School districts use the services of the mobile response teams to the extent that such services are available. Each school district shall establish policies and procedures to carry out the model response protocol developed under s. 1004.44.

c. Students who are referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns and ensure that the assessment of students at risk for mental health disorders occurs within 15 days of referral. School-based mental health services must be initiated within 15 days after identification and assessment, and support by community-based mental health service providers for students who are referred for community-based mental health services must be initiated within 30 days after the school or district makes a referral.

d. Referrals to behavioral health services available through other delivery systems or payors for which a student or individuals living in the household of a student receiving services under this subsection may qualify, if such services appear to be needed or enhancements in those individuals' behavioral health would contribute to the improved well-being of the student.

4. Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems, depression, anxiety disorders, suicidal tendencies, or substance use disorders.

5. Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders, to improve the provision of early intervention

services, and to assist students in dealing with trauma and violence.

Section 13. Paragraph (l) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(l) Notification of involuntary examinations.—The public school principal or the principal's designee shall immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to s. 394.463. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or the principal's designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect. Before a student is removed from school, school transportation, or a school-sponsored activity, the principal or the principal's designee must verify that de-escalation

strategies have been utilized and outreach to a mobile response team has been initiated under policies and procedures established under s. 1011.62(16), unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. Each district school board shall develop a policy and procedures for notification under this paragraph.

Section 14. Paragraph (q) of subsection (9) of section 1002.33, Florida Statutes, is amended to read:

1002.33 Charter schools.—

(9) CHARTER SCHOOL REQUIREMENTS.—

(q) The charter school principal or the principal's designee shall immediately notify the parent of a student who is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to s. 394.463. The principal or the principal's designee may delay notification for no more than 24 hours after the student is removed if the principal or the principal's designee deems the delay to be in the student's best interest and if a report has been submitted to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or suspicion of abuse, abandonment, or neglect. Before a student is removed from school, school transportation, or a school-sponsored activity, the principal or the principal's designee must verify that de-escalation strategies have been utilized and

outreach to a mobile response team has been initiated under policies and procedures established under s. 1011.62(16), unless the principal or the principal's designee reasonably believes that any delay in removing the student will increase the likelihood of harm to the student or others. Each charter school governing board shall develop a policy and procedures for notification under this paragraph.

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

Remove lines 21-60 and insert:

entities to lead the development of a plan promoting the development of a coordinated system of care for certain services; providing requirements for the planning process; requiring each managing entity to submit such plan by a specified date; requiring the entities involved in the planning process to implement such plan by a specified date; requiring that such plan be reviewed and updated periodically; amending s. 394.9082, F.S.; revising the duties of the department relating to priority populations that will benefit from care coordination; requiring that a managing entity's behavioral health care needs assessment include certain information regarding gaps in certain services; requiring a managing entity to promote the use of available crisis intervention services; amending s. 409.175, F.S.; revising requirements relating to preservice training for foster parents; amending s. 409.967,

F.S.; requiring the Agency for Health Care Administration to conduct, or contract for, the testing of provider network databases maintained by Medicaid managed care plans for specified purposes; amending s. 409.988, F.S.; revising the duties of a lead agency relating to individuals providing care for dependent children; amending s. 985.601, F.S.; requiring the Department of Juvenile Justice to participate in the planning process for promoting a coordinated system of care for children and adolescents; amending s. 1003.02, F.S.; requiring each district school board to participate in the planning process for promoting a coordinated system of care; amending s. 1004.44, F.S.; requiring the Louis de la Parte Florida Mental Health Institute to develop, in consultation with other entities, a model response protocol for schools; amending s. 1006.04, F.S.; requiring the educational multiagency network to participate in the planning process for promoting a coordinated system of care; amending s. 1011.62, F.S.; revising the elements of a plan required for school district funding under the mental health assistance allocation; amending ss. 1002.20 and 1002.33, F.S.; requiring verification that certain strategies have been utilized and certain outreach has been initiated before a student is removed from school, school transportation, or a school-sponsored activity under specified circumstances; 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.[1]

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.[2] 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.[3] 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. [4]

Maladaptive Behaviors

Maladaptive behaviors are those behaviors by persons with developmental disabilities that are disruptive, destructive, aggressive, or significantly repetitive.[5]

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

[1] *See* s. 393.063(12), F.S.
[2] 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 (last visited February 2, 2020).
[3] 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).
[4] S. 408.038, F.S.
[5] 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.[6] 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.[7]

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.[8]

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.[9] 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.[10] 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"[11], 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.[12]

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.[13] The CON

[6] 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.
[7] *Id.*
[8] 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).
[9] Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.
[10] S. 408.036, F.S.
[11] 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.
[12] Rule 59C-1.002(5), F.A.C.
[13] 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.[14] 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.[15] Applications for CON review must be submitted by the specified deadline for the particular batch cycle.[16] AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[17] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[18]

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.[19] AHCA must then publish the decision within 14 days.[20] 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.[21]

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.[22] 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.[23] A request for a CON exemption must be accompanied by a $250 fee payable to AHCA.[24]

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.[25] 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.

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.

[14] S. 408.039(2)(a), F.S.
[15] S. 408.039(2)(c), F.S.
[16] Rule 59C-1.008(1)(g), F.A.C.
[17] S. 408.039(3)(a), F.S.
[18] Id.
[19] S. 408.039(4)(b), F.S.
[20] S. 408.039(4)(c), F.S.
[21] S. 408.039(4)(d), F.S.
[22] S. 408.038, F.S.
[23] Id.
[24] S. 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.
[25] 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:[26]

- 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.

[26] 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 (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.[27]

   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.[28] 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.[29] 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.[30] 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.

[27] Agency for Health Care Administration, 2020 Agency Legislative Bill Analysis, HB 1163, January 4, 2020 (on file with Health & Human Services Committee staff).
[28] 2020 General Appropriations Act, HB 5001, specific appropriation 224.
[29] SUPRA FN 8.
[30] 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.

A bill to be entitled

An act relating to intermediate care facilities; amending s. 400.962, F.S.; requiring certain facilities that have been granted a certificate-of-need exemption to demonstrate and maintain compliance with specified criteria; amending s. 408.036, F.S.; providing an exemption from a certificate-of-need requirement for certain intermediate care facilities; prohibiting the Agency of Health Care Administration from granting an exemption to an applicant unless a certain condition is met; providing that a specific legislative appropriation is not required for such exemption; providing an effective date.

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

Section 1. Subsection (6) is added to section 400.962, Florida Statutes, to read:

400.962 License required; license application.—

(6) An applicant that has been granted a certificate-of-need exemption under s. 408.036(3)(o) must also demonstrate and maintain compliance with the following criteria:

(a) 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. Each eight-bed home must be colocated on

the same property with two other eight-bed homes and must serve individuals with severe maladaptive behaviors and co-occurring psychiatric diagnoses.

(b) A minimum of 16 beds within the facility must be designated for individuals with severe maladaptive behaviors who have been assessed using the Agency for Persons with Disabilities' Global Behavioral Service Need Matrix with a score of Level 4 through Level 6, or assessed using the criteria deemed appropriate by the Agency for Health Care Administration regarding the need for a specialized placement in an intermediate care facility for the developmentally disabled.

(c) The applicant has not had a facility license denied, revoked, or suspended within the 36 months preceding the request for exemption.

(d) The applicant must have at least 10 years of experience serving individuals with severe maladaptive behaviors in the state.

(e) The applicant must implement a state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.

(f) The applicant must make available medical and nursing services 24 hours per day, 7 days per week.

(g) The applicant must demonstrate a history of using interventions that are least restrictive following a behavioral

hierarchy.

(h) The applicant must maintain a policy prohibiting the use of mechanical restraints.

Section 2. Paragraph (o) is added to subsection (3) of section 408.036, Florida Statutes, to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from subsection (1):

(o) For a new intermediate care facility for the developmentally disabled that has a total of 24 beds, comprised of 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. 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. The agency may not grant an exemption to an applicant that has been granted an exemption under this paragraph unless the facility, awarded by exemption, has been licensed and operational for a period of at least 2 years. The exemption under this paragraph does not require a specific legislative appropriation.

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

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Burton offered the following:

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

period for a project, if the exemption holder demonstrates to the satisfaction of the agency that good-faith commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

3. This paragraph and subsection (6) of s. 400.962 are repealed July 1, 2022, unless reviewed and saved from repeal by the Legislature.

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

Remove lines 9-13 and insert:

limiting the number of exemptions to be issued under the bill; providing that a specific legislative appropriation is not required for such exemption; providing timeframes and a monitoring process for any exemption issued under the provisions of the bill; providing a sunset provision; providing an effective date.

HB 1341

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.[1] 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.[2]

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.[3]

Massage Therapist Licensure

A massage therapist is a person who administers massage for compensation.[4] To qualify for licensure as a massage therapist, an applicant must:[5]

- 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,[6]

- 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 fo Therapeutic Massage and Bodywork;
- National Certification Examination for Therapeutic Massage dministered by the National Certification Board fo 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.

[1] Section 480.033(3), F.S.
[2] Section 480.032, F.S.
[3] Section 480.035, F.S.
[4] Section 480.033(4), F.S.
[5] Section 480.041, F.S. DOH must deny an application if the applicant has been convicted or found guilty of, or entered a plea of nolo contedere to a crime related to prostitution or a felony offense related to certain other crimes.
[6] 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.[7] Classroom education must include:[8]

- 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.[9]

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[10] and must be completed within 12 months, in four quarters.[11] A massage therapist must complete training of no more than 500 hours per quarter. The training must include:[12]

- 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.[13]

[7] Rule 64B7-32.003, F.A.C.
[8] Id.
[9] Rule 64B7-32.005, F.A.C.
[10] 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.
[11] Rule 64B7-29.003, F.A.C.
[12] Id.
[13] 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.[14] 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.[15] 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[16] under the direct supervision of a sponsor.[17] The sponsor must be licensed to practice massage, authorized to practice colonic irrigation, and have practiced colonic irrigation for at least three years.[18] The apprenticeship must be completed within 12 months of commencement[19] and must consist of at least 100 hours of training, including 45 hours of clinical practicum with a minimum of 20 treatments given.[20] 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.[21]

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.

[14] 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.
[15] Department of Health, *2019 Agency Legislative Analysis for HB 7031*, on file with the Health Quality Subcommittee.
[16] 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.).
[17] Rule 64B7-29.001, F.A.C.
[18] Id.
[19] Rule 64B7-29.007, F.A.C.
[20] Rule 64B7-25.001, F.A.C.
[21] *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

A bill to be entitled

An act relating to massage therapy; renaming ch. 480, F.S., as "Massage Therapy Practice"; amending s. 480.031, F.S.; conforming a provision to changes made by the act; amending s. 480.032, F.S.; revising the purpose of ch. 480, F.S.; amending s. 480.033, F.S.; revising terms and definitions; amending s. 480.041, F.S.; revising requirements for licensure as a massage therapist; conforming provisions to changes made by the act; providing applicability for persons who were issued a license as a massage apprentice before a specified date; repealing s. 480.042, F.S., relating to examinations; amending ss. 477.013, 477.0135, 480.034, 480.035, 480.043, 480.046, 480.0465, 480.047, 480.052, 480.0535, 627.6407, 627.6619, 627.736, and 641.31 F.S.; conforming provisions to changes made by the act; making technical changes; providing an effective date.

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

Section 1. Chapter 480, Florida Statutes, entitled "Massage Practice," is renamed "Massage Therapy Practice."

Section 2. Section 480.031, Florida Statutes, is amended to read:

480.031 Short title.—This act ~~shall be known and~~ may be cited as the "Massage Therapy Practice Act."

Section 3. Section 480.032, Florida Statutes, is amended to read:

480.032 Purpose.—The Legislature recognizes that the practice of massage therapy is potentially dangerous to the public in that massage therapists must have a knowledge of anatomy and physiology and an understanding of the relationship between the structure and the function of the tissues being treated and the total function of the body. Massage therapy is a therapeutic health care practice, and regulations are necessary to protect the public from unqualified practitioners. It is therefore deemed necessary in the interest of public health, safety, and welfare to regulate the practice of massage therapy in this state; however, restrictions shall be imposed to the extent necessary to protect the public from significant and discernible danger to health and yet not in such a manner which will unreasonably affect the competitive market. Further, consumer protection for both health and economic matters shall be afforded the public through legal remedies provided for in this act.

Section 4. Subsections (3), (4), (5), (7), and (9) of section 480.033, Florida Statutes, are amended to read:

480.033 Definitions.—As used in this act:

(3) "Massage therapy" means the manipulation of the soft

tissues of the human body with the hand, foot, knee, arm, or elbow, regardless of whether ~~or not~~ such manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation, an over-the-counter topical agent, or a topical agent prescribed by a health care practitioner applied in accordance with board rule.

(4) "Massage therapist" means a person licensed as required by this act, who administers massage therapy for compensation and assesses or evaluates persons for massage therapy treatment.

(5) "Apprentice" means a person approved by the board to study colon irrigation ~~massage~~ under the instruction of a licensed massage therapist practicing colon irrigation.

(7) "Establishment" or "massage establishment" means a site or premises, or portion thereof, wherein a massage therapist practices massage therapy.

(9) "Board-approved massage therapy school" means a facility that meets minimum standards for training and curriculum as determined by rule of the board and that is licensed by the Department of Education pursuant to chapter 1005 or the equivalent licensing authority of another state or is within the public school system of this state or a college or university that is eligible to participate in the William L. Boyd, IV, Effective Access to Student Education Grant Program.

Section 5. Subsections (1), (2), and (4) of section 480.041, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(1) Any person is qualified for licensure as a massage therapist under this act who:

(a) Is at least 18 years of age or has received a high school diploma or high school equivalency diploma;

(b) Has completed a course of study at a board-approved massage therapy school ~~or has completed an apprenticeship program that meets standards adopted by the board~~; and

(c) Has received a passing grade on a national ~~an~~ examination designated ~~administered~~ by the board ~~department~~.

(2) Every person desiring to be examined for licensure as a massage therapist shall apply to the department in writing upon forms prepared and furnished by the department. Such applicants are ~~shall be~~ subject to ~~the provisions of~~ s. 480.046(1). ~~Applicants may take an examination administered by the department only upon meeting the requirements of this section as determined by the board.~~

(4) Upon an applicant's passing the examination and paying the initial licensure fee, the department shall issue to the applicant a license, valid until the next scheduled renewal date, to practice massage therapy.

(8) A person issued a license as a massage apprentice before July 1, 2020, may continue that apprenticeship and perform massage therapy as authorized under that license until its expiration. After completing his or her apprenticeship and before July 1, 2022, a massage apprentice may apply to the board for full licensure and the board must grant the application if the applicant meets all other applicable licensure requirements.

Section 6. Section 480.042, Florida Statutes, is repealed.

Section 7. Subsection (13) of section 477.013, Florida Statutes, is amended to read:

477.013 Definitions.—As used in this chapter:

(13) "Skin care services" means the treatment of the skin of the body, other than the head, face, and scalp, by the use of a sponge, brush, cloth, or similar device to apply or remove a chemical preparation or other substance, except that chemical peels may be removed by peeling an applied preparation from the skin by hand. Skin care services must be performed by a licensed cosmetologist or facial specialist within a licensed cosmetology or specialty salon, and such services may not involve massage therapy, as defined in s. 480.033(3), through manipulation of the superficial tissue.

Section 8. Paragraph (a) of subsection (1) of section 477.0135, Florida Statutes, is amended to read:

477.0135 Exemptions.—

(1) This chapter does not apply to the following persons

when practicing pursuant to their professional or occupational responsibilities and duties:

(a) Persons authorized under the laws of this state to practice medicine, surgery, osteopathic medicine, chiropractic medicine, massage therapy, naturopathy, or podiatric medicine.

Section 9. Subsection (4) of section 480.034, Florida Statutes, is amended to read:

480.034 Exemptions.—

(4) An exemption granted is effective to the extent that an exempted person's practice or profession overlaps with the practice of massage therapy.

Section 10. Subsection (2) of section 480.035, Florida Statutes, is amended to read:

480.035 Board of Massage Therapy.—

(2) Five members of the board shall be licensed massage therapists and shall have been engaged in the practice of massage therapy for not less than 5 consecutive years prior to the date of appointment to the board. The Governor shall appoint each member for a term of 4 years. Two members of the board shall be laypersons. Each board member shall be a high school graduate or shall have received a high school equivalency diploma. Each board member shall be a citizen of the United States and a resident of this state for not less than 5 years. The appointments are ~~will be~~ subject to confirmation by the Senate.

Section 11. Subsection (14) of section 480.043, Florida Statutes, is amended to read:

480.043 Massage establishments; requisites; licensure; inspection; human trafficking awareness training and policies.—

(14) Except for the requirements of subsection (13), this section does not apply to a physician licensed under chapter 457, chapter 458, chapter 459, or chapter 460 who employs a licensed massage therapist to perform massage therapy on the physician's patients at the physician's place of practice. This subsection does not restrict investigations by the department for violations of chapter 456 or this chapter.

Section 12. Paragraphs (a), (b), (c), (f), (g), (h), (i), and (o) of subsection (1) of section 480.046, Florida Statutes, are amended to read:

480.046 Grounds for disciplinary action by the board.—

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

(a) Attempting to procure a license to practice massage therapy by bribery or fraudulent misrepresentation.

(b) Having a license to practice massage therapy revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly

relates to the practice of massage therapy or to the ability to practice massage therapy. Any plea of nolo contendere shall be considered a conviction for purposes of this chapter.

(f) Aiding, assisting, procuring, or advising any unlicensed person to practice massage therapy contrary to ~~the provisions of~~ this chapter or to department or board ~~a~~ rule ~~of the department or the board~~.

(g) Making deceptive, untrue, or fraudulent representations in the practice of massage therapy.

(h) Being unable to practice massage therapy with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department ~~shall have~~, upon probable cause, may ~~authority to~~ compel a massage therapist to submit to a mental or physical examination by physicians designated by the department. Failure of a massage therapist to submit to such examination when so directed, unless the failure was due to circumstances beyond her or his control, constitutes ~~shall constitute~~ an admission of the allegations against her or him, consequent upon which a default and final order may be entered without the taking of testimony or presentation of evidence. A massage therapist affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of

massage therapy with reasonable skill and safety to clients.

(i) Gross or repeated malpractice or the failure to practice massage therapy with that level of care, skill, and treatment which is recognized by a reasonably prudent massage therapist as being acceptable under similar conditions and circumstances.

(o) Practicing massage therapy at a site, location, or place which is not duly licensed as a massage establishment, except that a massage therapist, as provided by ~~rules adopted by the~~ board rule, may provide massage therapy services, excluding colonic irrigation, at the residence of a client, at the office of the client, at a sports event, at a convention, or at a trade show.

Section 13. Section 480.0465, Florida Statutes, is amended to read:

480.0465 Advertisement.—Each massage therapist or massage establishment licensed under ~~the provisions of~~ this act shall include the number of the license in any advertisement of massage therapy services appearing in a newspaper, airwave transmission, telephone directory, or other advertising medium. Pending licensure of a new massage establishment pursuant to ~~the provisions of~~ s. 480.043(7), the license number of a licensed massage therapist who is an owner or principal officer of the establishment may be used in lieu of the license number for the establishment.

Section 14. Paragraphs (a), (b), and (c) of subsection (1) of section 480.047, Florida Statutes, are amended to read:

480.047 Penalties.—

(1) It is unlawful for any person to:

(a) Hold himself or herself out as a massage therapist or to practice massage therapy unless duly licensed under this chapter or unless otherwise specifically exempted from licensure under this chapter.

(b) Operate any massage establishment unless it has been duly licensed as provided herein, except that nothing herein shall be construed to prevent the teaching of massage therapy in this state at a board-approved massage therapy school.

(c) Permit an employed person to practice massage therapy unless duly licensed as provided herein.

Section 15. Section 480.052, Florida Statutes, is amended to read:

480.052 Power of county or municipality to regulate massage therapy.—A county or municipality, within its jurisdiction, may regulate persons and establishments licensed under this chapter. Such regulation shall not exceed the powers of the state under this act or be inconsistent with this act. This section shall not be construed to prohibit a county or municipality from enacting any regulation of persons or establishments not licensed pursuant to this act.

Section 16. Subsections (1) and (2) of section 480.0535,

Florida Statutes, are amended to read:

480.0535 Documents required while working in a massage establishment.—

(1) In order to provide the department and law enforcement agencies the means to more effectively identify, investigate, and arrest persons engaging in human trafficking, a person employed by a massage establishment and any person performing massage therapy therein must immediately present, upon the request of an investigator of the department or a law enforcement officer, valid government identification while in the establishment. A valid government identification for the purposes of this section is:

(a) A valid, unexpired driver license issued by any state, territory, or district of the United States;

(b) A valid, unexpired identification card issued by any state, territory, or district of the United States;

(c) A valid, unexpired United States passport;

(d) A naturalization certificate issued by the United States Department of Homeland Security;

(e) A valid, unexpired alien registration receipt card (green card); or

(f) A valid, unexpired employment authorization card issued by the United States Department of Homeland Security.

(2) A person operating a massage establishment must:

(a) Immediately present, upon the request of an

investigator of the department or a law enforcement officer:

1. Valid government identification while in the establishment.

2. A copy of the documentation specified in paragraph (1)(a) for each employee and any person performing massage therapy in the establishment.

(b) Ensure that each employee and any person performing massage therapy in the massage establishment is able to immediately present, upon the request of an investigator of the department or a law enforcement officer, valid government identification while in the establishment.

Section 17. Section 627.6407, Florida Statutes, is amended to read:

627.6407 Massage.—Any policy of health insurance that provides coverage for massage shall also cover the services of persons licensed to practice massage therapy pursuant to chapter 480, where the massage therapy, as defined in chapter 480, has been prescribed by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, as being medically necessary and the prescription specifies the number of treatments.

Section 18. Section 627.6619, Florida Statutes, is amended to read:

627.6619 Massage.—Any policy of health insurance that provides coverage for massage shall also cover the services of

persons licensed to practice massage therapy pursuant to chapter 480, where the massage therapy, as defined in chapter 480, has been prescribed by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, as being medically necessary and the prescription specifies the number of treatments.

Section 19. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing

services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the

following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage <u>therapy</u> as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage <u>therapy</u> or acupuncture, and a licensed massage therapist or

licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation

is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 20. Subsection (37) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(37) All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage <u>therapy</u> pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 as medically necessary and the prescription specifies the number of treatments. Such massage services are subject to the same terms, conditions, and limitations as those of other covered services.

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		

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Goff-Marcil offered the following:

Amendment

Remove lines 47-107 and insert:

Section 1. Section 480.033, Florida Statutes, is amended to read:

480.033 Definitions.—As used in this act:

(1) "Board" means the Board of Massage Therapy.

(2)~~(9)~~ "Board-approved massage therapy school" means a facility that meets minimum standards for training and curriculum as determined by rule of the board and that is licensed by the Department of Education pursuant to chapter 1005 or the equivalent licensing authority of another state or is within the public school system of this state or a college or

university that is eligible to participate in the William L. Boyd, IV, Effective Access to Student Education Grant Program.

(3) ~~(6)~~ "Colon hydrotherapy" ~~"Colonic irrigation"~~ means a method of hydrotherapy used to cleanse the colon with the aid of a mechanical device and water.

(4) ~~(5)~~ "Colon hydrotherapy apprentice" means a person approved by the board to study colon irrigation ~~massage~~ under the instruction of a licensed massage therapist practicing colonic irrigation.

(5) ~~(2)~~ "Department" means the Department of Health.

(6) ~~(11)~~ "Designated establishment manager" means a massage therapist who holds a clear and active license without restriction, who is responsible for the operation of a massage establishment in accordance with the provisions of this chapter, and who is designated the manager by the rules or practices at the establishment.

(7) "Establishment" or "massage establishment" means a site or premises, or portion thereof, wherein a massage therapist practices massage therapy.

(8) ~~(10)~~ "Establishment owner" means a person who has ownership interest in a massage establishment. The term includes an individual who holds a massage establishment license, a general partner of a partnership, an owner or officer of a corporation, and a member of a limited liability company and its subsidiaries who holds a massage establishment license.

(9)~~(8)~~ "Licensure" means the procedure by which a person, hereinafter referred to as a "practitioner," applies to the board for approval to practice massage or to operate an establishment.

(10)~~(3)~~ "Massage therapy" means the manipulation of the soft tissues of the human body with the hand, foot, knee, arm, or elbow, regardless of whether ~~or not~~ such manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation.

(11)~~(4)~~ "Massage therapist" means a person licensed as required by this act, who performs massage therapy, including massage therapy assessment ~~administers massage~~ for compensation.

(12) "Massage therapy assessment" means the determination of the course of massage therapy treatment.

Section 2. Subsections (1), (2), and (4) of section 480.041, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(1) Any person is qualified for licensure as a massage therapist under this act who:

(a) Is at least 18 years of age or has received a high school diploma or high school equivalency diploma;

(b) Has completed a course of study at a board-approved massage therapy school ~~or has completed an apprenticeship program that meets standards adopted by the board~~; and

(c) Has received a passing grade on a national ~~an~~ examination designated ~~administered~~ by the board ~~department~~.

(2) Every person desiring to be examined for licensure as a massage therapist must ~~shall~~ apply to the department in writing upon forms prepared by the board and furnished by the department. Such applicants are ~~shall be~~ subject to ~~the provisions of~~ s. 480.046(1). ~~Applicants may take an examination administered by the department only upon meeting the requirements of this section as determined by the board.~~

(4) Upon an applicant's passing the examination and paying the initial licensure fee, the department shall issue to the applicant a license, valid until the next scheduled renewal date, to practice massage therapy.

(8) A person issued a license as a massage apprentice before July 1, 2020, may continue that apprenticeship and perform massage therapy as authorized under that license until it expires. Upon completion of the apprenticeship, which must occur before July 1, 2023, a massage apprentice may apply to the board for full licensure and be granted a license if all other applicable licensure requirements are met.

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.[1] The SMMC program is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds.[2] Eligibility for the SMMC program is determined by the Department of Children and Families (DCF).[3]

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.[4] States are prohibited from limiting access to nursing facility services, but the provision of home and community based services is optional.[5] Home and community based services in Florida are delivered through a federal 1915(c), home and community based services waiver.[6] 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.[7]

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;

[1] This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.
[2] S. 409.963, F.S.
[3] Id.
[4] 42 C.F.R. §483p(b).
[5] 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).
[6] S. 409.906(13), F.S.
[7] 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 (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.[8]

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)[9]; and,
- Be in need of nursing home care, as determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program.[10]

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.[11] 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.[12]

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.[13] 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.[14]

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[8] S. 409.98, F.S.
[9] 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).
[10] S. 409.979(1), F.S.
[11] 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).
[12] 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 (last accessed January 26, 2020).
[13] S. 409.985(3), F.S.
[14] 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.[15]

The prioritization of the waitlist is not described in statute, but rather in administrative rule promulgated by AHCA.[16] 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.[17] 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.[18]

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[15] S. 409.979(3), F.S.
[16] Rule 59G-4.193, F.A.C.
[17] 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.
[18] 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. [19]

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.[20]

To be eligible for the CCE program, an individual must be age 60 or older and functionally impaired[21], 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.[22] 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.[23]

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.

