Health & Human Services Committee

Thursday, February 6, 2020
12:00 PM – 2:00 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: Thursday, February 06, 2020 12:00 pm

End Date and Time: Thursday, February 06, 2020 02:00 pm

Location: Morris Hall (17 HOB)

Duration: 2.00 hrs

Consideration of the following bill(s):

HB 43 Child Welfare by Latvala, Valdés
HB 57 Dispensing Medicinal Drugs by Willhite
CS/HB 599 Consultant Pharmacists by Health Quality Subcommittee, Rodriguez, A. M.
HB 707 Legislative Review of Occupational Regulations by Renner
HB 743 Nonopioid Alternatives by Plakon
CS/HB 747 Coverage for Air Ambulance Services by Health Market Reform Subcommittee, Williamson
HB 827 Recovery Care Services by Stevenson
HB 959 Medical Billing by Duggan
HB 1059 Parental Rights by Grall
CS/HB 1087 Domestic Violence Services by Children, Families & Seniors Subcommittee, Fernandez-Barquin
CS/HB 1461 Health Access Dental Licenses by Health Quality Subcommittee, Brown
HB 7021 Recovery Care Center Fees by Health Market Reform Subcommittee, McClure, Stevenson

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Wednesday, February 5, 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., Wednesday, February 5, 2020.

NOTICE FINALIZED on 02/04/2020 4:03PM by Dewees.Cheryl

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 43 Child Welfare
SPONSOR(S): Latvala, Valdes & others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	13 Y, 0 N	Woodruff	Brazzell
2) Appropriations Committee	29 Y, 0 N	Fontaine	Pridgeon
3) Health & Human Services Committee		Woodruff	Calamas

SUMMARY ANALYSIS

Florida's child welfare system identifies families whose children are in danger of suffering or have suffered abuse, abandonment, or neglect, and works with those families to address the problems that are endangering children, if possible. 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.

Jordan Belliveau, Jr., was murdered by his mother in September 2018 when he was two years old. At the time of Jordan's death, the family was under court supervision because a child protective investigation found Jordan to be living in an unsafe home environment that included gang violence and domestic violence. The court had reunified the family and they were receiving post-reunification services. Due to lack of communication to the court, lack of communication between law enforcement and the Department of Children and Families (DCF), and lack of evidence provided by case management regarding the parents' case plan compliance, ongoing family issues that provided an unsafe home environment for Jordan were never addressed.

HB 43 is entitled "Jordan's Law" and addresses some issues that arose in his dependency case.

The bill creates a communication process between DCF and law enforcement by requiring the systems used by both agencies to connect in a way that allows the Florida Department of Law Enforcement (FDLE) to make available to law enforcement agencies information that a person is a parent or caregiver involved in the child welfare system. The bill further requires that if a law enforcement officer interacts with such a person and has concerns for a child's health, safety, or well-being, the officer shall contact the Florida central abuse hotline so the hotline can provide relevant information to individuals involved in the child's case.

The bill amends several statutes to require child welfare professionals and law enforcement officers to receive training on the recognition of, and responses to, head trauma and brain injury in a child under six years of age.

The bill amends s. 409.988(3), F.S., to allow DCF and community-based care lead agencies to provide intensive family reunification services that combine child welfare and mental health services for families with dependent children under six years of age.

Finally, the bill amends s. 409.996, F.S., to give DCF discretion to select up to three lead agencies to develop and implement a program to improve case management services for dependent children under six years of age.

The bill has an insignificant negative, nonrecurring fiscal impact to DCF and FDLE. 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

Florida's Child Welfare System

The child welfare system identifies families whose children are in danger of suffering or have suffered abuse, abandonment, or neglect and works with those families to address the problems that are endangering children, if possible. If the child welfare system cannot address the problems, the Department of Children and Families (DCF) finds a safe out-of-home placement to protect children.

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.[1] Current law requires any person who knows or suspects that a child is abused, abandoned, or neglected to report such knowledge or suspicion to the hotline.[2] A child protective investigation begins if the hotline determines the allegations meet the statutory definition of abuse, abandonment, or neglect.[3] A child protective investigator investigates the situation either immediately or within 24 hours after the report is received, depending on the nature of the allegation.[4]

Current law requires DCF to notify law enforcement immediately when the alleged harm to the victim is the result of suspected "criminal conduct" by the child's parent or caregiver.[5] The term "criminal conduct" includes cases where a child is known or suspected to have died from child abuse or neglect or to be the victim of:

- child abuse or neglect.[6]
- aggravated child abuse.[7]
- sexual battery.[8]
- sexual abuse.[9]
- institutional child abuse or neglect.[10]
- human trafficking.[11]

Upon receiving information about alleged criminal conduct from DCF, the law enforcement agency reviews the information to determine whether the conduct calls for a criminal investigation.[12] If so, the law enforcement agency coordinates its investigative activities with DCF, when feasible.[13]

[1] S. 39.201, F.S.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] S. 39.301(2)(a), F.S.
[6] Ss. 827.03(1)(b), 827.03(1)(e), F.S.
[7] S. 827.03(1)(a), F.S.
[8] S. 827.071(1)(f), F.S.
[9] S. 39.01(77), F.S.
[10] Ss. 39.01(37), 39.302(1), F.S.
[11] S. 787.06, F.S.
[12] S. 39.301(2)(c), F.S.
[13] *Id.*

Other than reporting criminal conduct, current law does not require DCF to share any other information with law enforcement, such as when there is an open child protective investigation or when a family is under judicial supervision after an adjudication of dependency.

Dependency Case Process

When DCF removes a child from the home, a series of dependency court proceedings must occur to adjudicate the child dependent for placement in out-of-home care.

DCF must develop and refine a case plan throughout the dependency process with input from all parties to the child's dependency case. The case plan details the problems found during the child protective investigation as well as the goals, tasks, services, and responsibilities required to alleviate the concerns of the state.[14] Case plan services must focus on clearly defined objectives that will improve the conditions in the home and aid in maintaining the child in the home, facilitate the child's safe return to the home, ensure proper care of the child, or facilitate the child's permanent placement.[15] Once a court finds a child dependent, the judge reviews the case plan and orders the child's parent or parents to follow the case plan tasks.[16] The case plan follows the child from the provision of voluntary services through any dependency or termination of parental rights proceeding or related activity.[17]

Once the court approves a case plan, the dependency case continues with judicial review hearings, case plan reviews, custody or placement changes, and permanency planning. The goal is for the dependency court and all parties involved in the child's case to ensure the child remains safe.[18]

In determining the specific permanency goal for the child and whether requirements for its achievement have been met, or if other actions need to be taken to protect the child, the court follows the Rules of Juvenile Procedure[19] and relevant statutes. In addition, the court considers information about the parent's behavior and actions and other relevant details provided by parties to and participants in the case, such as through written reports submitted to the court and witness testimony at hearings.[20]

Services for Dependent Children

To serve families and children, DCF contracts for foster care and related services with lead agencies, also known as community-based care organizations (CBCs). The outsourced provision of child welfare services increases local community ownership of service delivery and design.[21] DCF, through the CBCs and other community partners, administers a system of care for children[22] to:

- Prevent children's separation from their families.
- Intervene to allow children to remain safely in their own homes.
- Reunify families who have had children removed from their care, if possible and appropriate.
- Ensure safety and normalcy for children who are separated from their families.
- Enhance the well-being of children through educational stability and timely health care;
- Provide permanency.
- Develop their independence and self-sufficiency.

[14] Ss. 39.6011, 39.6012, F.S.
[15] S. 39.6012(1)(a), F.S.
[16] S. 39.603, F.S.
[17] S. 39.01(11), F.S.
[18] S. 39. 001(1)(a), F.S.
[19] S. 39.013(1), F.S.
[20] For example, a social study report is submitted prior to judicial review hearings and it includes information on the child's placement, the child's safety in the placement, efforts of the parents to comply with case plan tasks, services provided to the foster family or legal custodian to address the child's needs, information on the visitation between the parent and child, and other information related to the child and the parent.
[21] Florida Department of Children and Families, *Community-Based Care*, http://www.dcf.state.fl.us/service-programs/community-based-care/ (last visited Sept. 30, 2019).
[22] Florida Department of Children and Families, *Office of Child Welfare*, https://myflfamilies.com/service-programs/child-welfare/ (last visited Sept. 30, 2019).

CBC case managers help parents identify their needs, plan their services, link them to the service systems, coordinate the various system components, monitor services delivery, and evaluate the effect of the services received. Services may include, but are not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption. CBCs contract with subcontractors for case management and direct care services to children and their families. There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[23]

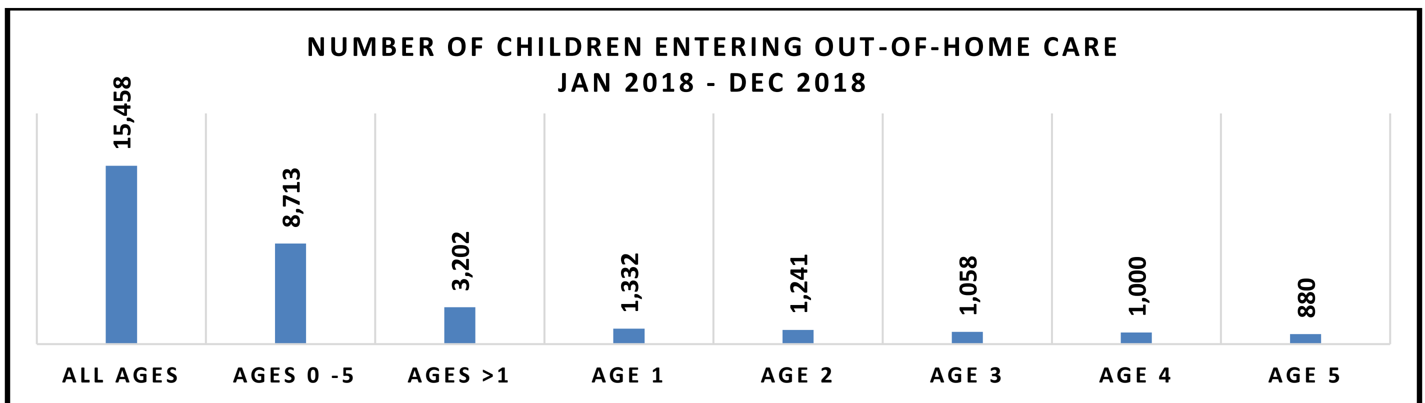
Service Needs of Children Under Six Years of Age

Children under age six are at a crucial developmental stage in their lives. From birth through five years of age, children develop foundational capabilities on which subsequent development builds.[24] Regions of the brain involved in regulating emotions, language, and abstract thought grow rapidly in the first three years of life.[25] By age three, a child's brain has reached almost 90 percent of its adult size, and the growth in each region of the brain during this time largely depends on the stimulation it receives.[26]

A child's experience with abuse or neglect, or other forms of toxic stress such as domestic violence, can negatively affect brain development.[27] These include changes to the structure and chemical activity (e.g., decreased size or connectivity in some parts of the brain) and in the emotional and behavioral functioning of the child (e.g., over-sensitivity to stressful situations).[28] When the brain develops under negative conditions, children learn to cope in a negative environment, and their ability to respond to nurturing may be impaired.[29]

The effect of abuse or neglect as a child can continue to influence brain development into teenage years as well as adulthood. Some youth who grow up in negative environments as children develop brains that focus on survival, which can lead to impulsive behavior as well as difficulty with tasks that require higher-level thinking and feeling.[30]

Young children are especially vulnerable to abuse and neglect due to their inability to protect themselves. In 2018, 15,458 children entered out-of-home care statewide, and around 56 percent were 0 to 5 years of age. A breakdown based on the age of children entering out-of-home care last year is in the table below.



[23] 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 Sept. 30, 2019).
[24] Committee on Integrating the Science of Early Childhood Development, From Neurons to Neighborhood: The Science of Childhood Development 5 (Jack P. Shonkoff & Deborah A. Philips).
[25] U.S. Department of Health, Administration for Children & Families, Children's Bureau, *Understanding the Effects of Maltreatment on Brain Development*, (April 2015) https://www.childwelfare.gov/pubpdfs/brain_development.pdf (last visited Sept. 30, 2019).
[26] *Id.* at 3.
[27] *Id.* at 5.
[28] *Id.*
[29] *Id.*
[30] *Id.* at 9.

An important predictor of a child's healthy growth and development is the attachment he or she forms with a consistent caregiver.[31] A secure bond with a caregiver helps children develop healthy attachments, nurture themselves, care for others, and be motivated to learn.[32] Because a young child's brain is rapidly developing and there is an important need to bond with a consistent caregiver, it is important to quickly remedy issues that contribute to an unsafe home environment so young children can be reunified with their parents, or be placed in an alternative stable placement, in the shortest time possible.

Jordan Belliveau, Jr.