[19] 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).
[20] Id.
[21] S. 430.203(7), F.S.
[22] S. 430.205(5)(a), F.S.
[23] 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.

A bill to be entitled

An act relating to long-term care; amending s. 409.979, F.S.; requiring aging resource centers to annually rescreen certain individuals with high priority scores for purposes of the statewide wait list for enrollment for home and community-based services; authorizing such centers to administer rescreening for certain individuals with low priority scores; requiring the Department of Elderly Affairs to maintain contact information for individuals with low priority scores for rescreening purposes; requiring aging resource centers to inform such individuals of community resources; amending s. 430.205, F.S.; authorizing community-care-for-the-elderly services providers to dispute certain referrals; providing that a referral decision by adult protective service prevails; providing an effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (3) of section 409.979, Florida Statutes, are amended to read:

409.979 Eligibility.—

(3) WAIT LIST, RELEASE, AND OFFER PROCESS.—The Department of Elderly Affairs shall maintain a statewide wait list for

enrollment for home and community-based services through the long-term care managed care program.

(a) The Department of Elderly Affairs shall prioritize individuals for potential enrollment for home and community-based services through the long-term care managed care program using a frailty-based screening tool that results in a priority score. The priority score is used to set an order for releasing individuals from the wait list for potential enrollment in the long-term care managed care program. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the wait list shall receive priority for release.

1. Pursuant to s. 430.2053, aging resource center personnel certified by the Department of Elderly Affairs shall perform the screening for each individual requesting enrollment for home and community-based services through the long-term care managed care program. The Department of Elderly Affairs shall request that the individual or the individual's authorized representative provide alternate contact names and contact information.

2. The individual requesting the long-term care services, or the individual's authorized representative, must participate in an initial screening or rescreening for placement on the wait list. The screening or rescreening must be completed in its entirety before placement on the wait list.

3. Pursuant to s. 430.2053, aging resource center personnel shall administer rescreening annually or upon notification of a significant change in an individual's circumstances for an individual with a high priority score. Aging resource center personnel may administer rescreening annually or upon notification of a significant change in an individual's circumstances for an individual with a low priority score.

4. The Department of Elderly Affairs shall adopt by rule a screening tool that generates the priority score, and shall make publicly available on its website the specific methodology used to calculate an individual's priority score.

(b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the individual or the individual's authorized representative that the individual has been placed on the wait list, unless the individual has a low priority score. The Department of Elderly Affairs must maintain contact information for each individual with a low priority score for purposes of any future rescreening. Aging resource center personnel shall inform individuals with low priority scores of community resources available to assist them and inform them that they may contact the aging resource center for a new assessment at any time if they experience a change in circumstances.

Section 2. Paragraph (a) of subsection (5) of section

430.205, Florida Statutes, is amended to read:

430.205 Community care service system.—

(5) Any person who has been classified as a functionally impaired elderly person is eligible to receive community-care-for-the-elderly core services.

(a) Those elderly persons who are determined by protective investigations to be vulnerable adults in need of services, pursuant to s. 415.104(3)(b), or to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm and are referred by the adult protective services program, shall be given primary consideration for receiving community-care-for-the-elderly services. As used in this paragraph, "primary consideration" means that an assessment and services must commence within 72 hours after referral to the department or as established in accordance with department contracts by local protocols developed between department service providers and the adult protective services program. Regardless, a community-care-for-the-elderly services provider may dispute a referral under this paragraph by requesting that adult protective services negotiate the referral placement of, and the services to be provided to, a vulnerable adult or victim of abuse, neglect, or exploitation. If an agreement cannot be reached with adult protective services for modification of the referral decision, the determination by adult protective services shall prevail.

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.[1] 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:[2]

- 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.[3]

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.[4]

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.[5] 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.[6] 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.[7] Regulatory boards, in consultation with DOH, must set renewal fees by rule that must be:[8]

- Based on revenue projections prepared using generally accepted accounting practices;
- Adequate to cover all expenses relating to that board;

[1] Fla. Const. art. VII, s. 19(a)-(b). The amendment appeared on the 2018 ballot as Amendment 5.
[2] Fla. Const. art. VII, s. 19(d).
[3] Fla. Const. art. VII, s. 19(e).
[4] Fla. Const. art. VII s. 19(c).
[5] 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.
[6] 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 20, 2020).
[7] Section 456.025(1), F.S.
[8] *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.[9] 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.

[9] Rule 64B9-7.001, F.A.C.

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

A bill to be entitled

An act relating to advanced practice registered nurses' registration fees; amending s. 464.0123, F.S.; requiring the Board of Nursing to establish registration and biennial renewal fees for advanced practice registered nurses to engage in autonomous practice; providing a contingent effective date.

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

Section 1. Subsection (9) of section 464.0123, Florida Statutes, as created by CS/HB 607, 2020 Regular Session, is renumbered as subsection (10), and a new subsection (9) is added to that section to read:

464.0123 Autonomous practice by an advanced practice registered nurse.—

(9) The board shall establish a registration fee not to exceed $100 and a biennial renewal fee not to exceed $50.

Section 2. This act shall take effect on the same date that CS/HB 607 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an 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.[1] If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.

DCF's child welfare practice model focuses on preserving and strengthening the child's family ties whenever possible, and removing the child from the home when the child's welfare cannot be adequately safeguarded otherwise.[2]

Community-Based Care Organizations and Services

DCF contracts for case management, out-of-home care, and related services with community-based care lead agencies (CBCs). Using CBCs to provide child welfare services is designed to increase local community ownership of service delivery and design.[3] DCF, through CBCs, administers a system of care for children with the goals of:

- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Well-being of children through emphasis on educational stability and timely health care;
- Achievement of permanency; and
- Effective transition to independence and self-sufficiency.

CBCs provide foster care and related services, including, but not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption.[4] CBCs contract with a number of subcontractors for case management and direct care services to children and their families.[5] There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[6]

[1] S. 39.001, F.S.
[2] S. 39.001(4), F.S.
[3] Florida Department of Children and Families, *Community-Based Care*, https://www.myflfamilies.com/service-programs/community-based-care/ (last visited Jan. 14, 2020).
[4] S. 409.145(1), F.S.
[5] *Id*.
[6] Florida Department of Children and Families, *Community-Based Care Lead Agency Map*, http://www.myflfamilies.com/service-programs/community-based-care/cbc-map (last visited Jan. 14, 2020).

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

Dependency Proceeding	Description of Process	Controlling Statute
Removal	A child protective investigation determines the child's home is unsafe, and the child is removed.	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment. The judge determines whether a child is dependent during trial.	s. 39.507, F.S.
Disposition Hearing	If the child is found dependent, disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews the case plan and placement of the child. The judge orders the case plan for the family and the appropriate placement of the child.	s. 39.506, F.S. s. 39.521, F.S.
Postdisposition hearing	The court may change temporary placement at a postdisposition hearing any time after disposition but before the child is residing in the permanent placement approved at a permanency hearing.	s. 39.522, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.
Petition for Termination of Parental Rights	Once the child has been out-of-home for 12 months, if DCF determines that reunification is no longer a viable goal, termination of parental rights is in the best interest of the child, and other requirements are met, a petition for termination of parental rights is filed.	s. 39.802, F.S. s. 39.8055, F.S. s. 39.806, F.S. s. 39.810, F.S.
Advisory Hearing	This hearing is set as soon as possible after all parties have been served with the petition for termination of parental rights. The hearing allows the parent to admit, deny, or consent to the allegations within the petition for termination of parental rights.	s. 39.808, F.S.
Adjudicatory Hearing	An adjudicatory trial shall be set within 45 days after the advisory hearing. The judge determines whether to terminate parental rights to the child at this trial.	s. 39.809, F.S.

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.[7] 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.[8] A child protective investigation begins if the hotline determines the allegations meet the statutory definition of abuse, abandonment or neglect.[9]

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.[10] Over the past four years, that equates to only one suspected false report per approximately more than 500 investigations.[11] Low rates have repeatedly been reported to the Legislature since 2006.[12]

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 plant 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.

[7] S. 39.201(5), F.S.
[8] S. 39.201(1)(a), F.S.
[9] S. 39.201(2)(a), F.S.
[10] Florida Department of Children and Families, Agency Analysis of 2020 House Bill 7085 (Feb. 11, 2020).
[11] *Id*.
[12] *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.[13]

During FY 2018-19, the court ordered a case plan at disposition for 9,186 children.[14] 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 60th 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 60th 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.[15] 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.[16]
- DCF must obtain the names of all parents and prospective parents when taking custody of a child.[17]
- They are provided written notice of their right to counsel and right to be heard and present evidence at the shelter hearing.[18]
- They are notified of every proceeding or hearing involving the child.[19]

[13] S. 39.6011(3), F.S.
[14] Florida Department of Children and Families, Agency Bill Analysis for Senate Bill 1548, p. 8 (Jan. 23, 2020).
[15] 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.
[16] S. 39.013(9), F.S.
[17] S 39.401(4), F.S.
[18] S. 39.402(5), F.S.
[19] 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 identify is unknown.[20]
- 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.[21]

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.[22] 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.[23] DCF reports that in FY 2018-19, diligent searches were performed for 2,968 children.[24] 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.[25]

[20] S. 39.503(1), F.S.
[21] S. 39.503(5), F.S.
[22] Ss. 39.503(8) and 39.803(3), F.S.
[23] *Supra* note 10.
[24] *Id*.
[25] *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.[26] 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 brining a paternity action even if the mother was married at the time of conception or birth.[27] 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.[28]

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.[29] 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.[30] 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.

[26] *Simmonds v. Perkins*, 247 So. 3d 397 (Fla. 2018)
[27] *Id.*
[28] *Dep't of Health & Rehab. Servs. v. Privette*, 617 So. 2d 305, 308 (Fla. 1993).
[29] 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).
[30] 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.[31] 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,[32] 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.[33] 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.[34]

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.[35] 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.

[31] Ch. No. 2016-80, L.O.F.
[32] Adoption Assistance and Child Welfare Act of 1980, Public L. No. 96-272, H.R. 3434, 96th Cong. (1980).
[33] 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).
[34] 42 U.S.C. § 671(a)(15)(D)(i).
[35] 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.[36] 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[37] or qualitied 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[38].

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.[39]

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.

[36] 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).
[37] 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.
[38] Relative is defined as a person related by blood to the person being adopted within the third degree.
[39] *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 filling 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. 1st 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.[40] 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.

[40] *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.[41] 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."[42] It was formed in 2005 to improve interagency policy and services coordination to support older foster youth aging out of foster care.[43] 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.[44] 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.

[41] S. 39.806(1), F.S.,
[42] S. 409.1451(5), F.S.
[43] 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).
[44] 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 complain 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.[45] 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.[46]

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.

[45] *Supra* note 10.
[46] *Id*.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to dependency proceedings and child protection services; amending s. 39.01, F.S.; revising the definition of "parent"; amending s. 39.205, F.S.; removing a reporting requirement to the Legislature; amending s. 39.407, F.S.; transferring certain duties to the department rather than the Agency for Health Care Administration; amending ss. 39.503 and 39.803, F.S.; revising procedures and requirements relating to the unknown identity or location of a parent of a dependent child; removing standing to file a sworn affidavit to establish parenthood after the entry of a certain judgment; creating s. 39.5035, F.S.; providing procedures and requirements relating to deceased parents of a dependent child; amending s. 39.6011, F.S.; providing timeframes in which case plans must be filed with the court and provided to specified parties; amending s. 39.6221, F.S.; revising the conditions under which a court determines permanent guardian placement for a child; amending s. 39.801, F.S.; conforming provisions to changes made by the act; amending s. 39.806, F.S.; providing that efforts to preserve or reunify a family are not required under specified circumstances; conforming cross-references; amending s. 39.811, F.S.; providing that the court

retains jurisdiction under certain circumstances; providing when certain decisions relating to adoption are reviewable; amending s. 39.812, F.S.; authorizing certain actions without a court order; providing that certain persons may file a petition to adopt a child without the department's consent; providing standing; providing a standard of proof; providing responsibilities of the court in such cases; amending s. 39.820, F.S.; revising the definition of the term "guardian ad litem;" amending s. 63.062, F.S.; requiring the department to consent to certain adoptions; providing exceptions; amending s. 63.082, F.S.; requiring a home study of a stepparent or relative under certain circumstances; amending s. 409.1451, F.S.; removing a reporting requirement of the department and the Independent Living Services Advisory Council; creating s. 742.0211, F.S.; defining the term "dependent child"; providing requirements for the determination of paternity when a child is dependent; requiring a hearing and written order within a specified time; providing the burden of proof for certain paternity complaints; providing applicability; providing an effective date.

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

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,

abandonment, or neglect.—

(7) The department shall establish procedures for determining whether a false report of child abuse, abandonment, or neglect has been made and for submitting all identifying information relating to such a report to the appropriate law enforcement agency ~~and shall report annually to the Legislature the number of reports referred~~.

Section 3. Subsection (6) of section 39.407, Florida Statutes, is amended to read:

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

(6) Children who are in the legal custody of the department may be placed by the department, without prior approval of the court, in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395 for residential mental health treatment only as provided in ~~pursuant to~~ this section or may be placed by the court in accordance with an order of involuntary examination or involuntary placement entered under ~~pursuant to~~ s. 394.463 or s. 394.467. All children placed in a residential treatment program under this subsection must have a guardian ad litem appointed.

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

1. "Residential treatment" means placement for observation, diagnosis, or treatment of an emotional disturbance

in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395.

2. "Least restrictive alternative" means the treatment and conditions of treatment that, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the child or adolescent or others from physical injury.

3. "Suitable for residential treatment" or "suitability" means a determination concerning a child or adolescent with an emotional disturbance as defined in s. 394.492(5) or a serious emotional disturbance as defined in s. 394.492(6) that each of the following criteria is met:

a. The child requires residential treatment.

b. The child is in need of a residential treatment program and is expected to benefit from mental health treatment.

c. An appropriate, less restrictive alternative to residential treatment is unavailable.

(b) Whenever the department believes that a child in its legal custody is emotionally disturbed and may need residential treatment, an examination and suitability assessment must be conducted by a qualified evaluator who is appointed by the department ~~Agency for Health Care Administration~~. This suitability assessment must be completed before the placement of the child in a residential treatment center for emotionally disturbed children and adolescents or a hospital. The qualified

evaluator must be a psychiatrist or a psychologist licensed in Florida who has at least 3 years of experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents and who has no actual or perceived conflict of interest with any inpatient facility or residential treatment center or program.

(c) Before a child is admitted under this subsection, the child shall be assessed for suitability for residential treatment by a qualified evaluator who has conducted a personal examination and assessment of the child and has made written findings that:

1. The child appears to have an emotional disturbance serious enough to require residential treatment and is reasonably likely to benefit from the treatment.

2. The child has been provided with a clinically appropriate explanation of the nature and purpose of the treatment.

3. All available modalities of treatment less restrictive than residential treatment have been considered, and a less restrictive alternative that would offer comparable benefits to the child is unavailable.

A copy of the written findings of the evaluation and suitability assessment must be provided to the department, to the guardian ad litem, and, if the child is a member of a Medicaid managed

care plan, to the plan that is financially responsible for the child's care in residential treatment, all of whom must be provided with the opportunity to discuss the findings with the evaluator.

(d) Immediately upon placing a child in a residential treatment program under this section, the department must notify the guardian ad litem and the court having jurisdiction over the child and must provide the guardian ad litem and the court with a copy of the assessment by the qualified evaluator.

(e) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director's designee must ensure that an individualized plan of treatment has been prepared by the program and has been explained to the child, to the department, and to the guardian ad litem, and submitted to the department. The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child's foster parents must be involved to the maximum extent consistent with the child's treatment needs. The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured. A copy of the plan must be provided to the child, to the

guardian ad litem, and to the department.

(f) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child's placement in the program. The residential treatment program must determine whether the child is receiving benefit toward the treatment goals and whether the child could be treated in a less restrictive treatment program. The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem and to the department. The department must submit the report to the court. The report must include a discharge plan for the child. The residential treatment program must continue to evaluate the child's treatment progress every 30 days thereafter and must include its findings in a written report submitted to the department. The department may not reimburse a facility until the facility has submitted every written report that is due.

(g)1. The department must submit, at the beginning of each month, to the court having jurisdiction over the child, a written report regarding the child's progress toward achieving the goals specified in the individualized plan of treatment.

2. The court must conduct a hearing to review the status of the child's residential treatment plan no later than 60 days after the child's admission to the residential treatment program. An independent review of the child's progress toward

achieving the goals and objectives of the treatment plan must be completed by a qualified evaluator and submitted to the court before its 60-day review.

3. For any child in residential treatment at the time a judicial review is held under ~~pursuant to~~ s. 39.701, the child's continued placement in residential treatment must be a subject of the judicial review.

4. If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the department to place the child in the least restrictive setting that is best suited to meet his or her needs.

(h) After the initial 60-day review, the court must conduct a review of the child's residential treatment plan every 90 days.

(i) The department must adopt rules for:

1. Implementing timeframes for the completion of suitability assessments by qualified evaluators. ~~and~~

2. A procedure that includes timeframes for completing the 60-day independent review by the qualified evaluators of the child's progress toward achieving the goals and objectives of the treatment plan which review must be submitted to the court.

3. ~~The Agency for Health Care Administration must adopt rules for~~ The registration of qualified evaluators, the procedure for selecting the evaluators to conduct the reviews

required under this section, and a reasonable, cost-efficient fee schedule for qualified evaluators.

Section 4. Section 39.503, Florida Statutes, is amended to read:

39.503 Identity or location of parent unknown; special procedures.—

(1) If the identity or location of a parent is unknown and a petition for dependency ~~or shelter~~ is filed, the court shall conduct under oath an ~~the following~~ inquiry of the parent or legal custodian who is available, or, if no parent or legal custodian is available, of any relative or custodian of the child who is present at the hearing and likely to have any of the following information:

(a) 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.

(b) Whether the mother was cohabiting with a male at the probable time of conception of the child.

(c) Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.

(d) Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.

(e) 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.

(f) Whether a man is named on the birth certificate of the child under ~~pursuant to~~ s. 382.013(2).

(g) Whether a man has been determined by a court order to be the father of the child.

(h) Whether a man has been determined to be the father of the child by the Department of Revenue as provided in s. 409.256.

(2) The information required in subsection (1) may be supplied to the court or the department in the form of a sworn affidavit by a person having personal knowledge of the facts.

(3) If the inquiry under subsection (1) identifies any person as a parent or prospective parent and that person's location is known, the court shall require notice of the hearing to be provided to that person. However, notice is not required to be provided to a prospective parent if there is an identified legal father, as defined in s. 39.01, of the child.

(4) If the inquiry under subsection (1) identifies a person as a legal father, as defined in s. 39.01, the court shall enter an order establishing the paternity of the father. Once an order establishing paternity has been entered, the court may not take any action to disestablish this paternity in the absence of an action filed under chapter 742. An action filed

under chapter 742 concerning a child who is the subject in a dependency proceeding must comply with s. 742.0211.

(5) ~~(4)~~ If the inquiry under subsection (1) fails to identify any person as a parent or prospective parent, the court shall so find and may proceed without further notice and the petitioner is relieved of performing any further search.

(6) ~~(5)~~ If the inquiry under subsection (1) identifies a parent or prospective parent, and that person's location is unknown, the court shall direct the petitioner to conduct a diligent search for that person before scheduling a disposition hearing regarding the dependency of the child unless the court finds that the best interest of the child requires proceeding without notice to the person whose location is unknown. However, a diligent search is not required to be conducted for a prospective parent if there is an identified legal father, as defined in s. 39.01, of the child.

(7) ~~(6)~~ The diligent search required by subsection (6) ~~(5)~~ must include, at a minimum, inquiries of all relatives of the parent or prospective parent made known to the petitioner, inquiries of all offices of program areas of the department likely to have information about the parent or prospective parent, inquiries of other state and federal agencies likely to have information about the parent or prospective parent, inquiries of appropriate utility and postal providers, a thorough search of at least one electronic database specifically

designed for locating persons, a search of the Florida Putative Father Registry, and inquiries of appropriate law enforcement agencies. Pursuant to s. 453 of the Social Security Act, 42 U.S.C. s. 653(c)(4), the department, as the state agency administering Titles IV-B and IV-E of the act, shall be provided access to the federal and state parent locator service for diligent search activities.

(8) ~~(7)~~ Any agency contacted by a petitioner with a request for information under ~~pursuant to~~ subsection (7) ~~(6)~~ must ~~shall~~ release the requested information to the petitioner without the necessity of a subpoena or court order.

(9) If the inquiry and diligent search identifies and locates a parent, that person is considered a parent for all purposes under this chapter and must be provided notice of all hearings.

(10) ~~(8)~~ If the inquiry and diligent search identifies and locates a prospective parent and there is no legal father, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or the department. A prospective parent who files a sworn affidavit of parenthood while the child is a dependent child but no later than at the time of or before the adjudicatory hearing in any termination of parental rights proceeding for the child shall be considered a parent for all purposes under this chapter ~~section~~ unless the other parent

contests the determination of parenthood. A person does not have standing to file a sworn affidavit of parenthood or otherwise establish parenthood, except through adoption, after entry of a judgment terminating the parental rights of the legal father for a child. If the known parent contests the recognition of the prospective parent as a parent, the court having jurisdiction over the dependency matter shall conduct a determination of parentage under chapter 742. The prospective parent may not be recognized as a parent until proceedings to determine maternity or paternity ~~under chapter 742~~ have been concluded. However, the prospective parent shall continue to receive notice of hearings as a participant pending results of the ~~chapter 742~~ proceedings to determine maternity or paternity.

(11) ~~(9)~~ If the diligent search under subsection (6) ~~(5)~~ fails to ~~identify and~~ locate a parent or prospective parent who was identified during the inquiry under subsection (1), the court shall so find and may proceed without further notice and the petitioner is relieved from performing any further search.

Section 5. Section 39.5035, Florida Statutes, is created to read:

39.5035 Deceased parents; special procedures.—

(1)(a)1. If both parents of a child are deceased and a legal custodian has not been appointed for the child through a probate or guardianship proceeding, then the attorney for any person who has knowledge of the facts alleged or is informed of

the alleged facts, and believes them to be true, may initiate a proceeding by filing a petition for adjudication and permanent commitment.

2. If a child has been placed in shelter status by order of the court but has not yet been adjudicated, a petition for adjudication and permanent commitment must be filed within 21 days after the shelter hearing. In all other cases, the petition must be filed within a reasonable time after the date the child was referred to protective investigation or after the petitioner first becomes aware of the facts that support the petition for adjudication and permanent commitment.

(b) If both parents die or the last living parent dies after a child has already been adjudicated dependent, any person who has knowledge of the facts alleged or is informed of the alleged facts, and believes them to be true, may file a petition for permanent commitment.

(2) The petition:

(a) Must be in writing, identify the alleged deceased parents, and provide facts that establish that both parents of the child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding.

(b) Must be signed by the petitioner under oath stating the petitioner's good faith in filing the petition.

(3) When a petition for adjudication and permanent

commitment or a petition for permanent commitment has been filed, the clerk of court shall set the case before the court for an adjudicatory hearing. The adjudicatory hearing must be held as soon as practicable after the petition is filed, but no later than 30 days after the filing date.

(4) Notice of the date, time, and place of the adjudicatory hearing and a copy of the petition must be served on the following persons:

(a) Any person who has physical custody of the child.

(b) A living relative of each parent of the child, unless a living relative cannot be found after a diligent search and inquiry.

(c) The guardian ad litem for the child or the representative of the guardian ad litem program, if the program has been appointed.

(5) The court shall conduct adjudicatory hearings without a jury and apply the rules of evidence in use in civil cases. The court must determine whether the petitioner has established by clear and convincing evidence that both parents of the child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding. A certified copy of the death certificate for each parent is sufficient evidence of the parents' deaths.

(6) Within 30 days after an adjudicatory hearing on a petition for adjudication and permanent commitment:

(a) If the court finds that the petitioner has met the clear and convincing standard, the court shall enter a written order adjudicating the child dependent and permanently committing the child to the custody of the department for the purpose of adoption. A disposition hearing shall be scheduled no later than 30 days after the entry of the order, in which the department shall provide a case plan that identifies the permanency goal for the child to the court. Reasonable efforts must be made to place the child in a timely manner in accordance with the permanency plan and to complete all steps necessary to finalize the permanent placement of the child. Thereafter, until the adoption of the child is finalized or the child reaches the age of 18 years, whichever occurs first, the court shall hold hearings every 6 months to review the progress being made toward permanency for the child as provided in s. 39.701.

(b) If the court finds that clear and convincing evidence does not establish that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding, but that a preponderance of the evidence establishes that the child does not have a parent or legal custodian capable of providing supervision or care, the court shall enter a written order adjudicating the child dependent. A disposition hearing shall be scheduled no later than 30 days after the entry of the order as provided in s. 39.521.

(c) If the court finds that clear and convincing evidence does not establish that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding and that a preponderance of the evidence does not establish that the child does not have a parent or legal custodian capable of providing supervision or care, the court shall enter a written order so finding and dismiss the petition.

(7) Within 30 days after an adjudicatory hearing on a petition for permanent commitment:

(a) If the court finds that the petitioner has met the clear and convincing standard, the court shall enter a written order permanently committing the child to the custody of the department for purposes of adoption. A disposition hearing shall be scheduled no later than 30 days after the entry of the order, in which the department shall provide an amended case plan that identifies the permanency goal for the child to the court. Reasonable efforts must be made to place the child in a timely manner in accordance with the permanency plan and to complete all steps necessary to finalize the permanent placement of the child. Thereafter, until the adoption of the child is finalized or the child reaches the age of 18 years, whichever occurs first, the court shall hold hearings every 6 months to review the progress being made toward permanency for the child.

(b) If the court finds that clear and convincing evidence

does not establish that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding, the court shall enter a written order denying the petition. The order has no effect on the child's prior adjudication. The order does not bar the petitioner from filing a subsequent petition for permanent commitment based on newly-discovered evidence that establishes that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding.

Section 6. Subsection (8) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(8) The case plan must be filed with the court and copies provided to all parties, including the child if appropriate:~~,~~ ~~not less than 3 business days before the disposition hearing.~~

(a) Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60th day after the date the child was placed in out-of-home care; or

(b) Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60th day after the date the child was placed in out-of-home care and a case plan has not been submitted under this subsection, or if the court does not approve the case plan at the disposition hearing.

Section 7. Paragraph (a) of subsection (1) of section 39.6221, Florida Statutes, is amended to read:

39.6221 Permanent guardianship of a dependent child.—

(1) If a court determines that reunification or adoption is not in the best interest of the child, the court may place the child in a permanent guardianship with a relative or other adult approved by the court if all of the following conditions are met:

(a) The child has been in the placement for not less than the preceding 6 months, or the preceding 3 months if the caregiver has been named as the successor guardian on the child's Guardianship Assistance Agreement.

Section 8. Paragraph (a) of subsection (3) of section 39.801, Florida Statutes, is amended to read:

39.801 Procedures and jurisdiction; notice; service of process.—

(3) Before the court may terminate parental rights, in addition to the other requirements set forth in this part, the following requirements must be met:

(a) Notice of the date, time, and place of the advisory hearing for the petition to terminate parental rights and a copy of the petition must be personally served upon the following persons, specifically notifying them that a petition has been filed:

1. The parents of the child.

2. The legal custodians of the child.

3. If the parents who would be entitled to notice are dead or unknown, a living relative of the child, unless upon diligent search and inquiry no such relative can be found.

4. Any person who has physical custody of the child.

5. Any grandparent entitled to priority for adoption under s. 63.0425.

6. Any prospective parent who has been identified and located under s. 39.503 or s. 39.803, unless a court order has been entered under s. 39.503(5) or (11) or s. 39.803(5) or (11) ~~pursuant to s. 39.503(4) or (9) or s. 39.803(4) or (9)~~ which indicates no further notice is required. Except as otherwise provided in this section, if there is not a legal father, notice of the petition for termination of parental rights must be provided to any known prospective father who is identified under oath before the court or who is identified and located by a diligent search of the Florida Putative Father Registry. Service of the notice of the petition for termination of parental rights is not required if the prospective father executes an affidavit of nonpaternity or a consent to termination of his parental rights which is accepted by the court after notice and opportunity to be heard by all parties to address the best interests of the child in accepting such affidavit.

7. The guardian ad litem for the child or the representative of the guardian ad litem program, if the program

has been appointed.

The document containing the notice to respond or appear must contain, in type at least as large as the type in the balance of the document, the following or substantially similar language: "FAILURE TO PERSONALLY APPEAR AT THIS ADVISORY HEARING CONSTITUTES CONSENT TO THE TERMINATION OF PARENTAL RIGHTS OF THIS CHILD (OR CHILDREN). IF YOU FAIL TO APPEAR ON THE DATE AND TIME SPECIFIED, YOU MAY LOSE ALL LEGAL RIGHTS AS A PARENT TO THE CHILD OR CHILDREN NAMED IN THE PETITION ATTACHED TO THIS NOTICE."

Section 9. Section 39.803, Florida Statutes, is amended to read:

39.803 Identity or location of parent unknown after filing of termination of parental rights petition; special procedures.—

(1) If the identity or location of a parent is unknown, ~~and~~ a petition for termination of parental rights is filed, and the court has not previously conducted an inquiry or entered an order relieving the petitioner of further search or notice under s. 39.503, the court shall conduct under oath the following inquiry of the parent who is available, or, if no parent is available, of any relative, caregiver, or legal custodian of the child who is present at the hearing and likely to have the information:

(a) 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.

(b) Whether the mother was cohabiting with a male at the probable time of conception of the child.

(c) Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.

(d) Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.

(e) 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.

(f) Whether a man is named on the birth certificate of the child under ~~pursuant to~~ s. 382.013(2).

(g) Whether a man has been determined by a court order to be the father of the child.

(h) Whether a man has been determined to be the father of the child by the Department of Revenue as provided in s. 409.256.

(2) The information required in subsection (1) may be supplied to the court or the department in the form of a sworn affidavit by a person having personal knowledge of the facts.

(3) If the inquiry under subsection (1) identifies any

person as a parent or prospective parent and that person's location is known, the court shall require notice of the hearing to be provided to that person. However, notice is not required to be provided to a prospective parent if there is an identified legal father, as defined in s. 39.01, of the child.

(4) If the inquiry under subsection (1) identifies a person as a legal father, as defined in s. 39.01, the court shall enter an order establishing the paternity of the father. Once an order establishing paternity has been entered, the court may not take any action to disestablish this paternity in the absence of an action filed under chapter 742. An action filed under chapter 742 concerning a child who is the subject in a dependency proceeding must comply with s. 742.0211.

(5) ~~(4)~~ If the inquiry under subsection (1) fails to identify any person as a parent or prospective parent, the court shall so find and may proceed without further notice and the petitioner is relieved of performing any further search.

(6) ~~(5)~~ If the inquiry under subsection (1) identifies a parent or prospective parent, and that person's location is unknown, the court shall direct the petitioner to conduct a diligent search for that person before scheduling an adjudicatory hearing regarding the petition for termination of parental rights to the child unless the court finds that the best interest of the child requires proceeding without actual notice to the person whose location is unknown. However, a

diligent search is not required to be conducted for a prospective parent if there is an identified legal father, as defined in s. 39.01, of the child.

(7) ~~(6)~~ The diligent search required by subsection (6) ~~(5)~~ must include, at a minimum, inquiries of all known relatives of the parent or prospective parent, inquiries of all offices of program areas of the department likely to have information about the parent or prospective parent, inquiries of other state and federal agencies likely to have information about the parent or prospective parent, inquiries of appropriate utility and postal providers, a thorough search of at least one electronic database specifically designed for locating persons, a search of the Florida Putative Father Registry, and inquiries of appropriate law enforcement agencies. Pursuant to s. 453 of the Social Security Act, 42 U.S.C. s. 653(c)(4), the department, as the state agency administering Titles IV-B and IV-E of the act, shall be provided access to the federal and state parent locator service for diligent search activities.

(8) ~~(7)~~ Any agency contacted by petitioner with a request for information under ~~pursuant to~~ subsection (7) ~~(6)~~ shall release the requested information to the petitioner without the necessity of a subpoena or court order.

(9) If the inquiry and diligent search identifies and locates a parent, that person is considered a parent for all purposes under this chapter and must be provided notice of all

hearings.

(10) ~~(8)~~ If the inquiry and diligent search identifies and locates a prospective parent and there is no legal father, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or the department. A prospective parent who files a sworn affidavit of parenthood while the child is a dependent child but no later than at the time of or before the adjudicatory hearing in the termination of parental rights proceeding for the child shall be considered a parent for all purposes under this chapter ~~section~~. A person does not have standing to file a sworn affidavit of parenthood or otherwise establish parenthood, except through adoption, after the entry of a judgment terminating the parental rights of the legal father for a child. If the known parent contests the recognition of the prospective parent as a parent, the court having jurisdiction over the dependency matter shall conduct a determination of parentage proceeding under chapter 742. The prospective parent may not be recognized as a parent until proceedings to determine maternity or paternity have been concluded. However, the prospective parent shall continue to receive notice of hearings as a participant pending results of the proceedings to determine maternity or paternity.

(11) ~~(9)~~ If the diligent search under subsection (6) ~~(5)~~ fails to ~~identify and~~ locate a parent or prospective parent who

was identified during the inquiry under subsection (1), the court shall so find and may proceed without further notice and the petitioner is relieved from performing any further search.

Section 10. Paragraph (e) of subsection (1) and subsection (2) of section 39.806, Florida Statutes, are amended to read:

39.806 Grounds for termination of parental rights.—

(1) Grounds for the termination of parental rights may be established under any of the following circumstances:

(e) When a child has been adjudicated dependent, a case plan has been filed with the court, and:

1. The child continues to be abused, neglected, or abandoned by the parent or parents. The failure of the parent or parents to substantially comply with the case plan for a period of 12 months after an adjudication of the child as a dependent child or the child's placement into shelter care, whichever occurs first, constitutes evidence of continuing abuse, neglect, or abandonment unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to reunify the parent and child. The 12-month period begins to run only after the child's placement into shelter care or the entry of a disposition order placing the custody of the child with the department or a person other than the parent and the court's approval of a case plan having the goal of reunification with the parent, whichever occurs first; ~~or~~

2. The parent or parents have materially breached the case plan by their action or inaction. Time is of the essence for permanency of children in the dependency system. In order to prove the parent or parents have materially breached the case plan, the court must find by clear and convincing evidence that the parent or parents are unlikely or unable to substantially comply with the case plan before time to comply with the case plan expires; or~~.~~

3. The child has been in care for any 12 of the last 22 months and the parents have not substantially complied with the case plan so as to permit reunification under s. 39.522(3) ~~s. 39.522(2)~~ unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to reunify the parent and child.

(2) Reasonable efforts to preserve and reunify families are not required if a court of competent jurisdiction has determined that any of the events described in paragraphs (1)(b)-(d) or paragraphs (1)(f)-(n) ~~(1)(f)-(m)~~ have occurred.

Section 11. Subsection (9) of section 39.811, Florida Statutes, is amended to read:

39.811 Powers of disposition; order of disposition.—

(9) After termination of parental rights or a written order of permanent commitment entered under s. 39.5035, the court shall retain jurisdiction over any child for whom custody

is given to a social service agency until the child is adopted. The court shall review the status of the child's placement and the progress being made toward permanent adoptive placement. As part of this continuing jurisdiction, for good cause shown by the guardian ad litem for the child, the court may review the appropriateness of the adoptive placement of the child. The department's decision to deny an application to adopt a child who is under the court's jurisdiction is reviewable only through a motion to file a chapter 63 petition as provided in s. 39.812(4), and is not subject to chapter 120.

Section 12. Subsections (1), (4), and (5) of section 39.812, Florida Statutes, are amended to read:

39.812 Postdisposition relief; petition for adoption.—

(1) If the department is given custody of a child for subsequent adoption in accordance with this chapter, the department may place the child with an agency as defined in s. 63.032, with a child-caring agency registered under s. 409.176, or in a family home for prospective subsequent adoption without the need for a court order unless otherwise required under this section. The department may allow prospective adoptive parents to visit with a child in the department's custody without a court order to determine whether the adoptive placement would be appropriate. The department may thereafter become a party to any proceeding for the legal adoption of the child and appear in any court where the adoption proceeding is pending and consent to

the adoption, and that consent alone shall in all cases be sufficient.

(4) The court shall retain jurisdiction over any child placed in the custody of the department until the child is adopted. After custody of a child for subsequent adoption has been given to the department, 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, for good cause shown by the guardian ad litem for the child, the court may review the appropriateness of the adoptive placement of the child.

(a) If the department has denied a person's application to adopt a child, the denied applicant may file a motion with the court within 30 days after the issuance of the written notification of denial. This motion allows the denied applicant to file a chapter 63 petition to adopt a child without the department's consent. The denied applicant must allege in its motion that the department unreasonably withheld its consent to the adoption. The court, as part of its continuing jurisdiction, may review and rule on the motion.

1. The denied applicant only has standing in the chapter 39 proceeding to file the motion in paragraph (a) and to present evidence in support of the motion at a hearing, which must be held within 30 days after the filing of the motion.

2. At the hearing on the motion, the court may only

consider whether the department's review of the application was consistent with its policies and made in an expeditious manner. The standard of review by the court is whether the department's denial of the application is an abuse of discretion. The court may not compare the denied applicant against another applicant to determine which placement is in the best interests of the child.

3. If the denied applicant establishes by a preponderance of the evidence that the department unreasonably withheld its consent, the court shall enter an order authorizing the denied applicant to file a petition to adopt the child under chapter 63 without the department's consent.

4. If the denied applicant does not prove by a preponderance of the evidence that the department unreasonably withheld its consent, the court shall enter an order so finding and dismiss the motion.

5. The standing of the denied applicant in a proceeding under this chapter is terminated upon entry of the court's order.

(b) When a licensed foster parent or court-ordered custodian has applied to adopt a child who has resided with the foster parent or custodian for at least 6 months and who has previously been permanently committed to the legal custody of the department and the department does not grant the application to adopt, the department may not, in the absence of a prior

court order authorizing it to do so, remove the child from the foster home or custodian, except when:

1.~~(a)~~ There is probable cause to believe that the child is at imminent risk of abuse or neglect;

2.~~(b)~~ Thirty days have expired following written notice to the foster parent or custodian of the denial of the application to adopt, within which period no formal challenge of the department's decision has been filed; ~~or~~

3.~~(c)~~ The foster parent or custodian agrees to the child's removal; or~~.~~

4. The department has selected another prospective adoptive parent to adopt the child and either the foster parent or custodian has not filed a motion with the court to allow him or her to file a chapter 63 petition to adopt a child without the department's consent, as provided under paragraph (a), or the court has denied such a motion.

(5) The petition for adoption must be filed in the division of the circuit court which entered the judgment terminating parental rights, unless a motion for change of venue is granted under ~~pursuant to~~ s. 47.122. A copy of the consent executed by the department must be attached to the petition, unless such consent is waived under subsection (4) ~~pursuant to s. 63.062(7)~~. The petition must be accompanied by a statement, signed by the prospective adoptive parents, acknowledging receipt of all information required to be disclosed under s.

63.085 and a form provided by the department which details the social and medical history of the child and each parent and includes the social security number and date of birth for each parent, if such information is available or readily obtainable. The prospective adoptive parents may not file a petition for adoption until the judgment terminating parental rights becomes final. An adoption proceeding under this subsection is governed by chapter 63.

Section 13. Subsection (1) of section 39.820, Florida Statutes, is amended to read:

39.820 Definitions.—As used in this chapter ~~part~~, the term:

(1) "Guardian ad litem" as referred to in any civil or criminal proceeding includes the following: the Statewide Guardian ad Litem Office, which includes circuit ~~a certified~~ guardian ad litem programs; ~~program,~~ a duly certified volunteer, a staff member, a staff attorney, a contract attorney, or a ~~certified~~ pro bono attorney working on behalf of a guardian ad litem ~~or the program; staff members of a program office~~; a court-appointed attorney; or a responsible adult who is appointed by the court to represent the best interests of a child in a proceeding as provided for by law, including, but not limited to, this chapter, who is a party to any judicial proceeding as a representative of the child, and who serves until discharged by the court.

Section 14. Subsection (7) of section 63.062, Florida Statutes, is amended to read:

63.062 Persons required to consent to adoption; affidavit of nonpaternity; waiver of venue.—

(7) If parental rights to the minor have previously been terminated, the adoption entity with which the minor has been placed for subsequent adoption may provide consent to the adoption. In such case, no other consent is required. If the minor has been permanently committed to the department for subsequent adoption, the department must consent to the adoption or, in the alternative, the court order entered under s. 39.812(4) finding that the department ~~The consent of the department shall be waived upon a determination by the court that such consent is being~~ unreasonably withheld its consent must be attached to the petition to adopt and ~~if~~ the petitioner must file ~~has filed with the court~~ a favorable preliminary adoptive home study as required under s. 63.092.

Section 15. Paragraph (b) of subsection (6) of section 63.082, Florida Statutes, is amended to read:

63.082 Execution of consent to adoption or affidavit of nonpaternity; family social and medical history; revocation of consent.—

(6)

(b) Upon execution of the consent of the parent, the adoption entity is ~~shall be~~ permitted to intervene in the

dependency case as a party in interest and must provide the court that acquired jurisdiction over the minor, pursuant to the shelter order or dependency petition filed by the department, a copy of the preliminary home study of the prospective adoptive parents and any other evidence of the suitability of the placement. The preliminary home study must be maintained with strictest confidentiality within the dependency court file and the department's file. A preliminary home study must be provided to the court in all cases in which an adoption entity has intervened under ~~pursuant to~~ this section. The exemption in s. 63.092(3) from the home study for a stepparent or relative does not apply if a minor is under the supervision of the department or is otherwise subject to the jurisdiction of the dependency court as a result of the filing of a shelter petition, dependency petition, or termination of parental rights petition under chapter 39. Unless the court has concerns regarding the qualifications of the home study provider, or concerns that the home study may not be adequate to determine the best interests of the child, the home study provided by the adoption entity is ~~shall be deemed to be~~ sufficient and no additional home study needs to be performed by the department.

Section 16. Subsection (6) and paragraphs (b) and (e) of subsection (7) of section 409.1451, Florida Statutes, are amended to read:

409.1451 The Road-to-Independence Program.—

(6) ACCOUNTABILITY.—The department shall develop outcome measures for the program and other performance measures ~~in order~~ to maintain oversight of the program. ~~No later than January 31 of each year, the department shall prepare a report on the outcome measures and the department's oversight activities and submit the report to the President of the Senate, the Speaker of the House of Representatives, and the committees with jurisdiction over issues relating to children and families in the Senate and the House of Representatives. The report must include:~~

~~(a) An analysis of performance on the outcome measures developed under this section reported for each community-based care lead agency 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 lead agency, any programmatic or fiscal deficiencies found, corrective actions required, and current status of compliance.~~

~~(c) Any rules adopted or proposed under this section since the last report. For the purposes of the first report, any rules adopted or proposed under this section must be included.~~

(7) INDEPENDENT LIVING SERVICES ADVISORY COUNCIL.—The secretary shall establish the Independent Living Services Advisory Council for the purpose of reviewing and making recommendations concerning the implementation and operation of

the provisions of s. 39.6251 and the Road-to-Independence Program. The advisory council shall function as specified in this subsection until the Legislature determines that the advisory council can no longer provide a valuable contribution to the department's efforts to achieve the goals of the services designed to enable a young adult to live independently.

~~(b) The advisory council shall report to the secretary on the status of the implementation of the Road-to-Independence Program, efforts to publicize the availability of the Road-to-Independence Program, the success of the services, problems identified, recommendations for department or legislative action, and the department's implementation of the recommendations contained in the Independent Living Services Integration Workgroup Report submitted to the appropriate substantive committees of the Legislature by December 31, 2013. The department shall submit a report by December 31 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes a summary of the factors reported on by the council and identifies the recommendations of the advisory council and either describes the department's actions to implement the recommendations or provides the department's rationale for not implementing the recommendations.~~

~~(c) The advisory council report required under paragraph (b) must include an analysis of the system of independent living~~

~~transition services for young adults who reach 18 years of age while in foster care before completing high school or its equivalent and recommendations for department or legislative action. The council shall assess and report on the most effective method of assisting these young adults to complete high school or its equivalent by examining the practices of other states.~~

Section 17. Section 742.0211, Florida Statutes, is created to read:

742.0211 Proceedings applicable to dependent children.—

(1) As used in this section, the term "dependent child" means a child who is the subject of any proceeding under chapter 39.

(2) In addition to the other requirements of this chapter, any paternity proceeding filed under this chapter that concerns a dependent child must also comply with the requirements of this section.

(3) Notwithstanding s. 742.021(1), a paternity proceeding filed under this chapter that concerns a dependent child may be filed in the circuit court of the county that is exercising jurisdiction over the chapter 39 proceeding, even if the plaintiff or defendant does not reside in that county.

(4) The court having jurisdiction over the dependency matter may conduct any paternity proceeding filed under this chapter either as part of the chapter 39 proceeding or as a

separate action under this chapter.

(5) A person does not have standing to file a complaint under this chapter after the entry of a judgment terminating the parental rights of the legal father, as defined in s. 39.01, for the dependent child in the chapter 39 proceeding.

(6) The court must hold a hearing on the complaint concerning a dependent child as required under s. 742.031 within 30 days after the complaint is filed.

(7)(a) If the dependent child has a legal father, as defined in s. 39.01, and a different man, who has reason to believe that he is the father of the dependent child, has filed a complaint to establish paternity under this chapter and disestablish the paternity of the legal father, the alleged father must prove at the hearing held under s. 742.031 that:

1. He has acted with diligence in seeking the establishment of paternity.

2. He is the father of the dependent child.

3. He has manifested a substantial and continuing concern for the welfare of the dependent child.

(b) If the alleged father establishes the facts under paragraph (a), he must then prove by clear and convincing evidence that there is a clear and compelling reason to disestablish the legal father's paternity and instead establish paternity with him by considering the best interest of the dependent child.

(c) There is a rebuttable presumption that it is not in the dependent child's best interest to disestablish the legal father's paternity if:

1. The dependent child has been the subject of a chapter 39 proceeding for 12 months or more before the alleged father files a complaint under this chapter.

2. The alleged father does not pass a preliminary home study as required under s. 63.092 to be a placement for the dependent child.

(8) The court must enter a written order on the paternity complaint within 30 days after the conclusion of the hearing.

(9) If the court enters an order disestablishing the paternity of the legal father and establishing the paternity of the alleged father, then the newly established father shall be considered a parent, as defined in s. 39.01, for all purposes of the chapter 39 proceeding.

Section 18. This act shall take effect October 1, 2020.

PCS for CS/HB 7053

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.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

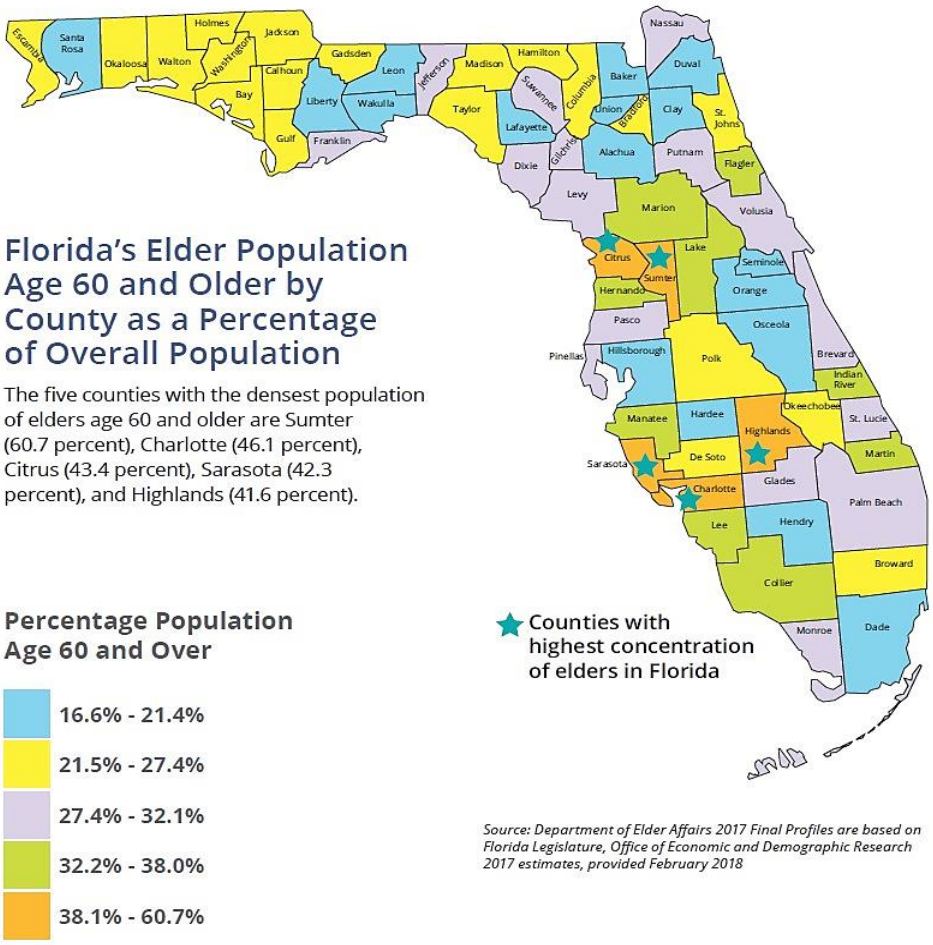
A. EFFECT OF PROPOSED CHANGES:

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.[1]

Florida ranks first in the nation in the percentage of residents who are age 65 or older.[2] It is estimated that 20.5 percent of the state's population is over the age of 65.[3] Florida ranks fourth in the nation in the percentage of residents who are 60 and older,[4] and there are 21 counties in which residents aged 60 and older comprise at least 25 percent of the population.[5]



[1] Paul Osterman, WHO WILL CARE FOR US: LONG-TERM CARE AND THE LONG-TERM CARE WORKFORCE 3 (2017).
[2] Department of Elder Affairs, *2019 Summary of Programs and Services*, (Jan. 2019), available at http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last visited January 10, 2020).
[3] U.S. Census Bureau, *Quick Facts: Florida*, (July 1, 2019), available at https://www.census.gov/quickfacts/FL (last visited January 10, 2020). Florida's population is estimated to be 21,477,737.
[4] *Supra* note 1 at p. 8.
[5] Id.

Someone turning 65 today has almost a 70 percent chance of needing some type of long term care services and supports in their remaining years.[6] As Florida grays, individuals with disabilities who need assistance with activities of daily living, such as eating, grooming, and making meals, may also lose their caretakers. Direct care workers may provide such care and enable these individuals to remain in the community.

Direct Care Workers

Direct care workers assist older individuals and those with disabilities with daily tasks, such as dressing, bathing, and eating.[7] They work in many different settings, such as private homes, group homes, residential care facilities, assisted living facilities, skilled nursing facilities, and hospitals.[8] Direct care workers account for 70 to 80 percent of all paid hands-on long-term care and personal assistance for the elderly or disabled.[9]

Florida Direct Care Workers

Nursing Assistants or Nursing Aides

Nursing assistants or nursing aides generally work in nursing homes, although some work in assisted living facilities, other community-based settings, or hospitals.[10] The Florida Board of Nursing, within the Department of Health, certifies nursing assistants (CNAs) who must, among other things, hold a high school diploma or equivalent, complete a 120-hour board-approved training program, and pass a nursing assistant competency exam, which includes written and practical portions.[11] A CNA must biennially complete 24 hours of inservice training to maintain certification.[12]

The Board of Nursing establishes the general scope of practice for CNAs. A CNA performs services under the general supervision[13] of a registered nurse or licensed practical nurse.[14] A CNA may perform the following services:[15]

- Personal care services, such as bathing, dressing grooming, and light housekeeping;
- Tasks associated with maintaining mobility, such as ambulating, transferring, positioning, lifting, and performing range of motion exercises;
- Nutrition and hydration tasks, such a feeding or assisting with eating and drinking;
- Tasks associated with elimination, such as toileting, providing catheter care, and emptying or changing ostomy bags;
- Tasks associated with using assistive devices;
- Maintaining the environment and resident safety;
- Taking measurements and gathering data, i.e. pulse, blood, pressure, height, and weight;

[6] U.S. Department of Health and Human Services, *How Much Care Will You Need?*, (last rev. Oct. 2017), available at https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html (last visited January 20, 2020).
[7] Paraprofessional Healthcare Institute, *Understanding the Direct Care Workforce*, available at https://phinational.org/policy-research/key-facts-faq/ (last visited November 8, 2019).
[8] Paraprofessional Healthcare Institute, *Direct Care Workforce 2018 Year in Review*, https://phinational.org/resource/the-direct-care-workforce-year-in-review-2018/ (last visited November 12, 2019) and Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?* https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[9] Id.
[10] Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?*, (Feb. 2011), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[11] Section 464.203, F.S., and r. 64B9-15.006, F.A.C. Eighty hours must be classroom instruction and 40 hours must be clinical instruction, 20 of which must be in long term care clinical instruction in a licensed nursing home. 42 C.F.R. § 483.95 requires 75 hours of training; Florida training requirements exceed the federal minimum training requirements.
[12] Section 464.203(7), F.S.
[13] Under general supervision, the registered nurse or licensed practical nurse does not need to be present but must be available for consultation and advice, either in person or by a communication device. Rule 64B9-15.001(5), F.A.C
[14] Rule 64B9-15.002, F.A.C.
[15] *Supra* note 14.