Jordan Belliveau, Jr., was murdered by his mother in September 2018. At the time of Jordan's death, the family was under court supervision because a child protective investigation found Jordan to be living in an unsafe home environment that included gang violence and domestic violence between his parents. The court had reunified the family and the parents were receiving post-reunification services. DCF first encountered the family in October 2016 when a report to the hotline alleged Jordan was in an unsafe home environment that included gang violence. The court subsequently found Jordan dependent on November 1, 2016, and placed him in foster care after his mother was unable to obtain alternative housing. Case management gave his parents a case plan with tasks including finding stable housing and receiving mental health services and counseling.

Throughout the entirety of Jordan's case, his mother and father were either non-compliant or only partially compliant with their case plans. Nevertheless, due to lack of communication to the court and lack of evidence provided by case management regarding compliance, the court reunified Jordan with his mother and father.[33] After reunification with his mother, and while still under judicial supervision, domestic violence continued between the parents, with law enforcement arresting Jordan's father for domestic violence against Jordan's mother in July 2018. However, because the incident was not immediately reported to the hotline upon arrest, the incident was not reported to the court at a hearing the next day regarding Jordan's reunification with his father. Three weeks later, the hotline received a report about the arrest, and a child protective investigation began. However, the investigator found Jordan was not *currently* in danger, and therefore, found no need to remove him from the home.[34]

Given the on going and escalating level of violence between the parents, the inability to control the situation in the home, and the risk of harm posed to Jordan should his parents engage in further altercations, the investigator should have identified an unsafe home environment.[35] With no concerns for Jordan's safety raised after the investigation or during subsequent hearings, there was no consideration of an emergency modification of his placement[36] and Jordan's reunification with his father occurred.[37]

On August 31, 2018, a case manager visited Jordan's parents to discuss several issues regarding lack of cooperation with the Guardian ad Litem and case plan tasks. The case manager emphasized the continued need for Jordan's parents to participate in services or risk losing custody of Jordan. Less than 24 hours after the visit, Jordan's mother reported him missing. Four days later, law enforcement found his body and arrested his mother with aggravated child abuse and first-degree murder after she admitted to killing Jordan by hitting him in a "moment of frustration" which "in turn caused the back of his head to strike an interior wall of her home."[38]

---

[31] Lucy Hudson, et al., *Healing the Youngest Children: Model Court-Community Partnerships* (Mar. 2007), https://www.americanbar.org/content/dam/aba/administrative/child_law/healing_young_children.pdf.
[32] *Id.*
[33] Florida Department of Children and Families, Special Review of the Case Involving Jordan Belliveau, Jr. (Jan. 11, 2019), http://www.dcf.state.fl.us/newsroom/docs/Belliveau%20Special%20Review%202018-632408.pdf.
[34] *Id.*
[35] *Id.*
[36] Any time before a child is living in a permanent placement approved at a permanency hearing, the court may change the child's placement if it is no longer in the child's best interest to remain in that placement. This process is known as an emergency modification of placement because it does not require the court to again find the child dependent based on abuse, abandonment or neglect. See s. 39.522, F.S.
[37] *Supra* note 33.
[38] *Id.*

Training on Head Trauma and Brain Injury in Abused and Neglected Children

Head Trauma and Brain Injury in Children

Abusive head trauma is a leading cause of child abuse deaths in children under five in the United States.[39] Head trauma and injuries can be mild, like a bump or bruise, or they can be more severe, like a concussion or a fractured skull bone, and may include internal bleeding and damage to the brain. A number of actions can cause head trauma and brain injury in children. The most commonly known physical abuse that results in a brain injury is shaken-baby syndrome[40]; however, head trauma and other forms of physical abuse, like hitting or striking a child, can cause brain injuries. Caregiver neglect can also cause brain injuries through inadequate supervision or by providing an unsafe home environment.

Additionally, other forms of abuse that do not involve physical abuse to the head, such as choking or strangling, can damage the brain. Disruption in oxygen to the brain, called hypoxia, can cause long-term disabilities and damage to a child's brain.[41]

Training on Head Trauma

Current law requires training for many professionals who work in the child welfare system. Some of these professions require training upon hire as well as continuing education throughout employment. The chart below details these requirements. Although training for these professionals may include some information on head trauma and brain injury in abused and neglected children, current law does not expressly require require training on this topic.

Professional	Training Requirement	Authority
Judges	All judges new to the bench are required to complete the Florida Judicial College Program during their first year of judicial service following selection to the bench.[42] Continuing judicial education is mandatory for all county, circuit, and appellate judges and the Supreme Court justices. The Florida Court Educational Council is required by statute to establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases.	s. 25.385, F.S. Fla. R. Jud. Admin. 2.320
Law Enforcement	New hires must successfully complete the Florida Basic Recruit Training Program for the respective discipline or equivalency for out-of-state officers.[43] Child abuse training is currently provided as part of the basic skills training for law enforcement officers. Officers must complete continuing education every four years. A continuing education class entitled Child Abuse Investigations is a 40-hour advanced training program that can be used for salary incentive, as an elective course for mandatory retraining, or as a Specialized Training Program course.	s. 943.13, F.S. s. 943.135, F.S.
Guardians ad Litem	The Statewide Guardian ad Litem Office has a curriculum committee to develop the training program for Guardian ad Litem staff and volunteers.	s. 39.8296(2), F.S.

[39] Spies, EL, Ph.D. and Klevens, J., MD, Ph.D., *Fatal Abusive Head Trauma among Children Aged <5 Years – United States, 1999-2014* (May 27, 2016).
[40] *See* Tina Joyce, Martin Huecker, *Pediatric Abusive Head Trauma (Shaken Baby Syndrome)*, https://www.ncbi.nlm.nih.gov/books/NBK499836/ (last visited Feb. 2, 2020).
[41] James E. Lewis, Ph.D., *Neuropsychological Evaluations of Children and Adults in Child Welfare Cases*, http://centervideo.forest.usf.edu/clsneuropsych/start.html (last visited Sept. 30, 2019).
[42] Florida Courts*, Information for New Judges*, https://www.flcourts.org/Resources-Services/Judiciary-Education/Information-for-New-Judges (last visited Sept. 30, 2019).
[43] Florida Department of Law Enforcement, *How to Become Employed in Florida,* http://www.fdle.state.fl.us/CJSTC/Officer-Requirements/Employment-Requirements.aspx (last visited Sept. 30, 2019).