- Reporting abnormal resident findings, signs, and symptoms;
- Post mortem care;
- Tasks associated with end of life care;
- Tasks associated with resident socialization, leisure activities, reality orientation, and validation techniques;
- Performing basic first aid, CPR, and emergency care; and
- Documentation of CNA services provided to the resident.

A CNA may not work independently and may not may not perform any tasks that requires specialized nursing knowledge, judgement, or skills.[16]

Home Health Aides

Home health aides (HHA) provide essentially the same care and services as nursing assistants, but they assist people in their homes or in community settings under the supervision of a nurse or a physical, speech, occupational, or respiratory therapist.[17] In Florida, HHAs are not licensed or certified. However, the Agency for Health Care Administration (AHCA) licenses home health agencies and establishes training requirements for HHAs employed by home health agencies. A HHA must complete at least 75 hours of training and/or successfully pass a competency evaluation by the home health agency.[18] HHAs who work for a home health agency that is not certified by Medicare or Medicaid or who work for a nurse registry must complete 40 hours of training or pass an AHCA-developed competency examination.[19]

AHCA establishes the scope of practice for HHAs performing services under a licensed home health agency. A HHA performs services delegated by and under the supervision of a registered nurse, which include:[20]

- Assisting the patient or client with personal hygiene, ambulation, eating, dressing, shaving, physical transfer, and other personal care activities;
- Maintaining a clean, safe, and healthy environment, including light housekeeping;
- Activities taught by a licensed health professional for a specific patient or client and restricted to:
    - Toileting;
    - Assisting with tasks related to elimination;
    - Assisting with the use of devices for aid to daily living, such as a wheelchair;
    - Assisting with prescribed range of motion exercises;
    - Assisting with prescribed ice cap or collar;
    - Doing simple urine tests for sugar, acetone, or albumin;
    - Measuring and preparing special diets; and
- Assisting with self-administration of medication.

A HHA may not change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, or any other services that has not been included in the patient's plan of care.[21]

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[16] *Supra* note 14.
[17] *Supra* note 10. If the only service the home health agency provides, is physical, speech, or occupational therapy, in additional to the home health aide or CNA services, the licensed therapist may provide supervision.
[18] Agency for Health Care Administration, *Home Health Aides,* available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/Home_health_aides.shtml (last visited January 20, 2020).
[19] Rules 59A-8.0095(5)
[20] Id., and 64B9-15.002, F.A.C.
[21] Rule 59A-8.0095(5)(p), F.A.C.

Personal Care Assistants

Personal care assistants (PCAs) work in either private or group homes.[22] They have many titles, including personal care attendant, home care worker, homemaker/companion, and direct support professional.[23] (The latter work with people with intellectual and developmental disabilities). In addition to providing assistance with activities of daily living, they also help individuals go to work and remain engaged in their communities.[24] A growing number of these workers are employed and supervised directly by consumers.

There are no minimum training requirements for PCAs, and there is no agency that directly regulates them. PCAs may be employed by or provide services through a home health agency or homemaker/companion agency, although some PCAs work independently and are directly supervised by the employing family or individual.

A PCA does not have a clearly defined scope of practice because it is not a regulated profession. However, the Florida Medicaid program defines personal care services as medically necessary assistance with activities of daily living to enable an individual to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.[25] Florida Medicaid authorizes the following personal care services:[26]

- Bathing or assistance with bathing;
- Assistance with dressing, including application of prosthetic devices or therapeutic stockings;
- Grooming and skin care;
- Positioning;
- Transfers;
- Toileting and maintaining continence;
- Assistance with eating; and
- Non-skilled medical task delegated by a registered nurse, and may include assisting with pre-measured medications, monitoring vital signs, and measuring intake and output.

Medication Administration and Assistance with Self-Administration

Medication Administration

Medication administration means to obtain and provide a single dose of a medication to a patient for his or her consumption.[27] Currently, neither CNAs nor HHAs may administer medication to a patient. However, Florida law authorizes unlicensed direct care personnel who complete a 6-hour training course to administer medication under the developmental disabilities program.[28] Many other states authorize HHAs or CNAs who complete additional training to administer medication.[29] For example, Texas authorizes home health medication aides.[30] Arizona, Georgia, Illinois, Minnesota, and North Arizona authorize CNAs to administer medication upon completion of specialized training.[31] Connecticut has a stand-alone medication administration technician profession.[32]

[22] *Supra* note 10.
[23] Id.
[24] Id.
[25] Agency for Health Care Administration, Florida Medicaid, *Personal Care Services Coverage Policy*, (Nov. 2016), adopted in r. 59G-4.215, F.A.C.
[26] Id.
[27] Section 465.003, F.S.
[28] Section 393.506, F.S.
[29] Some states specifically certify or license medication aides.
[30] *See* TEX. HEALTH & SAFETY CODE 242 and 26 TEX. ADMIN. CODE 557.128.
[31] *See* ARIZ. REV. STAT. §32-1650, GA. CODE. ANN. 31-7-12.2, 225 ILL. COMP. STAT. 65 (pilot program), MINN. R. 4658.1360, N.C. GEN. STAT. § 131E-114.2, respectively.
[32] *See* CONN. GEN. STAT. §17a-210-1, et. seq.

Assistance with Self-Administration

Some patients are capable of administering their own medication, but need assistance to ensure that they are taking the correct medication, at the proper dosage, and at the correct time. Under current law, HHAs may assist with self-administration after completion of prescribed training.

HHAs must complete two hours of training to assist with self-administration of medication.[33] The training must include state law and rule requirements for assistance with self-administration of medication in the home, procedures for assisting the patient with self-administration, common medications, recognition of side effects and adverse reactions, and procedures to follow if patients appear to be experiencing side effects or adverse reactions.[34] This 2-hour training may be included in the initial 75-hour or 40-hour HHA training.

Assistance with self-administration of medication includes:[35]

- Taking the medication, in its properly labeled container, from where it is stored to the patient;
- In the presence of the patient, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container;
- Placing an oral dose in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth;
- Applying topical medications;
- Returning the medication container to proper storage; and
- Keeping a record of when a patient receives assistance.

A HHA with the authority to assist with self-administration of medication may not:[36]

- Mix, compound, convert, or calculate medication doses;
- Prepare syringes for injection or the administration of medications by any injectable route;
- Administer medications through intermittent positive pressure breathing machines or a nebulizer;
- Administer medications by way of a tube inserted in a cavity of the body;
- Administer parenteral preparations;
- Irrigate or use debriding agents to treat a skin condition;
- Prepare rectal, urethral, or vaginal medications.
- Administer medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the HHA, and at the request of a competent patient;
- Administer medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

CNAs who are not working for a home health agency may not assist with medication administration.

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.[37] The demand for home

[33] *Supra* note 19.
[34] Id.
[35] Section 400.488(3), F.S.
[36] Section 400.488(4), F.S.
[37] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*,

health aides and nursing assistants is expected to increase by 34 percent by 2025.[38] However, the turnover rate in long term care is estimated to be between 45 to 66 percent.[39]

Many factors contribute to the high turnover rate, including compensation, lack of full-employment, and low job satisfaction.[40] Direct care workers also often have substantial family caregiving obligations, which adds to the stress of the job and contribute to the days missed from work.[41]

High turnover rates have a negative impact on both employers and patients. Turnover may have a negative impact on patient care and employers must incur costs for continuous recruitment and training of new employees.[42] Indirect costs to employers include lost productivity, lost revenue, and reduced service quality.[43] Employers must pay costs related to filling vacancies and training new employees. It is estimated that turnover costs direct care employers approximately $4.1 billion per year.[44] Turnover can cause a break in continuity of care and a reduction in the quality of care, which may ultimately affect the patient's quality of life.[45]

Approximately two-thirds of HHAs and PCAs work part time.[46] This may be due to personal needs; however, many home care workers receive several assignments to work in a day the total of which does not amount to a full work day. For example, a HHA may be scheduled to see two separate clients for three hours each, but due to the time to travel between patients, the HHA is unable to achieve a full 8-hour work day. Many direct workers also face other obstacles to remaining in their jobs, including challenges with transportation, family commitments, or health care.[47] Some states or regions have launched matching service registries to make it easier for workers to find clients and build schedules to suit individual needs and commitments.[48]

Low job satisfaction, which in turn leads to higher turnover, results from inadequate training and lack of opportunities for advancement.[49] Many direct care workers chose the career because they wanted to help people, and this motivation also plays a role in retaining workers in direct care.[50] However, many direct care workers leave the career field for other entry-level jobs in the food and hospitality industry that pay similarly, are less mentally and physically strenuous, and provide opportunities for advancement.[51] In fact, one in four CNAs and one in five HHAs report that they are actively seeking another job.[52]

(March 2018), available at https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hrsa-ltts-direct-care-worker-report.pdf (last visited January 14, 2020).
[38] Id.
[39] Kezia Scales, PhD, *Staffing in Long-Term Care is a National Crisis*, (June 8, 2018), available at https://phinational.org/recruitment-retention-long-term-care-national-perspective/ (last visited January 14, 2020).
[40] *Supra* note 1, at pp. 27-37.
[41] U.S. Department of Health and Human Services, *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs – Certified Nursing Assistants and Home Health Aides*, (March 2011), available at https://www.ahcancal.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf (last visited January 20, 2020).
[42] Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, Board on Health Care Services, *Retooling for an Aging America: Building the Health Care Workforce*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK215401/pdf/Bookshelf_NBK215401.pdf (last visited January 14, 2020).
[43] Dorie Seavey, Better Jobs Better Care, *The Cost of Frontline Turnover in Long-Term Care*, (Oct. 2004), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/TOCostReport.pdf (last visited January 25, 2020).
[44] *Supra* note 42.
[45] Id.
[46] Paraprofessional Healthcare Institute, *U.S. Home Care Workers: Key Facts*, available at https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf (last visited January 14, 2020).
[47] Paraprofessional Healthcare Institute, *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, available at https://phinational.org/wp-content/uploads/2018/05/RRGuide-PHI-2018.pdf (last visited January 20, 2020).
[48] Allison Cook, Paraprofessional Healthcare Institute, *Issue Brief: Localized Strategies For Addressing the Workforce Crisis in Home Care*, (Oct. 2019), available at https://phinational.org/wp-content/uploads/2019/11/Localized-Strategies-2019-PHI.pdf (last visited January 20, 2020).
[49] *Supra* note 41.
[50] *Supra* note 41, at p. 48.
[51] *Supra* note 42.
[52] Id.

Direct care workers are also at an increased risk of work-related injuries.[53] Direct care workers have an injury rate of 144 injuries per 10,000 workers among PCAs, 116 among HHAs, and 337 among CNAs.[54] By contrast, the injury rate across all occupations is 100 per 10,000 workers.[55]

In order to meet the future demand for direct care worker, employers will need to consider options such as offering better compensation, full-time hours, better training and advancement opportunities, and improved working conditions.[56]

Direct Care Workforce Data

In 2009, the federal Centers for Medicare and Medicaid Services (CMS) issued a report acknowledging that there was a lack of ongoing, reliable state-based information about the direct care workforce.[57] This lack of information has hampered the ability to develop policy to ensure that a stable and quality direct care workforce is available to meet the increasing demand for long term care services.[58]

CMS proposed that states collect a minimum data set of information on direct care workers, including the:

- Number umber of direct care workers (full time and part time);
- Stability of the direct care workforce (turnover and vacancies); and
- Average compensation of workers (wages and benefits).

Collecting this minimum data on the direct care workforce enables states to, among other things:[59]

- Create a baseline against which the progress of workforce initiatives can be measured;
- Inform policy formulation regarding workforce initiatives;
- Help identify and set long-term priorities for long-term care reform and system changes; and
- Promote integrated planning and coordinated approaches for long-term care and comparability of data across programs to assist in the assessment and evaluation of adopted policy initiatives.

This information will also enable states to determine the most useful deployment of state resources, anticipate increased demand for services, and assess trends in workforce turnover and related costs.[60]

In addition to direct care workers who are employed by entities, like home health agencies and nursing home facilities, there is a growing “gray market” comprised of independent providers. These independent providers are directly employed by the individuals to whom they provide care[61] and some may be employed by individuals through government-funded programs, such as Medicaid.[62] However, since these individuals are directly employed by patients, it is difficult to quantify the size of this market.

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[53] *Supra* note 41.
[54] Stephen Campbell, Paraprofessional Healthcare Institute, *Issue Brief: Workplace Injuries and the Direct Care Workforce*, (April 2018), available at https://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf (last visited January 20, 2020).
[55] Id.
[56] *Supra* note 46, at p. 8.
[57] Centers for Medicare and Medicaid Services, National Direct Service Workforce Resource Center, *The Need for Monitoring Long-Term Direct Service Workforce and Recommendations for Data Collection*, (Feb. 2009), available at https://www.medicaid.gov/sites/default/files/2019-12/monitoring-dsw.pdf (last visited January 8, 2020).
[58] Id.
[59] Id at p. 8.
[60] Id.
[61] *Supra* note 1 at 18.
[62] For example, see *supra* note 25.

Regulation of Long Term Care Providers

The Division of Health Quality Assurance (HQA) within AHCA licenses, certifies, and regulates 40 different types of health care providers. Regulated providers include, among others, these providers of long-term care services:

- Nursing home facilities under part II of ch. 400, F.S.
- Assisted living facilities under part I of ch. 429, F.S.
- Home health agencies under part III of ch. 400, F.S.
- Companion or homemaker services providers under part III of ch. 400, F.S.
- Nurse registries under part III of ch. 400, F.S.
- Hospices under part IV of ch. 400, F.S.

In addition to provider-specific requirements listed in the authorizing statutes for each provider type listed above, the Health Care Licensing Procedures Act (Act), in part II of ch. 408, F.S., establishes uniform licensing procedures and statutes for 29 provider types regulated by HQA. The Act authorizes HQA to inspect facilities, verify compliance with licensure requirements, identify deficiencies or violations, and impose fines and penalties for noncompliance.

Nursing Home Staffing

Section 400.23(3), F.S., establishes minimum staffing requirements for nursing home facilities:

- A minimum weekly[63] average of 3.6 hours of direct care per resident per day provided by a combination of certified nursing assistants and licensed nursing staff.
- A minimum of 2.5 hours of direct care per resident per day provided by certified nursing assistant staff. A facility may not staff at a ratio of less than one certified nursing assistant per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.

When computing the staffing ratio for certified nursing assistants, nursing home facilities are allowed to use uncertified nursing assistants under certain conditions to satisfy the staffing ratio requirements so long as their job duties only include nursing assistant-related duties.[64] If approved by AHCA, licensed nurses may also be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.[65] Additionally, non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing requirements.[66]

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.[67]

[63] A week is defined as Sunday through Saturday.
[64] Sections 400.23(3)(a)2. and 400.211(2), F.S. Nursing facilities may employ uncertified nursing assistants for up to 4 months if they are enrolled in, or have completed, a state-approving nursing assistant program, have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state, or have preliminarily passed the state's certification exam.
[65] Section 400.23(3)(a)4., F.S., and r. 59A-4.108(7), F.A.C. The hours of a licensed nurse with dual job responsibilities may not be counted twice.
[66] Sections 400.23(3)(b), F.S.
[67] 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:[68]

- 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[69] 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.[70] 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,[71] 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.[72]

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.[73] The FDLE notifies the employer or agency whether a screening has revealed any disqualifying information.[74]

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.[75] The Clearinghouse allows the background screening results to be shared among these agencies, so that the employee or licensee

[68] 42 C.F.R. s. 483.160.
[69] "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.
[70] Section 435.05(1)(a), F.S.
[71] 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).
[72] Section 435.04, F.S.
[73] Section 435.05(1)(b)-(c), F.S.
[74] Section 435.05(1)(c), F.S.
[75] Section 435.12, F.S.

does not have to undergo multiple background screenings when changing employers.[76] Employers register with the Clearinghouse and maintain the employment status of its employees listed in the Clearinghouse by timely reporting changes in employment.[77]

Health Care Workforce

Health Care Professional Shortage

The U.S. has a current health care provider shortage.[78] 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).[79]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[80] and ongoing efforts to expand access.[81] 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.[82] 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.[83] It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.[84]

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.[85] In 2018, there were 277.8 physicians[86] 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.[87] The states with the highest number of

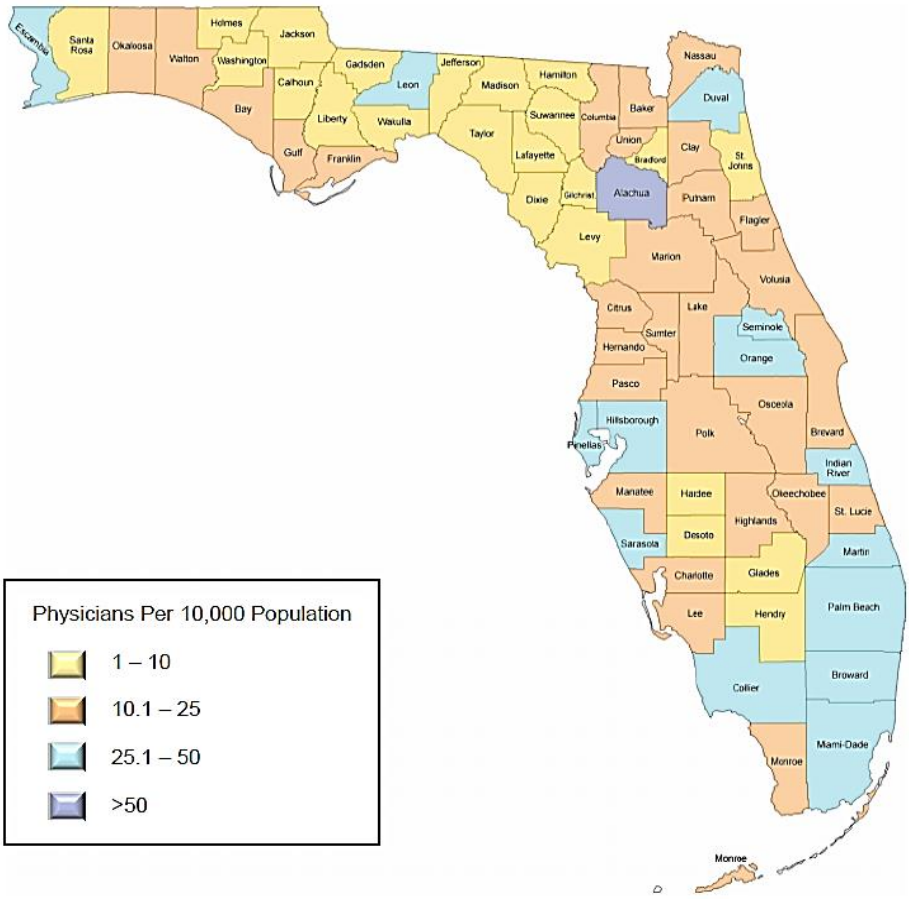
[76] Section 435.12(1), F.S.
[77] Section 435.12(20, F.S.
[78] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Dec. 31, 2019), 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.
[79] Id.
[80] 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."
[81] 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 (last visited February 20, 2020).
[82] Id.
[83] *Supra* note 78.
[84] Id.
[85] *Supra* note 81.
[86] These totals include allopathic and osteopathic physicians.
[87] 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.[88]

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.[89] Although Florida is the third most populous state in the nation,[90] it ranks as having the 23rd highest physician to population ratio.[91] 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.[92]

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.[93] Additionally, 35 percent of practicing physicians are age 60 and older.[94]

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.[95]

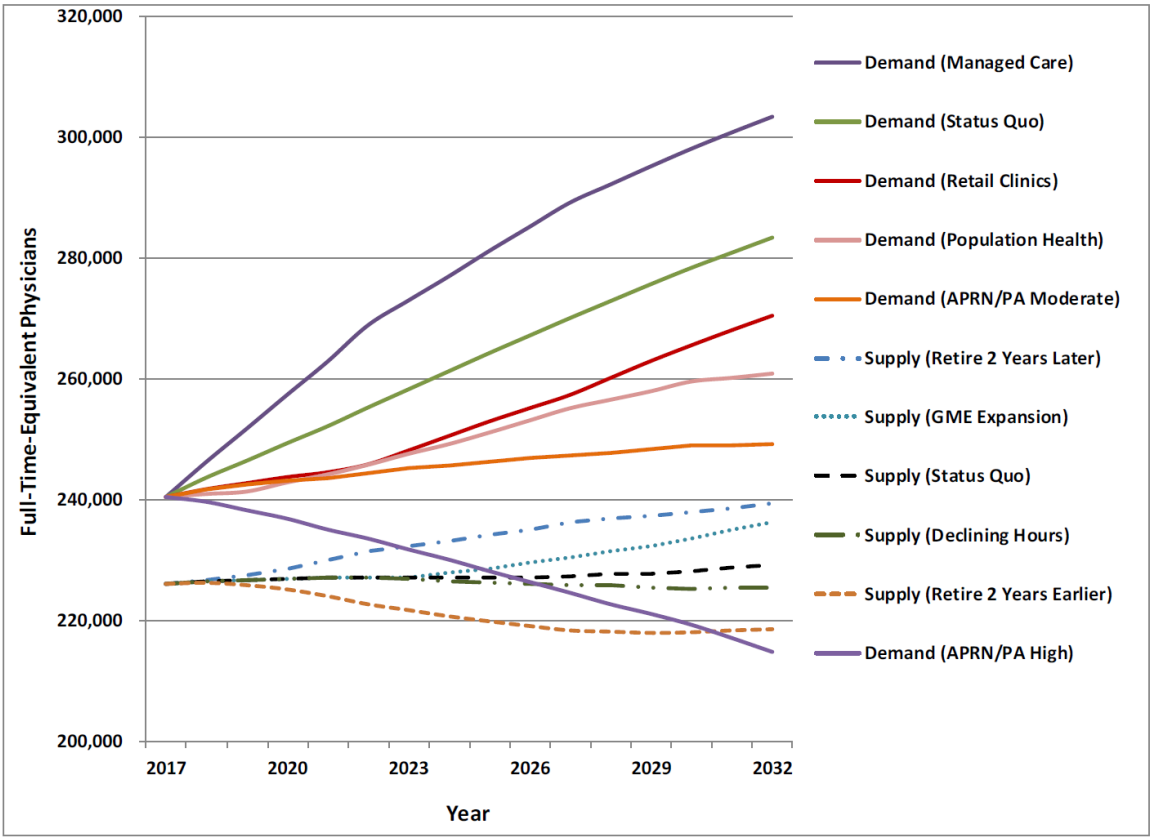


[88] Id.
[89] *Supra* note 87, at pp. 7-8
[90] As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 21,299,325 residents, behind California (39,557,045) and Texas (28,701,845). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on February 21, 2020).
[91] *Supra* note 87, at pp. 7-8.
[92] *Supra* note 87, at pp. 12-13.
[93] 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).
[94] Id. at p. 9.
[95] Id. at p. 42.

The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.[96] Currently, primary care physicians make up 28 percent of the physician workforce.[97] 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.[98] 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.[99]

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.[100]

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).[101] 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.[102]

[96] *Supra* note 81. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.
[97] Id. at p. 45.
[98] Id. at p. 46.
[99] Id at p. 18.
[100] Id.
[101] *Supra* note 93 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.
[102] Id at p. 25.

Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNPs), 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.[103] There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.[104]

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.[105] 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.[106] The Florida Center for Nursing Center) estimates that in 2016 and 2017, the number of APRNs who are actually working is 22,795,[107] and the number of RNs who are actually working is 208,870.[108] 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[109] and 39 percent of the state's APRNs[110] are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.[111]

Physician Assistant Workforce

In Florida, there are approximately 9,784 actively licensed physician assistants (PAs),[112] 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.[113] On average, a full-time PA sees 83 patients a week.[114]

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[103] 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).
[104] 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 (last visited on February 21, 2020) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.
[105] 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).
[106] 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 (last visited February 21, 2020).
[107] 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 (last visited on February 21, 2020).
[108] 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 (last visited on February 21, 2020).
[109] *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.
[110] *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.
[111] 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 (last visited on November 20, 2019).
[112] *Supra* note 105.
[113] 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.
[114] Id at p. 47.