Professional	Training Requirement	Authority
Child Protective Investigators and Supervisors	Child protective investigators and supervisors employed by DCF or a sheriff's office must obtain a Florida Child Protective Investigator certification within 12 months of hire. They must complete specialized training within two years of being hired, which focuses either on servicing a specific population or on performing certain aspects of child protection practice. The specialized training may be used to fulfill continuing education requirements.	s. 402.402(2), F.S.
Children's Legal Services	Attorneys employed by DCF must receive training within the first six months of employment but the training does not address head trauma and brain injuries.	s. 402.402(4), F.S.
Case Managers, Supervisors, Service Providers	CBC providers are required to ensure all individuals providing care for dependent children receive appropriate training.	s. 409.988(1)(f), F.S.

Information Technology Systems for Child Welfare and Law Enforcement

Florida Safe Families Network

The Florida Safe Families Network (FSFN) is DCF's Statewide Automated Child Welfare Information System. FSFN serves as the statewide electronic case record for all child abuse investigations and case management activities in Florida.

Florida Crime Information Center

The Florida Crime Information Center (FCIC), administered by the Florida Department of Law Enforcement (FDLE), is a state database that houses actionable criminal justice information. When law enforcement encounters an individual, the officer runs the individual's identifying information in FCIC to see if there are any open wants or warrants for their arrest. FDLE's Criminal Justice Information Services (CJIS) is the central repository of criminal history records for the state and provides criminal identification screening to criminal justice and non-criminal justice agencies.[44] The CJIS helps ensure the quality of data available on the FCIC system.

Effect of Proposed Changes

The bill is entitled "Jordan's Law" and addresses some issues that arose in his dependency case. It creates a communication process between DCF and law enforcement, requires training on head trauma and brain injury in children under six years of age, allows DCF to select lead agencies to develop and implement case management services for dependent children under six years of age, and allows CBCs to provide intensive reunification services to dependent children.

DCF Communication with Law Enforcement

The bill creates a communication process between DCF and law enforcement agencies. Although DCF and law enforcement agencies currently share information on cases possibly involving criminal conduct for the purpose of facilitating criminal investigations, law enforcement is not informed of individuals involved in the child welfare system for purposes of providing information for dependency cases.

[44] Florida Department of Law Enforcement, *Criminal Justice Information Services*, http://www.fdle.state.fl.us/CJIS/CJIS-Home.aspx (last visited Sept. 30, 2019).

The bill requires the FSFN and FCIC systems to connect in a way to allow FDLE to make available to law enforcement agencies information that a person is involved in the child welfare system in one of two statuses as a parent or caregiver:

- Currently the subject of a child protective investigation, or
- Under judicial supervision after an adjudication of dependency.

The bill further requires a law enforcement officer to contact the hotline if he or she interacts with a parent or caregiver and the officer has concerns about a child's health, safety, or well-being. The hotline then must provide any relevant information to either a child protective investigator or to the child's case manager and the attorney representing DCF, depending on who is involved in the child's case at the time of the report.

Training

The bill requires training on the recognition of and response to head trauma and brain injury in a child under six years of age. Training on this subject will be required for case managers, Guardian ad Litem staff and volunteers, dependency court judges, child protective investigators, Children's Legal Services attorneys, and foster parents and group home staff.

Additionally, the bill creates s. 943.17298, F.S., to require training for law enforcement officers on the recognition of and response to head trauma and brain injury in a child under six years of age to aid an officer in the detection of head trauma and brain injury due to child abuse. Each law enforcement officer must complete the training as part of basic recruit training or as part of continuing training or education. The bill requires the training to be available for new law enforcement offices and completed by current officers by July 1, 2022.

Each entity will have flexibility in developing the trainings it provides.

Services for Dependent Children

The bill amends s. 409.996, F.S., to allow DCF to establish a program to improve case management services for dependent children under six years of age by:

- Limiting caseloads comprised only of children under six years of age to no more than 15 children per case manager.
- Including case managers in the program who are trained specifically in:
  - Critical child development for children under six years of age.
  - Specific practices of child care for children under six years of age.
  - The scope of community resources available to children under six years of age.
  - Working with a parent or caregiver and assisting him or her in developing the skills necessary to care for a child under six years of age.
- Requiring DCF to evaluate the permanency, safety, and well-being of children served through the program and submit a report to the Governor, Speaker of the House and Senate President by October 1, 2025.

The bill requires DCF to choose lead agencies in circuits with high removal rates, significant budget deficits, significant case management turnover, and the highest numbers of children in out-of-home care or a significant increase over the last three fiscal years in children in out-of-home care. If DCF chooses to establish such a program, the bill requires DCF to select up to three lead agencies to develop and implement the program.

Further, the bill amends s. 409.988(3), F.S., to allow CBCs to provide intensive family reunification services that combine child welfare and mental health services for families with dependent children under six years of age.

This bill is effective July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Providing a title.
Section 2: Amending s. 25.385, F.S., relating to standards for instruction of circuit and county court judges.
Section 3: Creating s. 39.0142, F.S.; relating to notifying law enforcement of parent or caregiver names.
Section 4: Amending s. 39.8296, F.S.; relating to statewide Guardian ad Litem Office; legislative findings and intent; creation; appointment of executive director; duties of office.
Section 5: Amending s. 402.402, F.S.; relating to child protection and child welfare personnel; attorneys employed by the department.
Section 6: Amending s. 409.988, F.S.; relating to lead agency duties; general provisions.
Section 7: Amending s. 409.996, F.S.; relating to duties of the Department of Children and Families.
Section 8: Creating s. 943.17298, F.S.; relating to training in the recognition of and response to head trauma and brain injury.
Section 9: Providing an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has a negative fiscal impact among multiple entities, which in total is estimated to have nonrecurring training costs of $44,955 and technology costs of approximately $565,000. Other areas affected by the bill have costs that are indeterminate, as the costs depend on the means of implementation.

   Training

   - DCF estimates a nonrecurring cost of $35,000 to develop the training established in the bill. This includes the cost of research, front-end analysis to further define scope, subject matter experts, and the design and development of materials. These costs can be absorbed within existing resources.[45]
   - The Guardian ad Litem program can incorporate the changes of its training curriculum within existing resources.[46]
   - FDLE estimates a cost of approximately $9,955 to develop the required training curricula, which is based upon the need for curriculum development workshops and OPS staffing to develop the training. The department can utilize existing appropriations for these costs.[47]
   - The CBC's will be required to ensure that individuals providing care for dependent children receive training on the recognition of and response to head trauma and brain injury. However, they may be able to use or adapt training developed by DCF or available from other entities at low or no cost.

   Technology

   - FDLE estimates a technology cost of $45,000 to incorporate child welfare training into its current system.[48] The department indicates this cost can be absorbed within existing resources, although doing so may require the reprioritization of existing staff and resources.