Advanced Practice Nurses

Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)[115] 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).[116] As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.[117]

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.[118] 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.[119]

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.[120] A nursing specialty board must:[121]

- 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.[122] By comparison, physicians must establish some method of financial

[115] Section 464.003(3), F.S.
[116] 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.
[117] Email correspondence from DOH dated November 25, 2019, on file with committee staff.
[118] Section 464.012(3)-(4), F.S.
[119] Section 464.003, F.S., and s. 464.012, F.S.
[120] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.
[121] Rule 64B9-4.002(3), F.A.C.
[122] 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.[123]

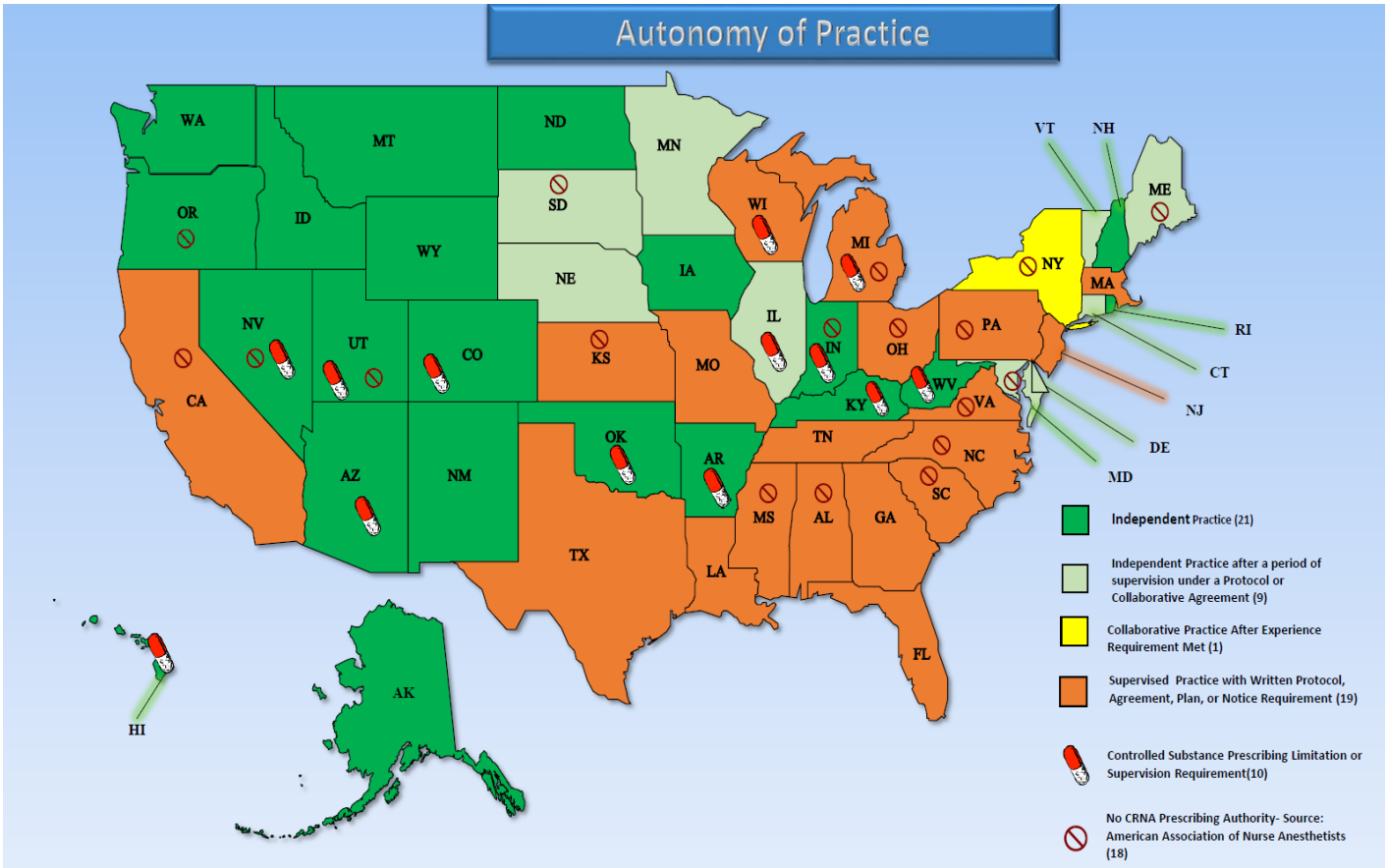
Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, HB 423 eliminated the joint committee and instead, authorized physicians and APRNs to determine the medical acts the APRN could perform within the supervisory protocol.[124]

APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:[125]

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.

[123] 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.
[124] Chapter 2016-224, Laws of Fla.
[125] 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.[126] 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.[127]

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,[128] 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.[129] Furthermore, a special

[126] 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).
[127] 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).
[128] 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.
[129] 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.[130]

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.[131] In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017. [132] The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,[133] as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.[134] 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.[135] 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.[136] 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;[137];
- 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.[138]

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[130] *Id*.
[131] *Supra* note 125. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.
[132] Chapter 2016-224, Laws of Fla.
[133] 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.
[134] *Supra* note 125.
[135] 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.
[136] 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.
[137] 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.
[138] 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.[139]

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APRNs provide a different quality of care than physicians,[140] 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:[141]

- 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.[142]

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.[143] 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.[144]

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[139] Sections 394.463(2) and 382.008, F.S.
[140] 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).
[141] 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).
[142] 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).
[143] 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).
[144] 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 (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.[145]

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.[146] The report estimated savings of $16.1 billion in total expenditures and $8 billion in output (gross product) each year.[147] 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.[148]

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.[149] 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).[150]

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.[151] 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.[152]

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.[153] 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.[154] 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.[155]

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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[145] 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%20Ultilization%20Economic%20Impact%20Report%20May%202012.pdf (last visited on February 21, 2020).
[146] Id.
[147] Id.
[148] Id.
[149] *Supra* note 144.
[150] Id.
[151] 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).
[152] Id.
[153] 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).
[154] Id.
[155] 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.[156] Two of the physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:[157]

- 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:[158]

- 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;[159]
- 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.[160] 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.[161]

PA Education

PA education programs are typically three years and award master's degrees.[162] Many programs require students to have health care experience as a condition for admission.[163] PA students receive classroom training in:[164]

- Anatomy;

[156] 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.
[157] Id,
[158] Sections 458.347(7) and 459.022(7), F.S.
[159] Section 456.0135, F.S.
[160] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[161] National Commission on Certification of Physician Assistants, *Maintaining Certification*, available at https://www.nccpa.net/CertificationProcess (last visited February 21, 2020).
[162] American Academy of PAs, *Become a PA*, available at https://www.aapa.org/career-central/become-a-pa/ (last visited February 21, 2020).
[163] Id.
[164] 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.[165] A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.[166]

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.[167] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[168] 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.[169]

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.[170]

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.[171] A supervising physician may delegate the authority for a PA to:

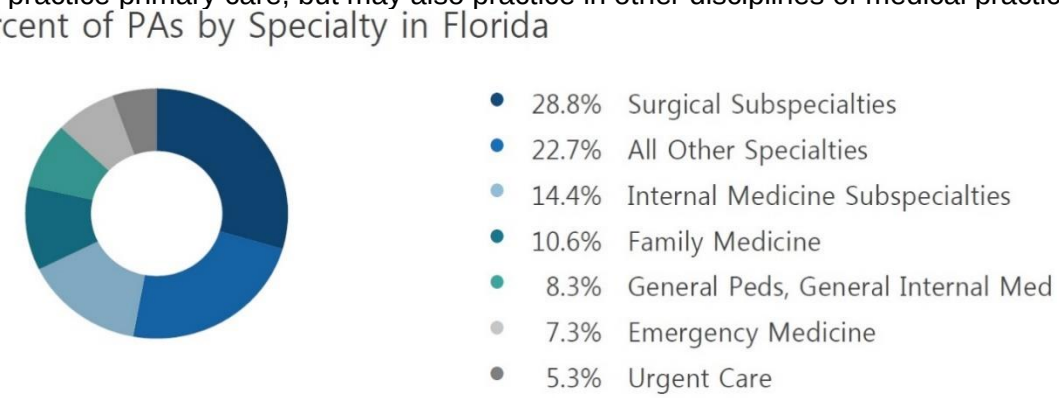
- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the formulary established by the Council;[172]

[165] Id.
[166] Id.
[167] 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.
[168] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[169] Sections 458.347(15) and 459.022(15), F.S.
[170] Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[171] "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.
[172] 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.;[173] 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.[174]

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.[175] Approximately 19 percent of Florida-licensed PAs practice primary care, but may also practice in other disciplines of medical practice:[176]



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.[177] DOH must review each report to determine if discipline against the PA's license is warranted.[178]

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:[179]

- 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

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.

[173] 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.

[174] Sections 458.347(4) and 459.022(e), F.S.

[175] *Supra* note 113.

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

[177] Sections 458.351 and 459.026, F.S.

[178] Sections 458.351(5) and 459.026(5), F.S.

[179] 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.[180] 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.[181] Additionally, the study noted that PAs provided more health education services than primary care physicians.[182]

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.[183]

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.[184]

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)[185] 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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[180] 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/lww-medicalcare/Abstract/2017/06000/A_Comparison_of_Nurse_Practitioners,_Physician.11.aspx (last visited February 21, 2020).
[181] Id.
[182] Id.
[183] 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).
[184] *Supra* note 143.
[185] 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.

<u>Direct Care Workforce Survey</u>

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,[186] 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,[187] 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;[188]
- 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

[186] 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.
[187] The bill expressly prohibits AHCA from displaying the social security number on its website.
[188] 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.[189] 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;

[189] 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.;[190]
- 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.[191] 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 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;

[190] This includes ambulatory surgical centers, hospitals, and nursing homes.
[191] *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[192] and the Good Samaritan Act;[193]
- 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.

[192] Section 766.103, F.S.
[193] 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 of183,895, 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 implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to direct care; amending s. 400.141, F.S.; authorizing a nursing home facility to use paid feeding assistants in accordance with federal law under certain circumstances; amending s. 400.23, F.S.; prohibiting paid feeding assistants from counting toward compliance with minimum staffing standards; amending s. 400.462, F.S.; revising the definition of "home health aide"; amending s. 400.464, F.S.; requiring a licensed home health agency that authorizes a registered nurse to delegate tasks to a certified nursing assistant to ensure that certain requirements are met; amending s. 400.488, F.S.; authorizing an unlicensed person to assist with self-administration of certain treatments; revising the requirements for such assistance; creating s. 400.489, F.S.; authorizing a home health aide to administer certain prescription medications under certain conditions; requiring the home health aide to meet certain training and competency requirements; requiring that the training, determination of competency, and annual validations be performed by a registered nurse or a physician; requiring a home health aide to complete annual inservice training in medication administration and medication error prevention in addition to existing annual inservice

training requirements; requiring the Agency for Health Care Administration, in consultation with the Board of Nursing, to adopt rules for medication administration; creating s. 400.490, F.S.; authorizing a certified nursing assistant or home health aide to perform tasks delegated by a registered nurse; creating s. 400.52, F.S.; creating the Excellence in Home Health Program within the agency; requiring the agency to adopt rules establishing program criteria; requiring the agency to annually evaluate certain home health agencies that apply for a program award; providing eligibility requirements; requiring an agency to reapply biennially for the award designation; authorizing an award recipient to use the designation in advertising and marketing; prohibiting a home health agency from using the award designation in any advertising or marketing under certain circumstances; providing that an application for an award designation under the program is not an application for licensure and such designation does not constitute final agency action subject to certain administrative procedures; creating s. 408.064, F.S.; providing definitions; requiring the agency to develop and maintain a voluntary registry of home care workers; providing requirements for the registry; requiring a home care worker to apply to be included in the registry; requiring the agency to

develop a process by which a home health services provider may include its employees on the registry; requiring certain home care workers to undergo background screening and training; requiring each page of the registry website to contain a specified notice; requiring the agency to adopt rules; creating s. 408.822, F.S.; defining the term "direct care worker"; requiring certain licensees to provide specified information about employees in a survey beginning on a specified date; requiring that the survey be completed on a form with a specified attestation adopted by the agency in rule; requiring a licensee to submit such survey before the agency renews its license; requiring the agency to analyze the results of such survey and publish its results on the agency's website; requiring the agency to update such information monthly; requiring the agency's analysis to include specified information; creating s. 464.0156, F.S.; authorizing a registered nurse to delegate tasks to a certified nursing assistant or home health aide under certain conditions; providing the criteria that a registered nurse must consider in determining if a task may be delegated; authorizing a registered nurse to delegate medication administration to a certified nursing assistant or home health aide if certain requirements are met; requiring the Board of Nursing, in

consultation with the agency, to adopt rules; amending s. 464.018, F.S.; providing that a registered nurse who delegates certain tasks to a person the registered nurse knows or has reason to know is unqualified is grounds for licensure denial or disciplinary action; creating s. 464.2035, F.S.; authorizing a certified nursing assistant to administer certain prescription medications under certain conditions; requiring the certified nursing assistant to meet certain training and competency requirements; requiring the training, determination of competency, and annual validations to be performed by a registered nurse or a physician; requiring a certified nursing assistant to complete annual inservice training in medication administration and medication error prevention in addition to existing annual inservice training requirements; requiring the board, in consultation with the agency, to adopt rules; amending s. 456.0391, F.S.; requiring an autonomous physician assistant to submit certain information to the Department of Health; requiring the department to send a notice to autonomous physician assistants regarding the required information; requiring autonomous physician assistants who have submitted required information to update such information in writing; providing penalties; amending s. 456.041, F.S.; requiring the department to provide

a practitioner profile for an autonomous physician assistant; amending ss. 458.347 and 459.022, F.S.; defining the term "autonomous physician assistant"; authorizing third-party payors to reimburse employers for services provided by autonomous physician assistants; deleting a requirement that a physician assistant must inform a patient of a right to see a physician before prescribing or dispensing a prescription; revising the requirements for physician assistant education and training programs; authorizing the Board of Medicine to impose certain penalties upon an autonomous physician assistant; requiring the board to register a physician assistant as an autonomous physician assistant if the applicant meets certain criteria; providing requirements; providing exceptions; requiring the department to distinguish such autonomous physician assistants' licenses; authorizing such autonomous physician assistants to perform specified acts without physician supervision or supervisory protocol; requiring biennial registration renewal; requiring the Council on Physician Assistants to establish rules; revising the membership and duties of the council; prohibiting a person who is not registered as an autonomous physician assistant from using the title; providing for the denial, suspension, or revocation of the

registration of an autonomous physician assistant; requiring the board to adopt rules; requiring autonomous physician assistants to report adverse incidents to the department; amending s. 464.012, F.S.; requiring applicants for registration as an advanced practice registered nurse to apply to the Board of Nursing; authorizing an advanced practice registered nurse to sign, certify, stamp, verify, or endorse a document that requires the signature, certification, stamp, verification, affidavit, or endorsement of a physician within the framework of an established protocol; providing an exception; creating s. 464.0123, F.S.; defining the term "autonomous practice"; providing for the registration of an advanced practice registered nurse to engage in autonomous practice; providing registration requirements; requiring the department to distinguish such advanced practice registered nurses' licenses and include the registration in their practitioner profiles; authorizing such advanced practice registered nurses to perform specified acts without physician supervision or supervisory protocol; requiring biennial registration renewal and continuing education; authorizing the Board of Nursing to establish an advisory committee to determine the medical acts that may be performed by such advanced

practice registered nurses; providing for appointment and terms of committee members; requiring the board to adopt rules; creating s. 464.0155, F.S.; requiring advanced practice registered nurses registered to engage in autonomous practice to report adverse incidents to the Department of Health; providing requirements; defining the term "adverse incident"; providing for department review of such reports; authorizing the department to take disciplinary action; amending s. 464.018, F.S.; providing additional grounds for denial of a license or disciplinary action for advanced practice registered nurses registered to engage in autonomous practice; amending s. 39.01, F.S.; revising the definition of the term "licensed health care professional" to include an autonomous physician assistant; amending s. 39.303, F.S.; authorizing a specified autonomous physician assistant to review certain cases of abuse or neglect and standards for face-to-face medical evaluations by a Child Protection Team; amending s. 39.304, F.S.; authorizing an autonomous physician assistant to perform or order an examination and diagnose a child without parental consent under certain circumstances; amending s. 110.12315, F.S.; revising requirements for reimbursement of pharmacies for specified prescription drugs and supplies under

the state employees' prescription drug program; amending s. 252.515, F.S.; providing immunity from civil liability for an autonomous physician assistant under the Postdisaster Relief Assistance Act; amending ss. 310.071, 310.073, and 310.081, F.S.; authorizing an autonomous physician assistant and a physician assistant to administer the physical examination required for deputy pilot certification and state pilot licensure; authorizing an applicant for a deputy pilot certificate or a state pilot license to use controlled substances prescribed by an autonomous physician assistant; amending s. 320.0848, F.S.; authorizing an autonomous physician assistant to certify that a person is disabled to satisfy requirements for certain permits; amending s. 381.00315, F.S.; providing for the temporary reactivation of the registration of an autonomous physician assistant in a public health emergency; amending s. 381.00593, F.S.; revising the definition of the term "health care practitioner" to include an autonomous physician assistant for purposes of the Public School Volunteer Health Care Practitioner Act; amending s. 381.026, F.S.; revising the definition of the term "health care provider" to include an advanced practice registered nurse and an autonomous physician assistant for purposes of the Florida Patient's Bill

of Rights and Responsibilities; amending s. 382.008, F.S.; authorizing an autonomous physician assistant, a physician assistant, and an advanced practice registered nurse to file a certificate of death or fetal death under certain circumstances; authorizing a certified nurse midwife to provide certain information to the funeral director within a specified time period; replacing the term "primary or attending physician" with "primary or attending practitioner"; defining the term "primary or attending practitioner"; amending s. 382.011, F.S.; conforming a provision to changes made by the act; amending s. 383.14, F.S.; authorizing the release of certain newborn tests and screening results to an autonomous physician assistant; revising the definition of the term "health care practitioner" to include an autonomous physician assistant for purposes of screening for certain disorders and risk factors; amending s. 390.0111, F.S.; authorizing a certain action by an autonomous physician assistant before an abortion procedure; amending s. 390.012, F.S.; authorizing certain actions by an autonomous physician assistant during and after an abortion procedure; amending s. 394.463, F.S.; authorizing an autonomous physician assistant, a physician assistant, and an advanced practice registered nurse to initiate an involuntary

examination for mental illness under certain circumstances; authorizing a physician assistant to examine a patient; amending s. 395.0191, F.S.; providing an exception to certain onsite medical direction requirements for a specified advanced practice registered nurse; amending 395.602, F.S.; authorizing the Department of Health to use certain funds to increase the number of autonomous physician assistants in rural areas; amending s. 397.501, F.S.; prohibiting the denial of certain services to an individual who takes medication prescribed by an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse; amending ss. 397.679 and 397.6793, F.S.; authorizing an autonomous physician assistant to execute a certificate for emergency admission of a person who is substance abuse impaired; amending s. 400.021, F.S.; revising the definition of the term "geriatric outpatient clinic" to include a site staffed by an autonomous physician assistant; amending s. 400.172, F.S.; authorizing an autonomous physician assistant and an advanced practice registered nurse to provide certain medical information to a prospective respite care resident; amending s. 400.487, F.S.; authorizing an autonomous physician assistant to establish treatment orders for certain patients under certain circumstances; amending

s. 400.506, F.S.; requiring an autonomous physician assistant to comply with specified treatment plan requirements; amending ss. 400.9973, 400.9974, 400.9976, and 400.9979, F.S.; authorizing an autonomous physician assistant to prescribe client admission to a transitional living facility and care for such client, order treatment plans, supervise and record client medications, and order physical and chemical restraints, respectively; amending s. 401.445, F.S.; prohibiting recovery of damages in court against a registered autonomous physician assistant under certain circumstances; requiring an autonomous physician assistant to attempt to obtain a person's consent before providing emergency services; amending ss. 409.906 and 409.908, F.S.; authorizing the agency to reimburse an autonomous physician assistant for providing certain optional Medicaid services; amending s. 409.973, F.S.; requiring managed care plans to cover autonomous physician assistant services; amending s. 429.26, F.S.; prohibiting autonomous physician assistants from having a financial interest in the assisted living facility at which they are employed; authorizing an autonomous physician assistant to examine an assisted living facility resident before admission; amending s. 429.918, F.S.; revising the definition of the term

"ADRD participant" to include a participant who has a specified diagnosis from an autonomous physician assistant; authorizing an autonomous physician assistant to provide signed documentation to an ADRD participant; amending s. 440.102, F.S.; authorizing an autonomous physician assistant to collect a specimen for a drug test for specified purposes; amending s. 456.053, F.S.; revising definitions; authorizing an advanced practice registered nurse registered to engage in autonomous practice and an autonomous physician assistant to make referrals under certain circumstances; conforming a cross-reference; amending s. 456.072, F.S.; providing penalties for an autonomous physician assistant who prescribes or dispenses a controlled substance in a certain manner; amending s. 456.44, F.S.; revising the definition of the term "registrant" to include an autonomous physician assistant for purposes of controlled substance prescribing; providing requirements for an autonomous physician assistant who prescribes controlled substances for the treatment of chronic nonmalignant pain; amending ss. 458.3265 and 459.0137, F.S.; requiring an autonomous physician assistant to perform a physical examination of a patient at a pain-management clinic under certain circumstances; amending ss. 458.331 and 459.015, F.S.; providing

grounds for denial of a license or disciplinary action against an autonomous physician assistant for certain violations; amending s. 464.003, F.S.; revising the definition of the term "practice of practical nursing" to include an autonomous physician assistant for purposes of authorizing such assistant to supervise a licensed practical nurse; amending s. 464.0205, F.S.; authorizing an autonomous physician assistant to directly supervise a certified retired volunteer nurse; amending s. 480.0475, F.S.; authorizing the operation of a massage establishment during specified hours if the massage therapy is prescribed by an autonomous physician assistant; amending s. 493.6108, F.S.; authorizing an autonomous physician assistant to certify the physical fitness of a certain class of applicants to bear a weapon or firearm; amending s. 626.9707, F.S.; prohibiting an insurer from refusing to issue and deliver certain disability insurance that covers any medical treatment or service furnished by an autonomous physician assistant or an advanced practice registered nurse; amending s. 627.357, F.S.; revising the definition of the term "health care provider" to include an autonomous physician assistant for purposes of medical malpractice self-insurance; amending s. 627.736, F.S.; requiring personal injury protection insurance to cover a certain percentage of

medical services and care provided by specified health care providers; providing for specified reimbursement of advanced practice registered nurses registered to engage in autonomous practice or autonomous physician assistants; amending s. 633.412, F.S.; authorizing an autonomous physician assistant to medically examine an applicant for firefighter certification; amending s. 641.495, F.S.; requiring certain health maintenance organization documents to disclose that certain services may be provided by autonomous physician assistants or advanced practice registered nurses; amending s. 744.2006, F.S.; authorizing an autonomous physician assistant to carry out guardianship functions under a contract with a public guardian; conforming terminology; amending s. 744.331, F.S.; authorizing an autonomous physician assistant or a physician assistant to be an eligible member of an examining committee; conforming terminology; amending s. 744.3675, F.S.; authorizing an advanced practice registered nurse, autonomous physician assistant, or physician assistant to provide the medical report of a ward in an annual guardianship plan; amending s. 766.103, F.S.; prohibiting recovery of damages against an autonomous physician assistant under certain conditions; amending s. 766.105, F.S.; revising the definition of the term "health care provider" to

include an autonomous physician assistants for purposes of the Florida Patient's Compensation Fund; amending ss. 766.1115 and 766.1116, F.S.; revising the definitions of the terms "health care provider" and "health care practitioner," respectively, to include autonomous physician assistants for purposes of the Access to Health Care Act; amending s. 766.118, F.S.; revising the definition of the term "practitioner" to include an advanced practice registered nurse registered to engage in autonomous practice and an autonomous physician assistant; amending s. 768.135, F.S.; providing immunity from liability for an advanced practice registered nurse registered to engage in autonomous practice or an autonomous physician assistant who provides volunteer services under certain circumstances; amending s. 794.08, F.S.; providing an exception to medical procedures conducted by an autonomous physician assistant under certain circumstances; amending s. 893.02, F.S.; revising the definition of the term "practitioner" to include an autonomous physician assistant; amending s. 943.13, F.S.; authorizing an autonomous physician assistant to conduct a physical examination for a law enforcement or correctional officer to satisfy qualifications for employment or appointment; amending s. 945.603, F.S.; authorizing the Correctional Medical Authority to

review and make recommendations relating to the use of autonomous physician assistants as physician extenders; amending s. 948.03, F.S.; authorizing an autonomous physician assistant to prescribe drugs or narcotics to a probationer; amending ss. 984.03 and 985.03, F.S.; revising the definition of the term "licensed health care professional" to include an autonomous physician assistant; amending ss. 1002.20 and 1002.42, F.S.; providing immunity from liability for autonomous physician assistants who administer epinephrine auto-injectors in public and private schools; amending s. 1006.062, F.S.; authorizing an autonomous physician assistant to provide training in the administration of medication to designated school personnel; requiring an autonomous physician assistant to monitor such personnel; authorizing an autonomous physician assistant to determine whether such personnel may perform certain invasive medical services; amending s. 1006.20, F.S.; authorizing an autonomous physician assistant to medically evaluate a student athlete; amending s. 1009.65, F.S.; authorizing an autonomous physician assistant to participate in the Medical Education Reimbursement and Loan Repayment Program; providing appropriations and authorizing positions; providing an effective date.

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

Section 1. Paragraph (v) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(v) Be allowed to use paid feeding assistants in accordance with federal nursing home regulations, if the paid feeding assistant has successfully completed a feeding assistant training program meeting federal nursing home requirements and approved by the agency. The feeding assistant training program must consist of a minimum of 12 hours of education.

Section 2. Paragraph (b) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(3)

(b) Paid feeding assistants and nonnursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.

Section 3. Subsection (15) of section 400.462, Florida Statutes, is amended to read:

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

(15) "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on

personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by the agency under this part or performs tasks delegated to him or her pursuant to chapter 464 ~~s. 400.497(1)~~.

Section 4. Subsections (5) and (6) of section 400.464, Florida Statutes, are renumbered as subsections (6) and (7), respectively, present subsection (6) is amended, and a new subsection (5) is added to that section, to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(5) If a licensed home health agency authorizes a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant pursuant to chapter 464 or a home health aide pursuant to s. 400.490, the licensed home health agency must ensure that such delegation meets the requirements of this chapter, chapter 464, and the rules adopted thereunder.

(7)~~(6)~~ Any person, entity, or organization providing home health services which is exempt from licensure under subsection (6) ~~(5)~~ may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that specifies its name or names and addresses, a statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A

certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant $100 for a certificate of exemption or charge the actual cost of processing the certificate.

Section 5. Subsections (2) and (3) of section 400.488, Florida Statutes, are amended to read:

400.488 Assistance with self-administration of medication.—

(2) Patients who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or the patient's surrogate, guardian, or attorney in fact. For purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical ophthalmic, otic, and nasal dosage forms, including solutions, suspensions, sprays, ~~and~~ inhalers, and nebulizer treatments.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient.

(b) In the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications, including routine preventive skin care and applying and replacing bandages for minor cuts and abrasions as provided by the agency in rule.

(e) Returning the medication container to proper storage.

(f) For nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

(g) ~~(f)~~ Keeping a record of when a patient receives assistance with self-administration under this section.

Section 6. Section 400.489, Florida Statutes, is created

to read:

400.489 Administration of medication by a home health aide; staff training requirements.—

(1) A home health aide may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the home health aide has been delegated such task by a registered nurse licensed under chapter 464; has satisfactorily completed an initial 6-hour training course approved by the agency; and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under chapter 464 or a physician licensed under chapter 458 or chapter 459.

(2) A home health aide must annually and satisfactorily complete a 2-hour inservice training course in medication administration and medication error prevention approved by the agency. The inservice training course shall be in addition to the annual inservice training hours required by agency rules.

(3) The agency, in consultation with the Board of Nursing, shall establish by rule standards and procedures that a home health aide must follow when administering medication to a patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of

medication, informed-consent requirements and records, and the training curriculum and validation procedures

Section 7. Section 400.490, Florida Statutes, is created to read:

400.490 Nurse delegated tasks.—A certified nursing assistant or home health aide may perform any task delegated by a registered nurse as provided in chapter 464, including, but not limited to, medication administration.

Section 8. Section 400.52, Florida Statutes, is created to read:

400.52 Excellence in Home Health Program.—

(1) There is created within the agency the Excellence in Home Health Program for the purpose of awarding home health agencies that meet the criteria specified in this section.

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, meeting standards relating to:

1. Patient satisfaction.

2. Patients requiring emergency care for wound infections.

3. Patients admitted or readmitted to an acute care hospital.

4. Patient improvement in the activities of daily living.

5. Employee satisfaction.

6. Quality of employee training.

7. Employee retention rates.

8. High performance under federal Medicaid electronic

visit verification requirements.

(b) The agency must annually evaluate home health agencies seeking the award which apply on a form and in the manner designated by rule.

(3) The home health agency must:

(a) Be actively licensed and operating for at least 24 months to be eligible to apply for a program award. An award under the program is not transferrable to another license, except when the existing home health agency is being relicensed in the name of an entity related to the current licenseholder by common control or ownership, and there will be no change in the management, operation, or programs of the home health agency as a result of the relicensure.

(b) Have had no licensure denials, revocations, or any Class I, Class II, or uncorrected Class III deficiencies within the 24 months preceding the application for the program award.

(4) The award designation shall expire on the same date as the home health agency's license. A home health agency must reapply and be approved for the award designation to continue using the award designation in the manner authorized under subsection (5).

(5) A home health agency that is awarded under the program may use the designation in advertising and marketing. A home health agency may not use the award designation in any advertising or marketing if the home health agency:

(a) Has not been awarded the designation;

(b) Fails to renew the award upon expiration of the award designation;

(c) Has undergone a change in ownership that does not qualify for an exception under paragraph (3)(a); or

(d) Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the award designation.

(6) An application for an award designation under the program is not an application for licensure. A designation award or denial by the agency under this section does not constitute final agency action subject to chapter 120.

Section 9. Section 408.064, Florida Statutes, is created to read:

408.064 Home Care Services Registry.—

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

(a) "Home care services provider" means a home health agency licensed under part III of chapter 400 or a nurse registry licensed under part III of chapter 400.

(b) "Home care worker" means a home health aide as defined in s. 400.462 or a certified nursing assistant certified under part II of chapter 464.

(2) The agency shall develop and maintain a voluntary registry of home care workers. The agency shall display a link to the registry on its website homepage.

(3) The registry shall include, at a minimum:

(a) Each home care worker's full name, date of birth,

social security number, and a full face, passport-type, color photograph of the home care worker. The home care worker's date of birth and social security number may not be publicly displayed on the website.

(b) Each home care worker's preferred contact information. If employed by a home care services provider, the home care worker may use the provider's contact information.

(c) Any other identifying information of the home care worker, as determined by the agency.

(d) The name of the state-approved training program successfully completed by the home care worker and the date on which such training was completed.

(e) The number of years the home care worker has provided home health care services for compensation. The agency may automatically populate employment history as provided by current and previous employers of the home care worker. The agency must provide a method for a home care worker to correct inaccuracies and supplement the automatically populated employment history.

(f) For a certified nursing assistant, any disciplinary action taken or pending against the nursing assistant's certification by the Department of Health. The agency may enter into an agreement with the Department of Health to obtain disciplinary history.

(g) Whether the home care worker provides services to special populations and the identities of such populations.

(4) A home care worker must submit an application on a

form adopted by the agency to be included in the registry. The agency shall develop a process by which a home care services provider may include its employees in the registry by providing the information listed in subsection (3).

(5) A home care worker who is not employed by a home care services provider must meet the background screening requirements under s. 408.809 and chapter 435 and the training requirements of part III of chapter 400 or part II of chapter 464, as applicable, which must be included in the registry.

(6) Each page of the registry website shall contain the following notice in at least 14-point boldfaced type:

NOTICE

The Home Care Services Registry provides limited information about home care workers. Information contained in the registry is provided by third parties. The Agency for Health Care Administration does not guarantee the accuracy of such third-party information and does not endorse any individual listed in the registry. In particular, the information in the registry may be outdated or the individuals listed in the registry may have lapsed certifications or may have been denied employment approval due to the results of a background screening. It is the responsibility of those accessing this registry to

verify the credentials, suitability, and competency of any individual listed in the registry.

(7) The agency shall develop rules necessary to implement the requirements of this section.

Section 10. Section 408.822, Florida Statutes, is created to read:

408.822 Direct care workforce survey.—

(1) For purposes of this section, the term "direct care worker" means a certified nursing assistant, home health aide, personal care assistant, companion services or homemaker services provider, paid feeding assistant, or other individuals who provide personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

(2) Beginning January 1, 2021, each licensee that applies for licensure renewal as a nursing home facility licensed under part II of chapter 400; an assisted living facility licensed under part I of chapter 429; or a home health agency, nurse registry, or a companion services or homemaker services provider licensed under part III of chapter 400 must furnish the following information to the agency in a survey on the direct care workforce:

(a) The number of registered nurses, licensed practical nurses, and direct care workers employed or contracted by the licensee.

(b) The turnover and vacancy rates of employed registered nurses, licensed practical nurses, and direct care workers and contributing factors to the rates, as applicable.

(c) Average wage for registered nurses, licensed practical nurses, and each category of direct care workers, including employees and independent contractors.

(d) Employment benefits for employed direct care workers or contractors and average cost to the employer and employee or contractor, as applicable.

(e) Type and availability of training for employed registered nurses, licensed practical nurses, and direct care workers, as applicable.

(3) An administrator or designee shall include the information required in subsection (2) on a survey form developed by the agency in rule which must contain an attestation that the information provided is true and accurate to the best of his or her knowledge.

(4) The licensee must submit the completed survey at such time designated by the agency in rule. The agency may not issue a license renewal until the licensee submits a completed survey.

(5) The agency shall continually analyze the results of the survey and publish the results on its website. The agency must update the information published on its website monthly. The analysis must include the:

(a) Number of direct workers in the state, including the number of full-time workers and the number of part-time workers.

(b) Turnover rate and causes of turnover.

(c) Vacancy rate.

(d) Average hourly wage.

(e) Benefits offered.

(f) Availability of post-employment training.

Section 11. Section 464.0156, Florida Statutes, is created to read:

464.0156 Delegation of duties.—

(1) A registered nurse may delegate a task to a certified nursing assistant certified under part II of this chapter or a home health aide as defined in s. 400.462, if the registered nurse determines that the certified nursing assistant or home health aide is competent to perform the task, the task is delegable under federal law, and the task:

(a) Is within the nurse's scope of practice.

(b) Frequently recurs in the routine care of a patient or group of patients.

(c) Is performed according to an established sequence of steps.

(d) Involves little or no modification from one patient to another.

(e) May be performed with a predictable outcome.

(f) Does not inherently involve ongoing assessment, interpretation, or clinical judgement.

(g) Does not endanger a patient's life or well-being.

(2) A registered nurse may delegate to a certified nursing

assistant or a home health aide the administration of medication of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a patient of a home health agency if the certified nursing assistant or home health aide meets the requirements of s. 464.2035 or s. 400.489, respectively. A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812.

(3) The board, in consultation with the Agency for Health Care Administration, shall adopt rules to implement this section.

Section 12. Paragraph (r) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

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

(r) Delegating professional responsibilities to a person when the nurse delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, certification, or licensure to perform them.

Section 13. Section 464.2035, Florida Statutes, is created to read:

464.2035 Administration of medication.—

(1) A certified nursing assistant may administer oral,

transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medication to a patient of a home health agency if the certified nursing assistant has been delegated such task by a registered nurse licensed under part I of this chapter, has satisfactorily completed an initial 6-hour training course approved by the board, and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under this chapter or a physician licensed under chapter 458 or chapter 459.

(2) A certified nursing assistant must annually and satisfactorily complete 2 hours of inservice training in medication administration and medication error prevention approved by the board, in consultation with the Agency for Health Care Administration. The inservice training is in addition to the annual inservice training hours required under this part.

(3) The board, in consultation with the Agency for Health Care Administration, shall establish by rule standards and procedures that a certified nursing assistant must follow when administering medication to a patient of a home health agency. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of

medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 14. Subsections (1), (2), and (3) of section 456.0391, Florida Statutes, are amended to read:

456.0391 Advanced practice registered nurses and autonomous physician assistants; information required for licensure or registration.—

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

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

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

3. The address at which the applicant will primarily

conduct his or her practice.

4. Any certification or designation that the applicant has received from a specialty or certification board that is recognized or approved by the regulatory board or department to which the applicant is applying.

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

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

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

department that a criminal offense is under appeal, the applicant must, within 15 days after the disposition of the appeal, submit to the department a copy of the final written order of disposition.

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

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

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

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

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

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

(b) Issue a citation to any certificateholder, ~~or~~ licensee, or registrant who fails to submit and update the required information and may fine the certificateholder, ~~or~~ licensee, or registrant up to $50 for each day that the certificateholder, ~~or~~ licensee, or registrant is not in

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

Section 15. Subsection (6) of section 456.041, Florida Statutes, is amended to read:

456.041 Practitioner profile; creation.—

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

Section 16. Subsections (8) through (17) of section 458.347, Florida Statutes, are renumbered as subsections (9) through (18), respectively, subsection (2), paragraphs (b), (e),

and (f) of subsection (4), paragraph (a) of subsection (6), paragraphs (a) and (f) of subsection (7), present subsection (9), and present subsections (11) through (13) are amended, paragraph (b) is added to subsection (2), and new subsections (8) and (19) are added to that section, to read:

458.347 Physician assistants.—

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

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

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

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

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

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

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

(g) "Proficiency examination" means an entry-level

examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.

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

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

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

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

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

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

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

3. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion

of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.

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

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

(f)1. The council shall establish a formulary of medicinal drugs that a registered autonomous physician assistant or fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include general anesthetics and radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 or 21 U.S.C. s. 812 to a 7-day supply. The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.

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

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

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each registered autonomous physician assistant or fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund ~~the provisions of~~ this paragraph and paragraph (e).

(6) PROGRAM APPROVAL.—

(a) The boards shall approve programs~~, based on recommendations by the council,~~ for the education and training of physician assistants which meet standards established by rule of the boards. ~~The council may recommend only those physician~~

~~assistant programs that hold full accreditation or provisional accreditation from the Commission on Accreditation of Allied Health Programs or its successor organization. Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians.~~

(7) PHYSICIAN ASSISTANT LICENSURE.—

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

1. Is at least 18 years of age.

2. Has satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Physician Assistants. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants to be eligible for licensure.

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

include:

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

b. Acknowledgment of any prior felony convictions.

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

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

(f) The Board of Medicine may impose any of the penalties authorized under ss. 456.072 and 458.331(2) upon an autonomous physician assistant or a physician assistant if the autonomous physician assistant, physician assistant, or ~~the~~ supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

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

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

2. Has not been subject to any disciplinary action as

specified in s. 456.072, s. 458.331, or s. 459.015, or any similar disciplinary action in any jurisdiction of the United States, within the 5 years immediately preceding the registration request.

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

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

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

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

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

c. Any person who practices as an autonomous physician assistant only in conjunction with his or her teaching duties at

an accredited school or its main teaching hospitals. Such practice is limited to that which is incidental to and a necessary part of duties in connection with the teaching position.

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

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

(c) An autonomous physician assistant may:

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

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

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

4. Order any medication for administration to a patient in

a facility licensed under chapter 395 or part II of chapter 400, notwithstanding chapter 465 or chapter 893.

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

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

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

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

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

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

2. The chairperson of the Board of Osteopathic Medicine shall appoint one member who is a physician and a member of the Board of Osteopathic Medicine. The physician must supervise a

physician assistant in his or her practice.

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

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

(c) The council shall:

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

2. Develop all rules regulating the primary care practice of autonomous physician assistants and the use of physician assistants by physicians under this chapter and chapter 459, except for rules relating to the formulary developed under paragraph (4)(f). The council shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council may not be

adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

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

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

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

1. Refuse to certify the applicant for licensure;

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

3. Approve the applicant for conditional licensure. Such conditions may include placement of the licensee on probation

for a period of time and subject to such conditions as the council may specify, including but not limited to, requiring the licensee to undergo treatment, to attend continuing education courses, to work under the direct supervision of a physician licensed in this state, or to take corrective action.

(12) ~~(11)~~ PENALTY.—Any person who has not been registered or licensed by the council and approved by the department and who holds himself or herself out as an autonomous physician assistant or a physician assistant or who uses any other term in indicating or implying that he or she is an autonomous physician assistant or a physician assistant commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.084 or by a fine not exceeding $5,000.

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

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

physicians or groups of physicians.

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

Section 17. Subsections (8) through (17) of section 459.022, Florida Statutes, are renumbered as subsections (9) through (18), respectively, subsection (2), paragraphs (b) and (e) of subsection (4), paragraph (a) of subsection (6), paragraphs (a) and (f) of subsection (7), present subsection (9), and present subsections (11) through (13) are amended, paragraph (b) is added to subsection (2), and new subsections (8) and (19) are added to that section, to read:

459.022 Physician assistants.—

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

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

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

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

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

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

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

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

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

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

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

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

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

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

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

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

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion

of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.

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

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

(6) PROGRAM APPROVAL.—

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

(7) PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician

assistant must apply to the department. The department shall issue a license to any person certified by the council as having met the following requirements:

1. Is at least 18 years of age.

2. Has satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Physician Assistants. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants to be eligible for licensure.

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

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

b. Acknowledgment of any prior felony convictions.

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

d. A copy of course transcripts and a copy of the course description from a physician assistant training program

describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.

(f) The Board of Osteopathic Medicine may impose any of the penalties authorized under ss. 456.072 and 459.015(2) upon an autonomous physician assistant or a physician assistant if the autonomous physician assistant, physician assistant, or ~~the~~ supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(8) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

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

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

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

3. Has completed, in any jurisdiction of the United States, at least 2,000 clinical practice hours within the 3 years immediately preceding the submission of the registration request while practicing as a physician assistant under the supervision of an allopathic or osteopathic physician who held

an active, unencumbered license issued by any state, the District of Columbia, or a possession or territory of the United States during the period of such supervision.

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

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

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

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

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

d. Any person who holds an active registration under this subsection who is not practicing as an autonomous physician assistant in this state. If such person initiates or resumes any practice as an autonomous physician assistant, he or she must notify the department of such activity and fulfill the

professional liability coverage requirements of this subparagraph.

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

(c) An autonomous physician assistant may:

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

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

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

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

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

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

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

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

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

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

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

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

(b) ~~Two of the members appointed to the council must be physicians who supervise physician assistants in their practice.~~ Members shall be appointed to terms of 4 years, except that of the initial appointments, two members shall be appointed to terms of 2 years, two members shall be appointed to terms of 3 years, and one member shall be appointed to a term of 4 years,

as established by rule of the boards. Council members may not serve more than two consecutive terms. The council shall annually elect a chairperson from among its members.

(c) The council shall:

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

2. Develop all rules regulating the primary care practice of autonomous physician assistants and the use of physician assistants by physicians under chapter 458 and this chapter, except for rules relating to the formulary developed under s. 458.347. The council shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council may not be adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all

matters relating to autonomous physician assistants and physician assistants.

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

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

1. Refuse to certify the applicant for licensure;

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

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

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

assistant or a physician assistant commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.084 or by a fine not exceeding $5,000.

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

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

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

Section 18. Subsections (1) and (3) of section 464.012, Florida Statutes, are amended to read:

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

(1) Any nurse desiring to be licensed as an advanced practice registered nurse must apply to the board ~~department~~ and

submit proof that he or she holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing pursuant to s. 464.0095 and ~~that he or she~~ meets one or more of the following requirements ~~as determined by the board~~:

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

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

1. For applicants graduating on or after October 1, 2001, graduation from a master's degree program is required for initial licensure as a certified registered nurse anesthetist who may perform the acts listed in paragraph (4)(b).

2. For applicants graduating on or after October 1, 1998,

graduation from a master's degree program is required for initial licensure as a certified nurse midwife who may perform the acts listed in paragraph (4)(c).

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

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

(a) Prescribe, dispense, administer, or order any drug; however, an advanced practice registered nurse may prescribe or dispense a controlled substance as defined in s. 893.03 only if the advanced practice registered nurse has graduated from a program leading to a master's or doctoral degree in a clinical

nursing specialty area with training in specialized practitioner skills.

(b) Initiate appropriate therapies for certain conditions.

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

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

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

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

Section 19. Section 464.0123, Florida Statutes, is created to read:

464.0123 Autonomous practice by an advanced practice registered nurse.—

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

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

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

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

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

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

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

(4)(a) An advanced practice registered nurse registered under this section must by one of the following methods

demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical or nursing care or services:

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

2. Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount of not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. The letter of credit must be payable to the advanced practice registered nurse as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the advanced practice registered nurse or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical or nursing care and services.

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

1. Any person registered under this subsection who

practices exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions.

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

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

4. Any person who holds an active registration under this section who is not practicing as an autonomous advanced practice registered nurse registered under this section in this state. If such person initiates or resumes any practice as an autonomous advanced practice registered nurse, he or she must notify the department of such activity and fulfill the professional liability coverage requirements of paragraph (a).

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

(6) An advanced practice registered nurse who is registered under this section may perform the general functions

of an advanced practice registered nurse under s. 464.012(3), the acts within his or her specialty under s. 464.012(4), and the following:

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

1. Admit the patient to the facility.

2. Manage the care received by the patient in the facility.

3. Discharge the patient from the facility, unless prohibited by federal law or rule.

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

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

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

this paragraph until the following biennial renewal period.

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

(9) The board shall adopt rules as necessary to implement this section.

Section 20. Section 464.0155, Florida Statutes, is created to read:

464.0155 Reports of adverse incidents by advanced practice registered nurses.—

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

(2) The report must be in writing, sent to the department

by certified mail, and postmarked within 15 days after the occurrence of the adverse incident if the adverse incident occurs when the patient is at the office of the advanced practice registered nurse. If the adverse incident occurs when the patient is not at the office of the advanced practice registered nurse, the report must be postmarked within 15 days after the advanced practice registered nurse discovers, or reasonably should have discovered, the occurrence of the adverse incident.

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

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

(b) Permanent physical injury to the patient.

(c) Death of the patient.

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

Section 21. Paragraph (r) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

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

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

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

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

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

4. Soliciting patients, either personally or through an agent, by the use of fraud, intimidation, undue influence, or a

form of overreaching or vexatious conduct. As used in this subparagraph, the term "soliciting" means directly or implicitly requesting an immediate oral response from the recipient.

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

6. Exercising influence on the patient to exploit the patient for the financial gain of the advanced practice registered nurse or a third party, including, but not limited to, the promoting or selling of services, goods, appliances, or drugs.

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

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

9. Delegating professional responsibilities to a person

when the advanced practice registered nurse delegating such responsibilities knows or has reason to believe that such person is not qualified by training, experience, or licensure to perform such responsibilities.

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

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

12. Failing to comply with the requirements of ss. 381.026 and 381.0261 related to providing patients with information about their rights and how to file a complaint.

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

Section 22. Subsection (43) of section 39.01, Florida Statutes, is amended to read:

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

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

Section 23. Paragraphs (d) and (e) of subsection (5) of section 39.303, Florida Statutes, are redesignated as paragraphs (e) and (f), respectively, a new paragraph (d) is added to that subsection, and paragraph (a) of subsection (6) of that section is amended, to read:

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

(5) All abuse and neglect cases transmitted for investigation to a circuit by the hotline must be simultaneously transmitted to the Child Protection Team for review. For the purpose of determining whether a face-to-face medical evaluation by a Child Protection Team is necessary, all cases transmitted to the Child Protection Team which meet the criteria in subsection (4) must be timely reviewed by:

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

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

(a) The child was examined for the alleged abuse or neglect by a physician who is not a member of the Child Protection Team, and a consultation between the Child Protection Team medical director or a Child Protection Team board-certified pediatrician, advanced practice registered nurse, autonomous physician assistant, or physician assistant working under the supervision of a Child Protection Team medical director or a

Child Protection Team board-certified pediatrician, or registered nurse working under the direct supervision of a Child Protection Team medical director or a Child Protection Team board-certified pediatrician, and the examining physician concludes that a further medical evaluation is unnecessary;

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

Section 24. Paragraph (b) of subsection (1) of section 39.304, Florida Statutes, is amended to read:

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

(1)

(b) If the areas of trauma visible on a child indicate a need for a medical examination, or if the child verbally complains or otherwise exhibits distress as a result of injury through suspected child abuse, abandonment, or neglect, or is alleged to have been sexually abused, the person required to investigate may cause the child to be referred for diagnosis to a licensed physician or an emergency department in a hospital without the consent of the child's parents or legal custodian. Such examination may be performed by any licensed physician, registered autonomous physician assistant, licensed physician assistant, or ~~an~~ advanced practice registered nurse licensed or

registered under ~~pursuant to~~ part I of chapter 464. Any licensed physician, registered autonomous physician assistant, licensed physician assistant, or advanced practice registered nurse licensed or registered under ~~pursuant to~~ part I of chapter 464 who has reasonable cause to suspect that an injury was the result of child abuse, abandonment, or neglect may authorize a radiological examination to be performed on the child without the consent of the child's parent or legal custodian.

Section 25. Paragraph (d) of subsection (2) of section 110.12315, Florida Statutes, is amended to read:

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

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

(d) The department shall establish the reimbursement schedule for prescription drugs and supplies dispensed under the program. Reimbursement rates for a prescription drug or supply must be based on the cost of the generic equivalent drug or supply if a generic equivalent exists, unless the physician, advanced practice registered nurse, autonomous physician

assistant, or physician assistant prescribing the drug or supply clearly states on the prescription that the brand name drug or supply is medically necessary or that the drug or supply is included on the formulary of drugs and supplies that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug or supply as specified in the reimbursement schedule adopted by the department.

Section 26. Paragraph (a) of subsection (3) of section 252.515, Florida Statutes, is amended to read:

252.515 Postdisaster Relief Assistance Act; immunity from civil liability.—

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

(a) "Emergency first responder" means:

1. A physician licensed under chapter 458.

2. An osteopathic physician licensed under chapter 459.

3. A chiropractic physician licensed under chapter 460.

4. A podiatric physician licensed under chapter 461.

5. A dentist licensed under chapter 466.

6. An advanced practice registered nurse licensed under s. 464.012.

7. An autonomous physician assistant or a physician assistant registered or licensed under chapter 458 ~~s. 458.347~~ or chapter 459 ~~s. 459.022~~.

8. A worker employed by a public or private hospital in the state.

9. A paramedic as defined in s. 401.23(17).

10. An emergency medical technician as defined in s. 401.23(11).

11. A firefighter as defined in s. 633.102.

12. A law enforcement officer as defined in s. 943.10.

13. A member of the Florida National Guard.

14. Any other personnel designated as emergency personnel by the Governor pursuant to a declared emergency.

Section 27. Paragraph (c) of subsection (1) of section 310.071, Florida Statutes, is amended to read:

310.071 Deputy pilot certification.—

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

(c) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, an advanced practice registered nurse, an autonomous physician assistant, or a physician assistant and that controlled

substance was prescribed by that physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant. To maintain eligibility as a certificated deputy pilot, each certificated deputy pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder satisfactorily meets the standards. The standards for certificateholders shall include a drug test.

Section 28. Subsection (3) of section 310.073, Florida Statutes, is amended to read:

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

(3) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, an advanced practice registered nurse, an autonomous physician assistant, or a physician assistant and that controlled

substance was prescribed by that physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant. To maintain eligibility as a licensed state pilot, each licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the licensee satisfactorily meets the standards. The standards for licensees shall include a drug test.

Section 29. Paragraph (b) of subsection (3) of section 310.081, Florida Statutes, is amended to read:

310.081 Department to examine and license state pilots and certificate deputy pilots; vacancies.—

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

(b) Are in good physical and mental health as evidenced by documentary proof of having satisfactorily passed a physical examination administered by a licensed physician or physician assistant within each calendar year. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot or a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, an advanced practice registered

nurse, an autonomous physician assistant, or a physician assistant and that controlled substance was prescribed by that physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant. To maintain eligibility as a certificated deputy pilot or licensed state pilot, each certificated deputy pilot or licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder or licensee satisfactorily meets the standards. The standards for certificateholders and for licensees shall include a drug test.

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

Section 30. Paragraph (b) of subsection (1) of section 320.0848, Florida Statutes, is amended to read:

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

(1)

(b)1. The person must be currently certified as being legally blind or as having any of the following disabilities

that render him or her unable to walk 200 feet without stopping to rest:

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

b. The need to permanently use a wheelchair.

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

d. Use of portable oxygen.

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

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

2. The certification of disability which is required under subparagraph 1. must be provided by a physician licensed under chapter 458, chapter 459, or chapter 460, by a podiatric physician licensed under chapter 461, by an optometrist licensed

under chapter 463, by an advanced practice registered nurse licensed under chapter 464 under the protocol of a licensed physician as stated in this subparagraph, by an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or by a similarly licensed physician from another state if the application is accompanied by documentation of the physician's licensure in the other state and a form signed by the out-of-state physician verifying his or her knowledge of this state's eligibility guidelines.

Section 31. Paragraph (c) of subsection (1) of section 381.00315, Florida Statutes, is amended to read:

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

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

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

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

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

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

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

4. Ordering an individual to be examined, tested, vaccinated, treated, isolated, or quarantined for communicable diseases that have significant morbidity or mortality and

present a severe danger to public health. Individuals who are unable or unwilling to be examined, tested, vaccinated, or treated for reasons of health, religion, or conscience may be subjected to isolation or quarantine.

a. Examination, testing, vaccination, or treatment may be performed by any qualified person authorized by the State Health Officer.

b. If the individual poses a danger to the public health, the State Health Officer may subject the individual to isolation or quarantine. If there is no practical method to isolate or quarantine the individual, the State Health Officer may use any means necessary to vaccinate or treat the individual.

Any order of the State Health Officer given to effectuate this paragraph shall be immediately enforceable by a law enforcement officer under s. 381.0012.

Section 32. Subsection (3) of section 381.00593, Florida Statutes, is amended to read:

381.00593 Public school volunteer health care practitioner program.—

(3) For purposes of this section, the term "health care practitioner" means a physician or autonomous physician assistant licensed or registered under chapter 458; an osteopathic physician or autonomous physician assistant licensed or registered under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under

chapter 461; an optometrist licensed under chapter 463; an advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a pharmacist licensed under chapter 465; a dentist or dental hygienist licensed under chapter 466; a midwife licensed under chapter 467; a speech-language pathologist or audiologist licensed under part I of chapter 468; a dietitian/nutritionist licensed under part X of chapter 468; or a physical therapist licensed under chapter 486.

Section 33. Paragraph (c) of subsection (2) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(2) DEFINITIONS.—As used in this section and s. 381.0261, the term:

(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, ~~or~~ a podiatric physician licensed under chapter 461, an autonomous physician assistant registered under s. 458.347(8), or an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123.