---

[45] Florida Department of Children and Families, Agency Analysis of 2020 House Bill 43, p. 6 (Aug. 20, 2019).
[46] Florida Guardian ad Litem, Agency Analysis of 2020 House Bill 43, p. 2 (Aug. 29, 2019).
[47] Florida Department of Law Enforcement, Agency Analysis of 2020 House Bill 43, p. 5 (Aug. 26, 2019).
[48] *Id.* at 4.

- FDLE suggest developing a web-based interface between FSFN and FCIC for a cost of $300,000, and notes these programming modifications may take two years to complete. Initial costs can be absorbed within available resources.[49] The FDLE can submit a legislative budget request for future needs should a comprehensive analysis indicate necessity.
- DCF estimates a nonrecurring need of between $160,000 and $270,000 for the development of a technology solution that interfaces FSFN and FCIC.[50] Based upon a review of budgetary reversions of technology appropriations, there exist sufficient resources for these costs.

Staffing

- DCF has indicated that the bill could have an indeterminate workload impact on the central abuse hotline's Crime Intelligence Unit due to additional calls from law enforcement and by requiring additional criminal records checks.[51]

Case Management Project

Should DCF elect to create a program that provides more effective case management for dependent children under six years of age, the CBCs selected for this program would work in collaboration with DCF to develop and implement the program in their respective circuits. The bill provides flexibility in how the program is implemented, and the cost to develop the program depends on its design. For example, the program design may involve hiring additional case management staff. In 2018, the annual mean wage estimates in Florida for a Child, Family and School Social Worker was $42,640, and for a Community and Social Service Specialist was $40,050.[52] At least five staff members would be needed to serve 75 children if caseloads are at the bill's target level of no more than 15 children. In this scenario, additional staffing resources would cost each CBC an estimated $200,000 (five additional case managers *x* $40,000 mean salary).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

---

[49] *Id.*
[50] *Supra* note 45 at 7.
[51] *Supra* note 45.
[52] Bureau of Labor Statistics, Occupational Employment Statistics, https://www.bls.gov/oes/current/oes_fl.htm (last visited Sept. 30, 2019).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Rulemaking is not necessary to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to child welfare; providing a short
3 title; amending s. 25.385, F.S.; requiring the Florida
4 Court Educational Council to establish certain
5 standards for instruction of circuit and county court
6 judges for dependency cases; creating s. 39.0142,
7 F.S.; requiring the Department of Law Enforcement to
8 provide certain information to law enforcement
9 officers relating to specified individuals; providing
10 how such information shall be provided to law
11 enforcement officers; providing requirements for law
12 enforcement officers and the central abuse hotline
13 relating to specified interactions with certain
14 persons and how to relay details of such interactions;
15 amending s. 39.8296, F.S.; requiring that the guardian
16 ad litem training program include training on the
17 recognition of and responses to head trauma and brain
18 injury in specified children; amending s. 402.402,
19 F.S.; requiring certain entities to provide training
20 to certain parties on the recognition of and responses
21 to head trauma and brain injury in specified children;
22 amending s. 409.988, F.S.; requiring lead agencies to
23 provide certain individuals with training on the
24 recognition of and responses to head trauma and brain
25 injury in specified children; authorizing lead

26 agencies to provide intensive family reunification
27 services that combine child welfare and mental health
28 services to certain families; amending s. 409.996,
29 F.S.; authorizing the Department of Children and
30 Families and certain lead agencies to create and
31 implement a program to more effectively provide case
32 management services to specified children; providing
33 criteria for selecting judicial circuits for
34 implementation of the program; specifying requirements
35 of the program; requiring a report to the Legislature
36 and Governor under specified conditions; creating s.
37 943.17298, F.S.; requiring the Criminal Justice
38 Standards and Training Commission to incorporate
39 training for specified purposes; requiring law
40 enforcement officers to complete such training as part
41 of either basic recruit training or continuing
42 training or education by a specified date; providing
43 an effective date.
44
45 Be It Enacted by the Legislature of the State of Florida:
46
47 Section 1. <u>This act may be cited as "Jordan's Law."</u>
48 Section 2. Section 25.385, Florida Statutes, is amended to
49 read:
50 25.385 Standards for instruction of circuit and county

51 court judges ~~in handling domestic violence cases~~.—
52 (1) The Florida Court Educational Council shall establish
53 standards for instruction of circuit and county court judges who
54 have responsibility for domestic violence cases, and the council
55 shall provide such instruction on a periodic and timely basis.
56 ~~(2)~~ As used in this subsection, ~~section:~~
57 ~~(a)~~ the term "domestic violence" has the meaning set forth
58 in s. 741.28.
59 ~~(b) "Family or household member" has the meaning set forth~~
60 ~~in s. 741.28.~~
61 (2) The Florida Court Educational Council shall establish
62 standards for instruction of circuit and county court judges who
63 have responsibility for dependency cases regarding the
64 recognition of and responses to head trauma and brain injury in
65 a child under 6 years of age. The council shall provide such
66 instruction on a periodic and timely basis.
67 Section 3. Section 39.0142, Florida Statutes, is created
68 to read:
69 39.0142 Notifying law enforcement officers of parent or
70 caregiver names.—The Department of Law Enforcement shall provide
71 information to a law enforcement officer stating whether a
72 person is a parent or caregiver who is currently the subject of
73 a child protective investigation for alleged child abuse,
74 abandonment, or neglect or is a parent or caregiver of a child
75 who has been allowed to return to or remain in the home under

76 judicial supervision after an adjudication of dependency. This
77 information shall be provided via a Florida Crime Information
78 Center query into the department's child protection database.
79 (1) If a law enforcement officer has an interaction with a
80 parent or caregiver as described in this section and the
81 interaction results in the officer having concern about a
82 child's health, safety, or well-being, the officer shall report
83 relevant details of the interaction to the central abuse hotline
84 immediately after the interaction even if the requirements of s.
85 39.201, relating to a person having actual knowledge or
86 suspicion of abuse, abandonment, or neglect, are not met.
87 (2) The central abuse hotline shall provide any relevant
88 information to:
89 (a) The child protective investigator, if the parent or
90 caregiver is the subject of a child protective investigation; or
91 (b) The child's case manager and the attorney representing
92 the department, if the parent or caregiver has a child under
93 judicial supervision after an adjudication of dependency.
94 Section 4. Paragraph (b) of subsection (2) of section
95 39.8296, Florida Statutes, is amended to read:
96 39.8296 Statewide Guardian Ad Litem Office; legislative
97 findings and intent; creation; appointment of executive
98 director; duties of office.—
99 (2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a
100 Statewide Guardian Ad Litem Office within the Justice