Section 34. Paragraph (a) of subsection (2) and subsections (3), (4), and (5) of section 382.008, Florida Statutes, are amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, certified nurse midwife, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent's primary or attending practitioner ~~physician~~ or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending

practitioner ~~physician~~ or the medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief. As used in this section, the term "primary or attending practitioner ~~physician~~" means a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department may grant the funeral director an extension of time upon a good and sufficient showing of any of the following conditions:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

(b) If the decedent's primary or attending practitioner ~~physician~~ or the district medical examiner of the county in which the death occurred or the body was found indicates that he or she will sign and complete the medical certification of cause of death but will not be available until after the 5-day registration deadline, the local registrar may grant an extension of 5 days. If a further extension is required, the funeral director must provide written justification to the registrar.

(4) If the department or local registrar grants an

extension of time to provide the medical certification of cause of death, the funeral director shall file a temporary certificate of death or fetal death which shall contain all available information, including the fact that the cause of death is pending. The decedent's primary or attending practitioner ~~physician~~ or the district medical examiner of the county in which the death occurred or the body was found shall provide an estimated date for completion of the permanent certificate.

(5) A permanent certificate of death or fetal death, containing the cause of death and any other information that was previously unavailable, shall be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or district medical examiner of the county in which the death occurred or the body was found, as appropriate.

Section 35. Subsection (1) of section 382.011, Florida Statutes, is amended to read:

382.011 Medical examiner determination of cause of death.—

(1) In the case of any death or fetal death due to causes or conditions listed in s. 406.11, any death that occurred more than 12 months after the decedent was last treated by a primary or attending physician ~~as defined in s. 382.008(3)~~, or any death

for which there is reason to believe that the death may have been due to an unlawful act or neglect, the funeral director or other person to whose attention the death may come shall refer the case to the district medical examiner of the county in which the death occurred or the body was found for investigation and determination of the cause of death.

Section 36. Paragraph (c) of subsection (1) of section 383.14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. The department shall also promote the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and

intervention efforts shall begin before ~~prior to~~ and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county health departments, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.

(c) Release of screening results.—Notwithstanding any law to the contrary, the State Public Health Laboratory may release, directly or through the Children's Medical Services program, the results of a newborn's hearing and metabolic tests or screenings to the newborn's health care practitioner, the newborn's parent or legal guardian, the newborn's personal representative, or a person designated by the newborn's parent or legal guardian. As used in this paragraph, the term "health care practitioner" means a physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458; an osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459; an advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a midwife licensed under chapter 467; a speech-language pathologist or audiologist licensed under part I of chapter 468; or a dietician or nutritionist licensed under part X of chapter 468.

Section 37. Paragraph (a) of subsection (3) of section 390.0111, Florida Statutes, is amended to read:

390.0111 Termination of pregnancies.—

(3) CONSENTS REQUIRED.—A termination of pregnancy may not be performed or induced except with the voluntary and informed written consent of the pregnant woman or, in the case of a mental incompetent, the voluntary and informed written consent of her court-appointed guardian.

(a) Except in the case of a medical emergency, consent to a termination of pregnancy is voluntary and informed only if:

1. The physician who is to perform the procedure, or the referring physician, has, at a minimum, orally, while physically present in the same room, and at least 24 hours before the procedure, informed the woman of:

a. The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.

b. The probable gestational age of the fetus, verified by an ultrasound, at the time the termination of pregnancy is to be performed.

(I) The ultrasound must be performed by the physician who is to perform the abortion or by a person having documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed by rule and who is working in conjunction with the physician.

(II) The person performing the ultrasound must offer the woman the opportunity to view the live ultrasound images and

hear an explanation of them. If the woman accepts the opportunity to view the images and hear the explanation, a physician or a registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant working in conjunction with the physician must contemporaneously review and explain the images to the woman before the woman gives informed consent to having an abortion procedure performed.

(III) The woman has a right to decline to view and hear the explanation of the live ultrasound images after she is informed of her right and offered an opportunity to view the images and hear the explanation. If the woman declines, the woman shall complete a form acknowledging that she was offered an opportunity to view and hear the explanation of the images but that she declined that opportunity. The form must also indicate that the woman's decision was not based on any undue influence from any person to discourage her from viewing the images or hearing the explanation and that she declined of her own free will.

(IV) Unless requested by the woman, the person performing the ultrasound may not offer the opportunity to view the images and hear the explanation and the explanation may not be given if, at the time the woman schedules or arrives for her appointment to obtain an abortion, a copy of a restraining order, police report, medical record, or other court order or documentation is presented which provides evidence that the

woman is obtaining the abortion because the woman is a victim of rape, incest, domestic violence, or human trafficking or that the woman has been diagnosed as having a condition that, on the basis of a physician's good faith clinical judgment, would create a serious risk of substantial and irreversible impairment of a major bodily function if the woman delayed terminating her pregnancy.

c. The medical risks to the woman and fetus of carrying the pregnancy to term.

The physician may provide the information required in this subparagraph within 24 hours before the procedure if requested by the woman at the time she schedules or arrives for her appointment to obtain an abortion and if she presents to the physician a copy of a restraining order, police report, medical record, or other court order or documentation evidencing that she is obtaining the abortion because she is a victim of rape, incest, domestic violence, or human trafficking.

2. Printed materials prepared and provided by the department have been provided to the pregnant woman, if she chooses to view these materials, including:

a. A description of the fetus, including a description of the various stages of development.

b. A list of entities that offer alternatives to terminating the pregnancy.

c. Detailed information on the availability of medical

assistance benefits for prenatal care, childbirth, and neonatal care.

3. The woman acknowledges in writing, before the termination of pregnancy, that the information required to be provided under this subsection has been provided.

Nothing in this paragraph is intended to prohibit a physician from providing any additional information which the physician deems material to the woman's informed decision to terminate her pregnancy.

Section 38. Paragraphs (c), (e), and (f) of subsection (3) of section 390.012, Florida Statutes, are amended to read:

390.012 Powers of agency; rules; disposal of fetal remains.—

(3) For clinics that perform or claim to perform abortions after the first trimester of pregnancy, the agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter, including the following:

(c) Rules relating to abortion clinic personnel. At a minimum, these rules shall require that:

1. The abortion clinic designate a medical director who is licensed to practice medicine in this state, and all physicians who perform abortions in the clinic have admitting privileges at a hospital within reasonable proximity to the clinic, unless the clinic has a written patient transfer agreement with a hospital within reasonable proximity to the clinic which includes the

transfer of the patient's medical records held by both the clinic and the treating physician.

2. If a physician is not present after an abortion is performed, a registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant be present and remain at the clinic to provide postoperative monitoring and care until the patient is discharged.

3. Surgical assistants receive training in counseling, patient advocacy, and the specific responsibilities associated with the services the surgical assistants provide.

4. Volunteers receive training in the specific responsibilities associated with the services the volunteers provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

(e) Rules relating to the abortion procedure. At a minimum, these rules shall require:

1. That a physician, registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant is available to all patients throughout the abortion procedure.

2. Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rule.

3. Appropriate use of general and local anesthesia, analgesia, and sedation if ordered by the physician.

4. Appropriate precautions, such as the establishment of intravenous access at least for patients undergoing post-first trimester abortions.

5. Appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

(f) Rules that prescribe minimum recovery room standards. At a minimum, these rules must require that:

1. Postprocedure recovery rooms be supervised and staffed to meet the patients' needs.

2. Immediate postprocedure care consist of observation in a supervised recovery room for as long as the patient's condition warrants.

3. A registered nurse, licensed practical nurse, advanced practice registered nurse, autonomous physician assistant, or physician assistant who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remain on the premises of the abortion clinic until all patients are discharged.

4. A physician sign the discharge order and be readily accessible and available until the last patient is discharged to facilitate the transfer of emergency cases if hospitalization of

the patient or viable fetus is necessary.

5. A physician discuss Rho(D) immune globulin with each patient for whom it is indicated and ensure that it is offered to the patient in the immediate postoperative period or will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses the Rho(D) immune globulin, she and a witness must sign a refusal form approved by the agency which must be included in the medical record.

6. Written instructions with regard to postabortion coitus, signs of possible problems, and general aftercare which are specific to the patient be given to each patient. The instructions must include information regarding access to medical care for complications, including a telephone number for use in the event of a medical emergency.

7. A minimum length of time be specified, by type of abortion procedure and duration of gestation, during which a patient must remain in the recovery room.

8. The physician ensure that, with the patient's consent, a registered nurse, licensed practical nurse, advanced practice registered nurse, <u>autonomous physician assistant,</u> or physician assistant from the abortion clinic makes a good faith effort to contact the patient by telephone within 24 hours after surgery to assess the patient's recovery.

9. Equipment and services be readily accessible to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the

hospital.

Section 39. Paragraphs (a) and (f) of subsection (2) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period

specified in the order itself, whichever comes first. If a ~~no~~ time limit is not specified in the order, the order is ~~shall be~~ valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, autonomous physician assistant, physician assistant, clinical psychologist, psychiatric nurse, advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462

for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(f) A patient shall be examined by a physician, physician assistant, or ~~a~~ clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved

by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.

Section 40. Paragraph (b) of subsection (2) of section 395.0191, Florida Statutes, is amended to read:

395.0191 Staff membership and clinical privileges.—

(2)

(b) An advanced practice registered nurse who is certified as a registered nurse anesthetist licensed under part I of chapter 464 shall administer anesthesia under the onsite medical direction of a professional licensed under chapter 458, chapter 459, or chapter 466, and in accordance with an established protocol approved by the medical staff. The medical direction shall specifically address the needs of the individual patient. This paragraph does not apply to a certified registered nurse anesthetist registered to engage in autonomous practice under s. 464.0123.

Section 41. Subsection (3) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(3) USE OF FUNDS.—It is the intent of the Legislature that

funds as appropriated shall be utilized by the department for the purpose of increasing the number of primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses in rural areas, either through the Medical Education Reimbursement and Loan Repayment Program as defined by s. 1009.65 or through a federal loan repayment program which requires state matching funds. The department may use funds appropriated for the Medical Education Reimbursement and Loan Repayment Program as matching funds for federal loan repayment programs for health care personnel, such as that authorized in Pub. L. No. 100-177, s. 203. If the department receives federal matching funds, the department shall only implement the federal program. Reimbursement through either program shall be limited to:

(a) Primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(b) Primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural area health education centers, as defined in this section. These personnel shall practice:

1. In a county with a population density of no greater than 100 persons per square mile; or

2. Within the boundaries of a hospital tax district which

encompasses a population of no greater than 100 persons per square mile.

If the department administers a federal loan repayment program, priority shall be given to obligating state and federal matching funds pursuant to paragraphs (a) and (b). The department may use federal matching funds in other health workforce shortage areas and medically underserved areas in the state for loan repayment programs for primary care physicians, autonomous physician assistants, physician assistants, certified nurse midwives, nurse practitioners, and nurses who are employed by publicly financed health care programs that serve medically indigent persons.

Section 42. Paragraph (a) of subsection (2) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(2) RIGHT TO NONDISCRIMINATORY SERVICES.—

(a) Service providers may not deny an individual access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may

not deny an individual who takes medication prescribed by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, if space and sufficient state resources are available, deny access to services based solely on inability to pay.

Section 43. Section 397.679, Florida Statutes, is amended to read:

397.679 Emergency admission; circumstances justifying.—A person who meets the criteria for involuntary admission in s. 397.675 may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of a certificate by a physician, an autonomous physician assistant, an advanced practice registered nurse, a psychiatric nurse, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician assistant working under the scope of practice of the supervising physician, or a master's-level-certified addictions professional for substance abuse services, if the certificate is specific to substance abuse impairment, and the completion of an application for emergency admission.

Section 44. Subsection (1) of section 397.6793, Florida Statutes, is amended to read:

397.6793 Professional's certificate for emergency admission.—

(1) A physician, a clinical psychologist, an autonomous physician assistant, a physician assistant working under the scope of practice of the supervising physician, a psychiatric nurse, an advanced practice registered nurse, a mental health counselor, a marriage and family therapist, a master's-level-certified addictions professional for substance abuse services, or a clinical social worker may execute a professional's certificate for emergency admission. The professional's certificate must include the name of the person to be admitted, the relationship between the person and the professional executing the certificate, the relationship between the applicant and the professional, any relationship between the professional and the licensed service provider, a statement that the person has been examined and assessed within the preceding 5 days after the application date, and factual allegations with respect to the need for emergency admission, including:

(a) The reason for the belief that the person is substance abuse impaired;

(b) The reason for the belief that because of such impairment the person has lost the power of self-control with respect to substance abuse; and

(c)1. The reason for the belief that, without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal

poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services, or there is substantial likelihood that the person has inflicted or, unless admitted, is likely to inflict, physical harm on himself, herself, or another; or

2. The reason for the belief that the person's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the person is incapable of appreciating his or her need for care and of making a rational decision regarding his or her need for care.

Section 45. Subsection (8) of section 400.021, Florida Statutes, is amended to read:

400.021 Definitions.—When used in this part, unless the context otherwise requires, the term:

(8) "Geriatric outpatient clinic" means a site for providing outpatient health care to persons 60 years of age or older, which is staffed by a registered nurse, a physician assistant, or a licensed practical nurse under the direct supervision of a registered nurse, advanced practice registered nurse, physician assistant, <u>autonomous physician assistant,</u> or physician.

Section 46. Subsection (3) of section 400.172, Florida Statutes, is amended to read:

400.172 Respite care provided in nursing home facilities.—

(3) A prospective respite care resident must provide medical information from a physician, autonomous physician assistant, physician assistant, or nurse practitioner and any other information provided by the primary caregiver required by the facility before or when the person is admitted to receive respite care. The medical information must include a physician's order for respite care and proof of a physical examination by a licensed physician, autonomous physician assistant, physician assistant, or nurse practitioner. The physician's order and physical examination may be used to provide intermittent respite care for up to 12 months after the date the order is written.

Section 47. Subsection (2) of section 400.487, Florida Statutes, is amended to read:

400.487 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.—

(2) When required by ~~the provisions of~~ chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, acting within his or her respective scope of practice, shall establish treatment orders for a patient who is to receive skilled care. The treatment orders must be signed by the physician, autonomous physician assistant, physician assistant, or advanced practice

registered nurse before a claim for payment for the skilled services is submitted by the home health agency. If the claim is submitted to a managed care organization, the treatment orders must be signed within the time allowed under the provider agreement. The treatment orders shall be reviewed, as frequently as the patient's illness requires, by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse in consultation with the home health agency.

Section 48. Paragraph (a) of subsection (13) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(13) All persons referred for contract in private residences by a nurse registry must comply with the following requirements for a plan of treatment:

(a) When, in accordance with the privileges and restrictions imposed upon a nurse under part I of chapter 464, the delivery of care to a patient is under the direction or supervision of a physician or when a physician is responsible for the medical care of the patient, a medical plan of treatment must be established for each patient receiving care or treatment provided by a licensed nurse in the home. The original medical plan of treatment must be timely signed by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, acting within his or her respective scope of practice, and reviewed in consultation with the

licensed nurse at least every 2 months. Any additional order or change in orders must be obtained from the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and reduced to writing and timely signed by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse. The delivery of care under a medical plan of treatment must be substantiated by the appropriate nursing notes or documentation made by the nurse in compliance with nursing practices established under part I of chapter 464.

Section 49. Subsection (5) and paragraph (b) of subsection (7) of section 400.9973, Florida Statutes, are amended to read:

400.9973 Client admission, transfer, and discharge.—

(5) A client admitted to a transitional living facility must be admitted upon prescription by a licensed physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and must remain under the care of a licensed physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse for the duration of the client's stay in the facility.

(7) A person may not be admitted to a transitional living facility if the person:

(b) Is a danger to himself or herself or others as determined by a physician, autonomous physician assistant, physician assistant, advanced practice registered nurse, or ~~a~~ mental health practitioner licensed under chapter 490 or chapter

491, unless the facility provides adequate staffing and support to ensure patient safety;

Section 50. Paragraphs (a) and (b) of subsection (2) of section 400.9974, Florida Statutes, are amended to read:

400.9974 Client comprehensive treatment plans; client services.—

(2) The comprehensive treatment plan must include:

(a) Orders obtained from the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and the client's diagnosis, medical history, physical examination, and rehabilitative or restorative needs.

(b) A preliminary nursing evaluation, including orders for immediate care provided by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, which shall be completed when the client is admitted.

Section 51. Section 400.9976, Florida Statutes, is amended to read:

400.9976 Administration of medication.—

(1) An individual medication administration record must be maintained for each client. A dose of medication, including a self-administered dose, shall be properly recorded in the client's record. A client who self-administers medication shall be given a pill organizer. Medication must be placed in the pill organizer by a nurse. A nurse shall document the date and time that medication is placed into each client's pill organizer. All medications must be administered in compliance with orders of a

physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse.

(2) If an interdisciplinary team determines that self-administration of medication is an appropriate objective, and if the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse does not specify otherwise, the client must be instructed by the physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse to self-administer his or her medication without the assistance of a staff person. All forms of self-administration of medication, including administration orally, by injection, and by suppository, shall be included in the training. The client's physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse must be informed of the interdisciplinary team's decision that self-administration of medication is an objective for the client. A client may not self-administer medication until he or she demonstrates the competency to take the correct medication in the correct dosage at the correct time, to respond to missed doses, and to contact the appropriate person with questions.

(3) Medication administration discrepancies and adverse drug reactions must be recorded and reported immediately to a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse.

Section 52. Subsections (2) through (5) of section

400.9979, Florida Statutes, are amended to read:

400.9979 Restraint and seclusion; client safety.—

(2) The use of physical restraints must be ordered and documented by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and must be consistent with the policies and procedures adopted by the facility. The client or, if applicable, the client's representative shall be informed of the facility's physical restraint policies and procedures when the client is admitted.

(3) The use of chemical restraints shall be limited to prescribed dosages of medications as ordered by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse and must be consistent with the client's diagnosis and the policies and procedures adopted by the facility. The client and, if applicable, the client's representative shall be informed of the facility's chemical restraint policies and procedures when the client is admitted.

(4) Based on the assessment by a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse, if a client exhibits symptoms that present an immediate risk of injury or death to himself or herself or others, a physician, physician assistant, or advanced practice registered nurse may issue an emergency treatment order to immediately administer rapid-response psychotropic medications or other chemical restraints. Each emergency treatment order must be documented and maintained in the client's record.

(a) An emergency treatment order is not effective for more than 24 hours.

(b) Whenever a client is medicated under this subsection, the client's representative or a responsible party and the client's physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse shall be notified as soon as practicable.

(5) A client who is prescribed and receives a medication that can serve as a chemical restraint for a purpose other than an emergency treatment order must be evaluated by his or her physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse at least monthly to assess:

(a) The continued need for the medication.

(b) The level of the medication in the client's blood.

(c) The need for adjustments to the prescription.

Section 53. Subsections (1) and (2) of section 401.445, Florida Statutes, are amended to read:

401.445 Emergency examination and treatment of incapacitated persons.—

(1) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced practice registered nurse licensed under s. 464.012, or any autonomous physician assistant or physician assistant registered or licensed under s. 458.347 or s. 459.022, or any person acting

under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

(2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced practice registered nurse, autonomous physician assistant, or physician assistant,

or any person acting under the direct medical supervision of a physician, shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.

Section 54. Subsection (18) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject

to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for all services provided to a recipient by an autonomous physician assistant or a physician assistant registered or licensed under s. 458.347 or s. 459.022. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

Section 55. Paragraph (m) of subsection (3) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester

shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(3) Subject to any limitations or directions provided for in the General Appropriations Act, the following Medicaid services and goods may be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods for which the agency makes payment using a methodology based on capitation rates, average costs, or negotiated fees.

(m) Autonomous physician assistant and physician assistant services.

Section 56. Paragraphs (c) through (cc) of subsection (1) of section 409.973, Florida Statutes, are redesignated as paragraphs (d) through (dd), respectively, and a new paragraph (c) is added to that subsection to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(c) Autonomous physician assistant services.

Section 57. Subsections (2), (4), and (5) of section 429.26, Florida Statutes, are amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(2) A physician, autonomous physician assistant, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.

(4) If possible, each resident shall have been examined by a licensed physician, an autonomous physician assistant, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued

stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, a registered autonomous physician assistant, a licensed physician assistant, or a licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.

Section 58. Paragraph (a) of subsection (2) and paragraph (a) of subsection (7) of section 429.918, Florida Statutes, are amended to read:

429.918 Licensure designation as a specialized Alzheimer's services adult day care center.—

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

(a) "ADRD participant" means a participant who has a documented diagnosis of Alzheimer's disease or a dementia-related disorder (ADRD) from a licensed physician, a registered autonomous physician assistant, a licensed physician assistant, or a licensed advanced practice registered nurse.

(7)(a) An ADRD participant admitted to an adult day care center having a license designated under this section, or the caregiver when applicable, must:

1. Require ongoing supervision to maintain the highest level of medical or custodial functioning and have a demonstrated need for a responsible party to oversee his or her care.

2. Not actively demonstrate aggressive behavior that places himself, herself, or others at risk of harm.

3. Provide the following medical documentation signed by a licensed physician, a registered autonomous physician assistant, a licensed physician assistant, or a licensed advanced practice registered nurse:

a. Any physical, health, or emotional conditions that require medical care.

b. A listing of the ADRD participant's current prescribed and over-the-counter medications and dosages, diet restrictions, mobility restrictions, and other physical limitations.

4. Provide documentation signed by a health care provider licensed in this state which indicates that the ADRD participant is free of the communicable form of tuberculosis and free of

signs and symptoms of other communicable diseases.

Section 59. Paragraph (e) of subsection (5) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(e) A specimen for a drug test may be taken or collected by any of the following persons:

1. A physician, an autonomous physician assistant, a physician assistant, a registered professional nurse, a licensed practical nurse, or a nurse practitioner or a certified paramedic who is present at the scene of an accident for the purpose of rendering emergency medical service or treatment.

2. A qualified person employed by a licensed or certified laboratory as described in subsection (9).

Section 60. Paragraphs (a), (i), (o), and (r) of subsection (3) and paragraph (g) of subsection (5) of section 456.053, Florida Statutes, are amended to read:

456.053 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(a) "Board" means any of the following boards relating to the respective professions: the Board of Medicine as created in s. 458.307; the Board of Osteopathic Medicine as created in s. 459.004; the Board of Chiropractic Medicine as created in s. 460.404; the Board of Podiatric Medicine as created in s. 461.004; the Board of Optometry as created in s. 463.003; the Board of Nursing as created in s. 464.004; the Board of Pharmacy as created in s. 465.004; and the Board of Dentistry as created in s. 466.004.

(i) "Health care provider" means a ~~any~~ physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461; an autonomous physician assistant registered under chapter 458 or chapter 459; an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123;~~,~~ or any health care provider licensed under chapter 463 or chapter 466.

(o) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. The following orders, recommendations, or plans of care

shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, ~~that effective July 1, 1999,~~ a health care provider ~~physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461~~ may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice

billed both the technical and the professional fee for or on behalf of the patient, if the referring health care provider does not have an ~~physician has no~~ investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a urologist for lithotripsy services.

i. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

j. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

k. By a nephrologist for renal dialysis services and supplies, except laboratory services.

l. By a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency

licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

m. By a health care provider for sleep-related testing.

(r) "Sole provider" means one health care provider licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or registered under s. 464.0123, who maintains a separate medical office and a medical practice separate from any other health care provider and who bills for his or her services separately from the services provided by any other health care provider. A sole provider shall not share overhead expenses or professional income with any other person or group practice.

(5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as provided in this section:

(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to be taken by the applicable board pursuant to s. 458.331(2), s. 459.015(2), s. 460.413(2), s. 461.013(2), s. 463.016(2), s. 464.018, or s. 466.028(2). Any hospital licensed under chapter 395 found in violation of this section shall be subject to s. 395.0185(2).

Section 61. Subsection (7) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) Notwithstanding subsection (2), upon a finding that a physician or autonomous physician assistant has prescribed or

dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s. 466.028(1)(p) or (x), or that an advanced practice registered nurse has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 464.018(1)(n) or (p)6., the physician, autonomous physician assistant, or advanced practice registered nurse shall be suspended for a period of not less than 6 months and pay a fine of not less than $10,000 per count. Repeated violations shall result in increased penalties.

Section 62. Paragraph (h) of subsection (1) and subsection (2) of section 456.44, Florida Statutes, are amended to read:

456.44 Controlled substance prescribing.—

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

(h) "Registrant" means a physician, an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse who meets the requirements of subsection (2).

(2) REGISTRATION.—A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under part I of chapter 464

who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her practitioner profile.

(b) Comply with the requirements of this section and applicable board rules.

Section 63. Paragraph (c) of subsection (3) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(3) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(c) A physician, an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse must perform a physical examination of a patient on the same day that the physician prescribes a controlled substance to a patient at a pain-management clinic. If the physician prescribes more than a 72-hour dose of controlled substances for the treatment of chronic nonmalignant pain, the physician must document in the patient's record the reason for prescribing that quantity.

Section 64. Paragraph (ii) of subsection (1) and subsection (10) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

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

(ii) Failing to report to the department any licensee under this chapter or under chapter 459 who the physician, autonomous physician assistant, or physician assistant knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the physician, autonomous physician assistant, or physician assistant also provides services.

(10) A probable cause panel convened to consider disciplinary action against an autonomous physician assistant or a physician assistant alleged to have violated s. 456.072 or this section must include one physician assistant. The physician assistant must hold a valid license to practice as a physician assistant in this state and be appointed to the panel by the Council of Physician Assistants. The physician assistant may hear only cases involving disciplinary actions against a physician assistant. If the appointed physician assistant is not present at the disciplinary hearing, the panel may consider the matter and vote on the case in the absence of the physician assistant. The training requirements set forth in s. 458.307(4) do not apply to the appointed physician assistant. Rules need

not be adopted to implement this subsection.

Section 65. Paragraph (c) of subsection (3) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(3) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(c) An osteopathic physician, an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse must perform a physical examination of a patient on the same day that the physician prescribes a controlled substance to a patient at a pain-management clinic. If the osteopathic physician prescribes more than a 72-hour dose of controlled substances for the treatment of chronic nonmalignant pain, the osteopathic physician must document in the patient's record the reason for prescribing that quantity.

Section 66. Paragraph (ll) of subsection (1) and subsection (10) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

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

(ll) Failing to report to the department any licensee under chapter 458 or under this chapter who the osteopathic

physician, autonomous physician assistant, or physician assistant knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the osteopathic physician, autonomous physician assistant, or physician assistant also provides services.