101 Administrative Commission. The Justice Administrative Commission
102 shall provide administrative support and service to the office
103 to the extent requested by the executive director within the
104 available resources of the commission. The Statewide Guardian Ad
105 Litem Office is ~~shall~~ not ~~be~~ subject to control, supervision, or
106 direction by the Justice Administrative Commission in the
107 performance of its duties, but the employees of the office are
108 ~~shall be~~ governed by the classification plan and salary and
109 benefits plan approved by the Justice Administrative Commission.
110 (b) The Statewide Guardian Ad Litem Office shall, within
111 available resources, have oversight responsibilities for and
112 provide technical assistance to all guardian ad litem and
113 attorney ad litem programs located within the judicial circuits.
114 1. The office shall identify the resources required to
115 implement methods of collecting, reporting, and tracking
116 reliable and consistent case data.
117 2. The office shall review the current guardian ad litem
118 programs in Florida and other states.
119 3. The office, in consultation with local guardian ad
120 litem offices, shall develop statewide performance measures and
121 standards.
122 4. The office shall develop a guardian ad litem training
123 program, which shall include, but not be limited to, training on
124 the recognition of and responses to head trauma and brain injury
125 in a child under 6 years of age. The office shall establish a

126 curriculum committee to develop the training program specified
127 in this subparagraph. The curriculum committee shall include,
128 but not be limited to, dependency judges, directors of circuit
129 guardian ad litem programs, active certified guardians ad litem,
130 a mental health professional who specializes in the treatment of
131 children, a member of a child advocacy group, a representative
132 of the Florida Coalition Against Domestic Violence, and a social
133 worker experienced in working with victims and perpetrators of
134 child abuse.
135 5. The office shall review the various methods of funding
136 guardian ad litem programs, ~~shall~~ maximize the use of those
137 funding sources to the extent possible, and ~~shall~~ review the
138 kinds of services being provided by circuit guardian ad litem
139 programs.
140 6. The office shall determine the feasibility or
141 desirability of new concepts of organization, administration,
142 financing, or service delivery designed to preserve the civil
143 and constitutional rights and fulfill other needs of dependent
144 children.
145 7. In an effort to promote normalcy and establish trust
146 between a court-appointed volunteer guardian ad litem and a
147 child alleged to be abused, abandoned, or neglected under this
148 chapter, a guardian ad litem may transport a child. However, a
149 guardian ad litem volunteer may not be required or directed by
150 the program or a court to transport a child.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

151 8. The office shall submit to the Governor, the President
152 of the Senate, the Speaker of the House of Representatives, and
153 the Chief Justice of the Supreme Court an interim report
154 describing the progress of the office in meeting the goals as
155 described in this section. The office shall submit to the
156 Governor, the President of the Senate, the Speaker of the House
157 of Representatives, and the Chief Justice of the Supreme Court a
158 proposed plan including alternatives for meeting the state's
159 guardian ad litem and attorney ad litem needs. This plan may
160 include recommendations for less than the entire state, may
161 include a phase-in system, and shall include estimates of the
162 cost of each of the alternatives. Each year the office shall
163 provide a status report and provide further recommendations to
164 address the need for guardian ad litem services and related
165 issues.
166 Section 5. Subsections (2) and (4) of section 402.402,
167 Florida Statutes, are amended to read:
168 402.402 Child protection and child welfare personnel;
169 attorneys employed by the department.—
170 (2) SPECIALIZED TRAINING.—All child protective
171 investigators and child protective investigation supervisors
172 employed by the department or a sheriff's office must complete
173 the following specialized training:
174 (a) Training on the recognition of and responses to head
175 trauma and brain injury in a child under 6 years of age.

176 (b) Training that is either focused on serving a specific
177 population, including, but not limited to, medically fragile
178 children, sexually exploited children, children under 3 years of
179 age, or families with a history of domestic violence, mental
180 illness, or substance abuse, or focused on performing certain
181 aspects of child protection practice, including, but not limited
182 to, investigation techniques and analysis of family dynamics.
183
184 The specialized training may be used to fulfill continuing
185 education requirements under s. 402.40(3)(e). Individuals hired
186 before July 1, 2014, shall complete the specialized training by
187 June 30, 2016, and individuals hired on or after July 1, 2014,
188 shall complete the specialized training within 2 years after
189 hire. An individual may receive specialized training in multiple
190 areas.
191 (4) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD
192 WELFARE CASES.—Attorneys hired on or after July 1, 2014, whose
193 primary responsibility is representing the department in child
194 welfare cases shall, within the first 6 months of employment,
195 receive training in all of the following:
196 (a) The dependency court process, including the attorney's
197 role in preparing and reviewing documents prepared for
198 dependency court for accuracy and completeness.~~;~~
199 (b) Preparing and presenting child welfare cases,
200 including at least 1 week shadowing an experienced children's

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

201 legal services attorney preparing and presenting cases.~~;~~
202 (c) Safety assessment, safety decisionmaking tools, and
203 safety plans.~~;~~
204 (d) Developing information presented by investigators and
205 case managers to support decisionmaking in the best interest of
206 children.~~; and~~
207 (e) The experiences and techniques of case managers and
208 investigators, including shadowing an experienced child
209 protective investigator and an experienced case manager for at
210 least 8 hours.
211 (f) The recognition of and responses to head trauma and
212 brain injury in a child under 6 years of age.
213 Section 6. Paragraph (f) of subsection (1) and subsection
214 (3) of section 409.988, Florida Statutes, are amended to read:
215 409.988 Lead agency duties; general provisions.—
216 (1) DUTIES.—A lead agency:
217 (f) Shall ensure that all individuals providing care for
218 dependent children receive appropriate training and meet the
219 minimum employment standards established by the department.
220 Appropriate training shall include, but is not limited to,
221 training on the recognition of and responses to head trauma and
222 brain injury in a child under 6 years of age.
223 (3) SERVICES.—A lead agency must provide dependent
224 children with services that are supported by research or that
225 are recognized as best practices in the child welfare field. The

226 agency shall give priority to the use of services that are
227 evidence-based and trauma-informed and may also provide other
228 innovative services, including, but not limited to, family-
229 centered and cognitive-behavioral interventions designed to
230 mitigate out-of-home placements and intensive family
231 reunification services that combine child welfare and mental
232 health services for families with dependent children under 6
233 years of age.
234 Section 7. Subsection (24) is added to section 409.996,
235 Florida Statutes, to read:
236 409.996 Duties of the Department of Children and
237 Families.—The department shall contract for the delivery,
238 administration, or management of care for children in the child
239 protection and child welfare system. In doing so, the department
240 retains responsibility for the quality of contracted services
241 and programs and shall ensure that services are delivered in
242 accordance with applicable federal and state statutes and
243 regulations.
244 (24) The department in collaboration with the lead
245 agencies serving the judicial circuits selected in paragraph (a)
246 may create and implement a program to more effectively provide
247 case management services for dependent children under 6 years of
248 age.
249 (a) If the program is created, the department shall select
250 up to three judicial circuits in which to develop and implement

CODING: Words stricken are deletions; words underlined are additions.

251 a program under this subsection, with priority given to a
252 circuit that has a high removal rate, significant case
253 management turnover rate, and the highest numbers of children in
254 out-of-home care or a significant increase in the number of
255 children in out-of-home care over the last 3 fiscal years.
256 (b) If the program is created, it shall:
257 1. Include caseloads for dependency case managers
258 comprised solely of children who are under 6 years of age,
259 except as provided in paragraph (c). The maximum caseload for a
260 case manager shall be no more than 15 children if possible.
261 2. Include case managers who are trained specifically in:
262 a. Critical child development for children under 6 years
263 of age.
264 b. Specific practices of child care for children under 6
265 years of age.
266 c. The scope of community resources available to children
267 under 6 years of age.
268 d. Working with a parent or caregiver and assisting him or
269 her in developing the skills necessary to care for the health,
270 safety, and well-being of a child under 6 years of age.
271 (c) If a child being served through the program has a
272 dependent sibling, the sibling may be assigned to the same case
273 manager as the child being served through the program; however,
274 each sibling counts toward the case manager's maximum caseload
275 as provided under paragraph (b).

276 (d) If the program is created, the department shall
277 evaluate the permanency, safety, and well-being of children
278 being served through the program and submit a report to the
279 Governor, the President of the Senate, and the Speaker of the
280 House of Representatives by October 1, 2025, detailing its
281 findings.
282 Section 8. Section 943.17298, Florida Statutes, is created
283 to read:
284 943.17298 Training in the recognition of and responses to
285 head trauma and brain injury.—The commission shall establish
286 standards for the instruction of law enforcement officers in the
287 subject of recognition of and responses to head trauma and brain
288 injury in a child from under 6 years of age to aid an officer in
289 the detection of head trauma and brain injury due to child
290 abuse. Each law enforcement officer must successfully complete
291 the training as part of the basic recruit training for a law
292 enforcement officer, as required under s. 943.13(9), or as a
293 part of continuing training or education required under s.
294 943.135(1) before July 1, 2022.
295 Section 9. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Latvala offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 91-165 and insert:
7 39.820 Definitions.—As used in this chapter~~part~~, the term:
8 (1) "Guardian ad litem" as referred to in any civil or
9 criminal proceeding includes the following: the Statewide
10 Guardian ad Litem Office, which includes circuit~~a certified~~
11 guardian ad litem programs;~~,~~ a duly certified volunteer, a staff
12 member, a staff attorney, contract attorney, or ~~certified~~ pro
13 bono attorney working on behalf of a guardian ad litem~~ or the~~
14 ~~program; staff members of a program office~~; a court-appointed
15 attorney; or a responsible adult who is appointed by the court
16 to represent the best interests of a child in a proceeding as

17 provided for by law, including, but not limited to, this
18 chapter, who is a party to any judicial proceeding as a
19 representative of the child, and who serves until discharged by
20 the court.
21 (2) "Guardian advocate" means a person appointed by the
22 court to act on behalf of a drug dependent newborn pursuant to
23 the provisions of this part.
24 Section 6. Paragraph (b) of subsection (2) of section
25 39.8296, Florida Statutes, is amended to read:
26 39.8296 Statewide Guardian Ad Litem Office; legislative
27 findings and intent; creation; appointment of executive
28 director; duties of office.—
29 (2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a
30 Statewide Guardian Ad Litem Office within the Justice
31 Administrative Commission. The Justice Administrative Commission
32 shall provide administrative support and service to the office
33 to the extent requested by the executive director within the
34 available resources of the commission. The Statewide Guardian Ad
35 Litem Office <u>is</u> ~~shall~~ not ~~be~~ subject to control, supervision, or
36 direction by the Justice Administrative Commission in the
37 performance of its duties, but the employees of the office <u>are</u>
38 ~~shall be~~ governed by the classification plan and salary and
39 benefits plan approved by the Justice Administrative Commission.
40 (b) The Statewide Guardian Ad Litem Office shall, within
41 available resources, have oversight responsibilities for and

42 provide technical assistance to all guardian ad litem and
43 attorney ad litem programs located within the judicial circuits.
44 1. The office shall identify the resources required to
45 implement methods of collecting, reporting, and tracking
46 reliable and consistent case data.
47 2. The office shall review the current guardian ad litem
48 programs in Florida and other states.
49 3. The office, in consultation with local guardian ad litem
50 offices, shall develop statewide performance measures and
51 standards.
52 4. The office shall develop a guardian ad litem training
53 program, which shall include, but not be limited to, training on
54 the recognition of and responses to head trauma and brain injury
55 in a child under 6 years of age. The office shall establish a
56 curriculum committee to develop the training program specified
57 in this subparagraph. The curriculum committee shall include,
58 but not be limited to, dependency judges, directors of circuit
59 guardian ad litem programs, active certified guardians ad litem,
60 a mental health professional who specializes in the treatment of
61 children, a member of a child advocacy group, a representative
62 of a domestic violence advocacy group ~~the Florida Coalition~~
63 ~~Against Domestic Violence~~, and a social worker experienced in
64 working with victims and perpetrators of child abuse.
65
66

67 ---
68 **T I T L E A M E N D M E N T**
69 Remove lines 15-18 and insert:
70 Amending s. 39.820, F.S.; amending the definition of Guardian ad
71 Litem; amending s. 39.8296, F.S.; requiring that the guardian ad
72 litem training program include training on the recognition of
73 and responses to head trauma and brain injury in specified
74 children; amending members of the curriculum committee; amending
75 s. 402.402,

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 57 Dispensing Medicinal Drugs
SPONSOR(S): Willhite
TIED BILLS: **IDEN. /SIM. BILLS:**

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

SUMMARY ANALYSIS

Currently, a physician may dispense up to a 24-hour supply of a medicinal drug to a patient the physician is treating in an emergency department of a hospital that holds an appropriate institutional pharmacy permit. The physician must determine that the medicinal drug is needed and that community pharmacy services are not readily accessible to the patient. If the patient needs more than a 24-hour supply of a drug, the physician must provide the patient with a prescription for use after the initial 24-hour period.