(10) A probable cause panel convened to consider disciplinary action against an autonomous physician assistant or a physician assistant alleged to have violated s. 456.072 or this section must include one physician assistant. The physician assistant must hold a valid license to practice as a physician assistant in this state and be appointed to the panel by the Council of Physician Assistants. The physician assistant may hear only cases involving disciplinary actions against a physician assistant. If the appointed physician assistant is not present at the disciplinary hearing, the panel may consider the matter and vote on the case in the absence of the physician assistant. The training requirements set forth in s. 458.307(4) do not apply to the appointed physician assistant. Rules need not be adopted to implement this subsection.

Section 67. Subsection (17) of section 464.003, Florida Statutes, is amended to read:

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

(17) "Practice of practical nursing" means the performance

of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, a registered autonomous physician assistant, or a licensed dentist; and the teaching of general principles of health and wellness to the public and to students other than nursing students. A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

Section 68. Paragraph (a) of subsection (4) of section 464.0205, Florida Statutes, is amended to read:

464.0205 Retired volunteer nurse certificate.—

(4) A retired volunteer nurse receiving certification from the board shall:

(a) Work under the direct supervision of the director of a county health department, a physician working under a limited license issued pursuant to s. 458.317 or s. 459.0075, a physician or an autonomous physician assistant licensed or registered under chapter 458 or chapter 459, an advanced practice registered nurse licensed under s. 464.012, or a registered nurse licensed under s. 464.008 or s. 464.009.

Section 69. Paragraph (b) of subsection (1) of section 480.0475, Florida Statutes, is amended to read:

480.0475 Massage establishments; prohibited practices.—

(1) A person may not operate a massage establishment between the hours of midnight and 5 a.m. This subsection does not apply to a massage establishment:

(b) In which every massage performed between the hours of midnight and 5 a.m. is performed by a massage therapist acting under the prescription of a physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458; ~~,~~ an osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459; ~~,~~ a chiropractic physician licensed under chapter 460; ~~,~~ a podiatric physician licensed under chapter 461; ~~,~~ an advanced practice registered nurse licensed under part I of chapter 464; ~~,~~ or a dentist licensed under chapter 466; or

Section 70. Subsection (2) of section 493.6108, Florida Statutes, is amended to read:

493.6108 Investigation of applicants by Department of Agriculture and Consumer Services.—

(2) In addition to subsection (1), the department shall make an investigation of the general physical fitness of the Class "G" applicant to bear a weapon or firearm. Determination of physical fitness shall be certified by a physician, autonomous physician assistant, or physician assistant currently licensed or registered under ~~pursuant to~~ chapter 458, chapter 459, or any similar law of another state or authorized to act as a licensed physician by a federal agency or department or by an advanced practice registered nurse currently licensed pursuant

to chapter 464. Such certification shall be submitted on a form provided by the department.

Section 71. Subsection (1) of section 626.9707, Florida Statutes, is amended to read:

626.9707 Disability insurance; discrimination on basis of sickle-cell trait prohibited.—

(1) An ~~No~~ insurer authorized to transact insurance in this state may not ~~shall~~ refuse to issue and deliver in this state any policy of disability insurance, whether such policy is defined as individual, group, blanket, franchise, industrial, or otherwise, which is currently being issued for delivery in this state and which affords benefits and coverage for any medical treatment or service authorized and permitted to be furnished by a hospital, a clinic, a health clinic, a neighborhood health clinic, a health maintenance organization, a physician, an autonomous physician assistant, a physician ~~physician's~~ assistant, an advanced practice registered nurse ~~practitioner~~, or a medical service facility or personnel solely because the person to be insured has the sickle-cell trait.

Section 72. Paragraph (b) of subsection (1) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.—

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

(b) "Health care provider" means any:

1. Hospital licensed under chapter 395.

2. Physician, autonomous physician assistant ~~licensed~~, or

physician assistant registered or licensed~~,~~ under chapter 458.

3. Osteopathic physician, autonomous physician assistant, or physician assistant registered or licensed under chapter 459.

4. Podiatric physician licensed under chapter 461.

5. Health maintenance organization certificated under part I of chapter 641.

6. Ambulatory surgical center licensed under chapter 395.

7. Chiropractic physician licensed under chapter 460.

8. Psychologist licensed under chapter 490.

9. Optometrist licensed under chapter 463.

10. Dentist licensed under chapter 466.

11. Pharmacist licensed under chapter 465.

12. Registered nurse, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464.

13. Other medical facility.

14. Professional association, partnership, corporation, joint venture, or other association established by the individuals set forth in subparagraphs 2., 3., 4., 7., 8., 9., 10., 11., and 12. for professional activity.

Section 73. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal

injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician or an autonomous physician assistant licensed or registered under chapter 458 or chapter 459, a dentist licensed under chapter 466, ~~or~~ a chiropractic physician licensed under chapter 460, or an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a

person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician or an autonomous physician assistant licensed or registered under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or an advanced practice registered nurse registered to engage in autonomous practice under s. 464.0123, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians or autonomous physician assistants licensed or registered under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 74. Subsection (5) of section 633.412, Florida Statutes, is amended to read:

633.412 Firefighters; qualifications for certification.—A person applying for certification as a firefighter must:

(5) Be in good physical condition as determined by a medical examination given by a physician, surgeon, or autonomous physician assistant or physician assistant licensed or registered under ~~to practice in the state pursuant to~~ chapter

458; an osteopathic physician, surgeon, autonomous physician assistant, or physician assistant licensed or registered under ~~to practice in the state pursuant to~~ chapter 459; or an advanced practice registered nurse licensed under ~~to practice in the state pursuant to~~ chapter 464. Such examination may include, but need not be limited to, the National Fire Protection Association Standard 1582. A medical examination evidencing good physical condition shall be submitted to the division, on a form as provided by rule, before an individual is eligible for admission into a course under s. 633.408.

Section 75. Subsection (8) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(8) Each organization's contracts, certificates, and subscriber handbooks shall contain a provision, if applicable, disclosing that, for certain types of described medical procedures, services may be provided by autonomous physician assistants, physician assistants, advanced practice registered nurses ~~nurse practitioners~~, or other individuals who are not licensed physicians.

Section 76. Subsection (1) of section 744.2006, Florida Statutes, is amended to read:

744.2006 Office of Public and Professional Guardians; appointment, notification.—

(1) The executive director of the Office of Public and

Professional Guardians, after consultation with the chief judge and other circuit judges within the judicial circuit and with appropriate advocacy groups and individuals and organizations who are knowledgeable about the needs of incapacitated persons, may establish, within a county in the judicial circuit or within the judicial circuit, one or more offices of public guardian and if so established, shall create a list of persons best qualified to serve as the public guardian, who have been investigated pursuant to s. 744.3135. The public guardian must have knowledge of the legal process and knowledge of social services available to meet the needs of incapacitated persons. The public guardian shall maintain a staff or contract with professionally qualified individuals to carry out the guardianship functions, including an attorney who has experience in probate areas and another person who has a master's degree in social work, or a gerontologist, psychologist, autonomous physician assistant, advanced practice registered nurse, or registered nurse~~, or nurse practitioner~~. A public guardian that is a nonprofit corporate guardian under s. 744.309(5) must receive tax-exempt status from the United States Internal Revenue Service.

Section 77. Paragraph (a) of subsection (3) of section 744.331, Florida Statutes, is amended to read:

744.331 Procedures to determine incapacity.—

(3) EXAMINING COMMITTEE.—

(a) Within 5 days after a petition for determination of incapacity has been filed, the court shall appoint an examining

committee consisting of three members. One member must be a psychiatrist or other physician. The remaining members must be either a psychologist, a gerontologist, a ~~another~~ psychiatrist, a ~~or other~~ physician, an autonomous physician assistant, a physician assistant, an advanced practice registered nurse, a registered nurse, ~~nurse practitioner,~~ a licensed social worker, a person with an advanced degree in gerontology from an accredited institution of higher education, or any other person who by knowledge, skill, experience, training, or education may, in the court's discretion, advise the court in the form of an expert opinion. One of three members of the committee must have knowledge of the type of incapacity alleged in the petition. Unless good cause is shown, the attending or family physician may not be appointed to the committee. If the attending or family physician is available for consultation, the committee must consult with the physician. Members of the examining committee may not be related to or associated with one another, with the petitioner, with counsel for the petitioner or the proposed guardian, or with the person alleged to be totally or partially incapacitated. A member may not be employed by any private or governmental agency that has custody of, or furnishes, services or subsidies, directly or indirectly, to the person or the family of the person alleged to be incapacitated or for whom a guardianship is sought. A petitioner may not serve as a member of the examining committee. Members of the examining committee must be able to communicate, either directly or

through an interpreter, in the language that the alleged incapacitated person speaks or to communicate in a medium understandable to the alleged incapacitated person if she or he is able to communicate. The clerk of the court shall send notice of the appointment to each person appointed no later than 3 days after the court's appointment.

Section 78. Paragraph (b) of subsection (1) of section 744.3675, Florida Statutes, is amended to read:

744.3675 Annual guardianship plan.—Each guardian of the person must file with the court an annual guardianship plan which updates information about the condition of the ward. The annual plan must specify the current needs of the ward and how those needs are proposed to be met in the coming year.

(1) Each plan for an adult ward must, if applicable, include:

(b) Information concerning the medical and mental health conditions and treatment and rehabilitation needs of the ward, including:

1. A resume of any professional medical treatment given to the ward during the preceding year.

2. The report of a physician, autonomous physician assistant, physician assistant, or advanced practice registered nurse who examined the ward no more than 90 days before the beginning of the applicable reporting period. The report must contain an evaluation of the ward's condition and a statement of the current level of capacity of the ward.

3. The plan for providing medical, mental health, and rehabilitative services in the coming year.

Section 79. Subsection (3) of section 766.103, Florida Statutes, is amended to read:

766.103 Florida Medical Consent Law.—

(3) ~~No~~ Recovery is not ~~shall be~~ allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced practice registered nurse licensed under s. 464.012, autonomous physician assistant registered under chapter 458 or chapter 459, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced practice registered nurse, autonomous physician assistant, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided

by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced practice registered nurse, autonomous physician assistant, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced practice registered nurse, autonomous physician assistant, or physician assistant in accordance with ~~the provisions of~~ paragraph (a).

Section 80. Paragraph (b) of subsection (1) and paragraph (e) of subsection (2) of section 766.105, Florida Statutes, are amended to read:

766.105 Florida Patient's Compensation Fund.—

(1) DEFINITIONS.—The following definitions apply in the interpretation and enforcement of this section:

(b) The term "health care provider" means any:

1. Hospital licensed under chapter 395.

2. Physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458.

3. Osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459.

4. Podiatric physician licensed under chapter 461.

5. Health maintenance organization certificated under part I of chapter 641.

6. Ambulatory surgical center licensed under chapter 395.

7. "Other medical facility" as defined in paragraph (c).

8. Professional association, partnership, corporation, joint venture, or other association by the individuals set forth in subparagraphs 2., 3., and 4. for professional activity.

(2) COVERAGE.—

(e) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, trainees, committee members (including physicians, osteopathic physicians, podiatric physicians, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, autonomous physician assistants or physician assistants registered or licensed under chapter 458 or chapter 459, osteopathic physicians licensed under chapter 459, dentists licensed under chapter 466, and podiatric physicians licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to house physicians, interns, employed physician residents in a resident

training program, or physicians performing purely administrative duties for the participating hospitals other than the treatment of patients. This coverage shall apply to the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

Section 81. Paragraph (d) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:

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

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

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458.

5. An osteopathic physician, autonomous physician assistant, or ~~osteopathic~~ physician assistant licensed or registered under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter

464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed

professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

Section 82. Subsection (1) of section 766.1116, Florida Statutes, is amended to read:

766.1116 Health care practitioner; waiver of license renewal fees and continuing education requirements.—

(1) As used in this section, the term "health care practitioner" means a physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 458; an osteopathic physician, autonomous physician assistant, or physician assistant licensed or registered under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; an advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a dentist or dental hygienist licensed under chapter 466; or a midwife licensed under chapter 467, who participates as a health care provider under s. 766.1115.

Section 83. Paragraph (c) of subsection (1) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

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

(c) "Practitioner" means any person licensed or registered under chapter 458, chapter 459, chapter 460, chapter 461,

chapter 462, chapter 463, chapter 466, chapter 467, chapter 486, ~~or~~ s. 464.012, or s. 464.0123. "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "practitioner" includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner.

Section 84. Subsection (3) of section 768.135, Florida Statutes, is amended to read:

768.135 Volunteer team physicians; immunity.—

(3) A practitioner licensed or registered under chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 who gratuitously and in good faith conducts an evaluation pursuant to s. 1006.20(2)(c) is not liable for any civil damages arising from that evaluation unless the evaluation was conducted in a wrongful manner.

Section 85. Subsection (5) of section 794.08, Florida Statutes, is amended to read:

794.08 Female genital mutilation.—

(5) This section does not apply to procedures performed by or under the direction of a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a

registered nurse licensed under part I of chapter 464, a practical nurse licensed under part I of chapter 464, an advanced practice registered nurse licensed under part I of chapter 464, a midwife licensed under chapter 467, or an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459 when necessary to preserve the physical health of a female person. This section also does not apply to any autopsy or limited dissection conducted pursuant to chapter 406.

Section 86. Subsection (23) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(23) "Practitioner" means a physician licensed under chapter 458, a dentist licensed under chapter 466, a veterinarian licensed under chapter 474, an osteopathic physician licensed under chapter 459, an advanced practice registered nurse licensed under chapter 464, a naturopath licensed under chapter 462, a certified optometrist licensed under chapter 463, a psychiatric nurse as defined in s. 394.455, a podiatric physician licensed under chapter 461, an autonomous physician assistant registered under chapter 458 or chapter 459, or a physician assistant licensed under chapter 458 or chapter 459, provided such practitioner holds a valid federal controlled substance registry number.

Section 87. Subsection (6) of section 943.13, Florida Statutes, is amended to read:

943.13 Officers' minimum qualifications for employment or appointment.—On or after October 1, 1984, any person employed or appointed as a full-time, part-time, or auxiliary law enforcement officer or correctional officer; on or after October 1, 1986, any person employed as a full-time, part-time, or auxiliary correctional probation officer; and on or after October 1, 1986, any person employed as a full-time, part-time, or auxiliary correctional officer by a private entity under contract to the Department of Corrections, to a county commission, or to the Department of Management Services shall:

(6) Have passed a physical examination by a licensed physician, registered autonomous physician assistant, licensed physician assistant, or licensed advanced practice registered nurse, based on specifications established by the commission. In order to be eligible for the presumption set forth in s. 112.18 while employed with an employing agency, a law enforcement officer, correctional officer, or correctional probation officer must have successfully passed the physical examination required by this subsection upon entering into service as a law enforcement officer, correctional officer, or correctional probation officer with the employing agency, which examination must have failed to reveal any evidence of tuberculosis, heart disease, or hypertension. A law enforcement officer, correctional officer, or correctional probation officer may not

use a physical examination from a former employing agency for purposes of claiming the presumption set forth in s. 112.18 against the current employing agency.

Section 88. Subsection (2) of section 945.603, Florida Statutes, is amended to read:

945.603 Powers and duties of authority.—The purpose of the authority is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions. For this purpose, the authority has the authority to:

(2) Review and make recommendations regarding health care for the delivery of health care services including, but not limited to, acute hospital-based services and facilities, primary and tertiary care services, ancillary and clinical services, dental services, mental health services, intake and screening services, medical transportation services, and the use of nurse practitioner, autonomous physician assistant, and physician assistant personnel to act as physician extenders as these relate to inmates in the Department of Corrections.

Section 89. Paragraph (n) of subsection (1) of section 948.03, Florida Statutes, is amended to read:

948.03 Terms and conditions of probation.—

(1) The court shall determine the terms and conditions of probation. Conditions specified in this section do not require oral pronouncement at the time of sentencing and may be considered standard conditions of probation. These conditions may include among them the following, that the probationer or offender in community control shall:

(n) Be prohibited from using intoxicants to excess or possessing any drugs or narcotics unless prescribed by a physician, an advanced practice registered nurse, an autonomous physician assistant, or a physician assistant. The probationer or community controllee may not knowingly visit places where intoxicants, drugs, or other dangerous substances are unlawfully sold, dispensed, or used.

Section 90. Subsection (34) of section 984.03, Florida Statutes, is amended to read:

984.03 Definitions.—When used in this chapter, the term:

(34) "Licensed health care professional" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a nurse licensed under part I of chapter 464, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or a dentist licensed under chapter 466.

Section 91. Subsection (30) of section 985.03, Florida

Statutes, is amended to read:

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

(30) "Licensed health care professional" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a nurse licensed under part I of chapter 464, an autonomous physician assistant or a physician assistant registered or licensed under chapter 458 or chapter 459, or a dentist licensed under chapter 466.

Section 92. Paragraph (i) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(i) Epinephrine use and supply.—

1. A student who has experienced or is at risk for life-threatening allergic reactions may carry an epinephrine auto-injector and self-administer epinephrine by auto-injector while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities if the school has been provided with parental and physician authorization. The State Board of Education, in cooperation with the Department of Health, shall adopt rules for such use of

epinephrine auto-injectors that shall include provisions to protect the safety of all students from the misuse or abuse of auto-injectors. A school district, county health department, public-private partner, and their employees and volunteers shall be indemnified by the parent of a student authorized to carry an epinephrine auto-injector for any and all liability with respect to the student's use of an epinephrine auto-injector pursuant to this paragraph.

2. A public school may purchase a supply of epinephrine auto-injectors from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer as defined in s. 499.003 for the epinephrine auto-injectors at fair-market, free, or reduced prices for use in the event a student has an anaphylactic reaction. The epinephrine auto-injectors must be maintained in a secure location on the public school's premises. The participating school district shall adopt a protocol developed by a licensed physician for the administration by school personnel who are trained to recognize an anaphylactic reaction and to administer an epinephrine auto-injection. The supply of epinephrine auto-injectors may be provided to and used by a student authorized to self-administer epinephrine by auto-injector under subparagraph 1. or trained school personnel.

3. The school district and its employees, agents, and the physician who provides the standing protocol for school epinephrine auto-injectors are not liable for any injury arising

from the use of an epinephrine auto-injector administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is having an anaphylactic reaction:

a. Unless the trained school personnel's action is willful and wanton;

b. Notwithstanding that the parents or guardians of the student to whom the epinephrine is administered have not been provided notice or have not signed a statement acknowledging that the school district is not liable; and

c. Regardless of whether authorization has been given by the student's parents or guardians or by the student's physician, autonomous physician assistant, physician ~~physician's~~ assistant, or advanced practice registered nurse.

Section 93. Paragraph (b) of subsection (17) of section 1002.42, Florida Statutes, is amended to read:

1002.42 Private schools.—

(17) EPINEPHRINE SUPPLY.—

(b) The private school and its employees, agents, and the physician who provides the standing protocol for school epinephrine auto-injectors are not liable for any injury arising from the use of an epinephrine auto-injector administered by trained school personnel who follow the adopted protocol and whose professional opinion is that the student is having an anaphylactic reaction:

1. Unless the trained school personnel's action is willful

and wanton;

2. Notwithstanding that the parents or guardians of the student to whom the epinephrine is administered have not been provided notice or have not signed a statement acknowledging that the school district is not liable; and

3. Regardless of whether authorization has been given by the student's parents or guardians or by the student's physician, autonomous physician assistant, physician ~~physician's~~ assistant, or advanced practice registered nurse.

Section 94. Paragraph (a) of subsection (1) and subsections (4) and (5) of section 1006.062, Florida Statutes, are amended to read:

1006.062 Administration of medication and provision of medical services by district school board personnel.—

(1) Notwithstanding the provisions of the Nurse Practice Act, part I of chapter 464, district school board personnel may assist students in the administration of prescription medication when the following conditions have been met:

(a) Each district school board shall include in its approved school health services plan a procedure to provide training, by a registered nurse, a licensed practical nurse, or an advanced practice registered nurse licensed under chapter 464 or by a physician, autonomous physician assistant, or physician assistant licensed or registered under ~~pursuant to~~ chapter 458 or chapter 459~~, or a physician assistant licensed pursuant to chapter 458 or chapter 459~~, to the school personnel designated

by the school principal to assist students in the administration of prescribed medication. Such training may be provided in collaboration with other school districts, through contract with an education consortium, or by any other arrangement consistent with the intent of this subsection.

(4) Nonmedical assistive personnel shall be allowed to perform health-related services upon successful completion of child-specific training by a registered nurse or advanced practice registered nurse licensed under chapter 464 or~~,~~ a physician, autonomous physician assistant, or physician assistant licensed or registered under ~~pursuant to~~ chapter 458 or chapter 459~~, or a physician assistant licensed pursuant to chapter 458 or chapter 459~~. All procedures shall be monitored periodically by a nurse, advanced practice registered nurse, autonomous physician assistant, physician assistant, or physician, including, but not limited to:

(a) Intermittent clean catheterization.

(b) Gastrostomy tube feeding.

(c) Monitoring blood glucose.

(d) Administering emergency injectable medication.

(5) For all other invasive medical services not listed in this subsection, a registered nurse or advanced practice registered nurse licensed under chapter 464 or~~,~~ a physician, autonomous physician assistant, or physician assistant licensed or registered under ~~pursuant to~~ chapter 458 or chapter 459~~, or a physician assistant licensed pursuant to chapter 458 or chapter~~

~~459~~ shall determine if nonmedical district school board personnel shall be allowed to perform such service.

Section 95. Paragraph (c) of subsection (2) of section 1006.20, Florida Statutes, is amended to read:

1006.20 Athletics in public K-12 schools.—

(2) ADOPTION OF BYLAWS, POLICIES, OR GUIDELINES.—

(c) The FHSAA shall adopt bylaws that require all students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year before ~~prior to~~ participating in interscholastic athletic competition or engaging in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team. Such medical evaluation may be administered only by a practitioner licensed or registered under chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 and in good standing with the practitioner's regulatory board. The bylaws shall establish requirements for eliciting a student's medical history and performing the medical evaluation required under this paragraph, which shall include a physical assessment of the student's physical capabilities to participate in interscholastic athletic competition as contained in a uniform preparticipation physical evaluation and history form. The evaluation form shall incorporate the recommendations of the American Heart Association for participation cardiovascular screening and shall provide a place for the signature of the

practitioner performing the evaluation with an attestation that each examination procedure listed on the form was performed by the practitioner or by someone under the direct supervision of the practitioner. The form shall also contain a place for the practitioner to indicate if a referral to another practitioner was made in lieu of completion of a certain examination procedure. The form shall provide a place for the practitioner to whom the student was referred to complete the remaining sections and attest to that portion of the examination. The preparticipation physical evaluation form shall advise students to complete a cardiovascular assessment and shall include information concerning alternative cardiovascular evaluation and diagnostic tests. Results of such medical evaluation must be provided to the school. A student is not eligible to participate, as provided in s. 1006.15(3), in any interscholastic athletic competition or engage in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team until the results of the medical evaluation have been received and approved by the school.

Section 96. Subsection (1) of section 1009.65, Florida Statutes, is amended to read:

1009.65 Medical Education Reimbursement and Loan Repayment Program.—

(1) To encourage qualified medical professionals to practice in underserved locations where there are shortages of

such personnel, there is established the Medical Education Reimbursement and Loan Repayment Program. The function of the program is to make payments that offset loans and educational expenses incurred by students for studies leading to a medical or nursing degree, medical or nursing licensure, ~~or~~ advanced practice registered nurse licensure, autonomous physician assistant registration, or physician assistant licensure. The following licensed or certified health care professionals are eligible to participate in this program: medical doctors with primary care specialties, doctors of osteopathic medicine with primary care specialties, autonomous physician assistants, physician ~~physician's~~ assistants, licensed practical nurses and registered nurses, and advanced practice registered nurses with primary care specialties such as certified nurse midwives. Primary care medical specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties which may be identified by the Department of Health.

Section 97. For the 2020-2021 fiscal year, four full-time equivalent positions with associated salary rate of 166,992 are authorized and the sums of $643,659 in recurring and $555,200 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing sections 400.52, 408.064, and 408.822, Florida Statutes, as created by this act.

Section 98. For the 2020-2021 fiscal year, 3.5 full-time

equivalent positions with associated salary rate of 183,895 are authorized and the sums of $219,089 in recurring funds and $17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health for the purpose of implementing section 464.0123, Florida Statutes, as created by this act.

Section 99. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Yarborough offered the following:

Amendment (with title amendment)

Remove lines 559-605 and insert:

Home Health Program for the purpose of awarding home health agencies or nurse registries that meet the criteria specified in this section.

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, meeting standards relating to:

1. Patient or client satisfaction.

2. Patients or clients requiring emergency care for wound infections.

3. Patients or clients admitted or readmitted to an acute care hospital.

4. Patient or client improvement in the activities of daily living.

5. Employee satisfaction, as applicable.

6. Quality of employee training, as applicable.

7. Employee retention rates, as applicable.

8. High performance under federal Medicaid electronic visit verification requirements, as applicable.

(b) The agency must annually evaluate home health agencies and nurse registries seeking the award which apply on a form and in the manner designated by rule.

(3) The home health agency or nurse registry must:

(a) Be actively licensed and operating for at least 24 months to be eligible to apply for a program award. An award under the program is not transferrable to another license, except when the existing home health agency or nurse registry is being relicensed in the name of an entity related to the current licenseholder by common control or ownership, and there will be no change in the management, operation, or programs of the home health agency or nurse registry as a result of the relicensure.

(b) Have had no licensure denials, revocations, or any Class I, Class II, or uncorrected Class III deficiencies within the 24 months preceding the application for the program award.

(4) The award designation shall expire on the same date as the home health agency's or nurse registry's license. A home health agency or nurse registry must reapply and be approved for the award designation to continue using the award designation in the manner authorized under subsection (5).

(5) A home health agency or nurse registry that is awarded under the program may use the designation in advertising and marketing. A home health agency or nurse registry may not use the award designation in any advertising or marketing if the home health agency or nurse registry:

(a) Has not been awarded the designation;

(b) Fails to renew the award upon expiration of the award designation;

(c) Has undergone a change in ownership that does not qualify for an exception under paragraph (3)(a); or

(d) Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the award designation.

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

Remove lines 36-41 and insert:

annually evaluate certain home health agencies and nurse registries that apply for a program award; providing eligibility requirements; requiring an agency to reapply biennially for the

award designation; authorizing an award recipient to use the designation in advertising and marketing; prohibiting a home health agency or nurse registry from

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

Amendment

Remove lines 1124-1128 and insert:

States, at least 2,000 clinical practice hours within the 5 years immediately preceding the submission of the registration request while practicing as a physician assistant under the supervision of an allopathic or osteopathic physician who held an active, unencumbered license issued by any state, the

Remove line 1427 and insert:

States, at least 2,000 clinical practice hours within the 5