HB 57 expands this authorization to allow all prescribers, not just physicians, to prescribe medicinal drugs under these circumstances and extends patient eligibility to include a hospital inpatient upon discharge. The bill also authorizes a hospital pharmacy to dispense the greater of a 24-hour supply of a medicinal drug or a supply of a medicinal drug that is sufficient to last a patient until the next business day. The bill corrects current statutory language to reflect that it is the hospital pharmacy that dispenses the medicinal drug, rather than the prescriber.

The bill has an insignificant, negative fiscal impact on the Department of Health, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Practice of Pharmacy

The Florida Pharmacy Act (Act) regulates Florida pharmacies and imposes minimum requirements for safe practice.[1] The Board of Pharmacy (board) within the Department of Health (DOH) is tasked with adopting rules to implement the provisions of the Act and setting standards of practice.[2]

Dispensing of Medicinal Drugs

Pharmacists, licensed under the Act, are authorized to dispense medicinal drugs[3] in this state, and authorized prescribers may dispense medicinal drugs to their patients.[4] Authorized prescribers include allopathic and osteopathic physicians, podiatrists, dentists, optometrists, advanced practice registered nurses and physician assistants.[5] A prescriber who dispenses medicinal drugs for a fee or remuneration of any kind, must:[6]

- Register with his or her professional licensing board as a dispensing practitioner and pay the fee established by the board;
- Comply with and be subject to all state and federal laws, rules, and regulations applicable to pharmacists and pharmacies;
- Give each patient a written prescription and advise the patient that the prescription may be filled in the practitioner's office or at any pharmacy, orally or in writing; and
- Verify the identity of a patient who is not known to the dispenser before dispensing a controlled substance.

Pharmacy Regulation

A person must obtain a DOH-issued permit to operate one of five types of pharmacies:

- **Community pharmacy** – Where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[7]
- **Institutional pharmacy** – Hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility locations where medicinal drugs are compounded, dispensed, stored, or sold.[8]
- **Nuclear pharmacy** – Where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold, other than hospitals.[9]
- **Special pharmacy** - Locations where medicinal drugs are compounded, dispensed, stored, or sold if that do not otherwise meet an applicable pharmacy definition in s. 465.003, F.S.[10]

---

[1] Chapter 465, F.S.
[2] Sections 465.005, 465.0155(1), and 465.022, F.S.
[3] A medicinal drug is a substance or preparation commonly known as a prescription or legend drug, which by federal or state law may only be dispensed pursuant to a prescription. *See* s. 465.003(8), F.S.
[4] Section 465.0276, F.S.
[5] For limitations on an optometrist's authority to prescribe or dispense a medicinal drug, see s. 463.0055, F.S.; for an advanced practice registered nurse's limitations, see s. 464.012 ; and for a physician assistant's limitations, see ss. 458.347(4)(e) or 459.022(4)(e), F.S.
[6] *Supra* note 4.
[7] Sections 465.003(11)(a)1. and 465.018, F.S.
[8] Sections 465.003(11)(a)2. and 465.019, F.S.
[9] Sections 465.003(11)(a)3. and 465.0193, F.S.
[10] Sections 465.003(11)(a)4. and 465.0196, F.S.

- **Internet pharmacy** – Locations not otherwise licensed or issued a pharmacy permit within or outside this state, which use the Internet to communicate with or obtain information from consumers in this state to fill or refill prescriptions or to dispense, distribute, or otherwise practice pharmacy in this state.[11]

All permitted pharmacies must pass an on-site inspection before DOH will issue an initial permit and any time a pharmacy changes its ownership or address.[12]

Institutional Pharmacies

All institutional pharmacies must designate a consultant pharmacist of record.[13] The consultant pharmacist's responsibilities include:[14]

- Maintaining all drug records required by law;
- Establishing drug handling procedures for the safe handling and storage of drugs;
- Ordering and evaluating laboratory and clinical testing when necessary for the proper performance of the consultant pharmacist's responsibilities;[15]
- Conducting drug regimen reviews as required by state or federal law; and
- Inspecting the facility and preparing a written report to be filed at the permitted facility monthly.

There are four types of institutional pharmacy permits issued by the board to institutional pharmacies:[16]

- Class I Institutional permits are issued to institutional pharmacies in which all medicinal drugs are administered from individual prescription containers to individual patients; and in which medicinal drugs are not dispensed on the premises, except licensed nursing homes[17] may purchase medical oxygen for administration to residents.
- Class II Institutional permits are issued to institutional pharmacies that employs a registered pharmacist who dispenses to and consults with patients on the premises of the institution and for use on the premises of the institution.
- Modified Class II Institutional permits are issued to institutional pharmacies in a short-term, primary care treatment center that meet all the requirements for a Class II permit, except space and equipment requirements.
- Class III Institutional permits are issued to institutional pharmacies, including central distribution facilities, affiliated with a hospital that provide the same services that are authorized by a Class II institutional pharmacy permit. Additionally, an Class III Institutional pharmacy may:

    - Dispense, distribute, compound, and fill prescriptions for medicinal drugs;
    - Prepare prepackaged drug products;
    - Conduct other pharmaceutical services for the affiliated hospital and for entities under common control that are appropriately permitted;
    - Provide the above-listed services to an entity under common control which holds an active health care clinic establishment permit.[18]

---

[11] Sections 465.003(11)(a)5. and 465.0197, F.S.
[12] Rule 64B16-28(1)(d), F.A.C.
[13] Section 465.019(5), F.S., and r. 64B16-28.501, F.A.C.
[14] Section 465.0125, F.S., and r. 64B16-28.501, F.A.C.
[15] A consultant pharmacist may only order these tests for patients residing in a nursing home facility and when authorized by the nursing home facility's medical director. The consultant pharmacist must complete additional training and meet additional qualifications in the practice of institutional pharmacy, as required by the board.
[16] Section 465.019, F.S.
[17] Nursing homes are licensed under part II, ch. 400, F.S.
[18] A health care clinic establishment permit is required for the purchase of a prescription drug by a place of business at one general physical location that provides health care or veterinary services, which is owned or operated by a business entity. *See* s. 499.01(2)(r), F.S.

Class III Institutional pharmacies must also maintain policies and procedures which address:[19]

- Safe practices for the preparation, dispensing, prepackaging, distribution, and transportation of medicinal drugs and prepackaged drug products;
- Recordkeeping to monitor the movement, distribution, and transportation of medicinal drugs and prepackaged drug products;
- Recordkeeping of pharmacy staff responsible for each step in the preparation, dispensing, prepackaging, transportation, and distribution of medicinal drugs and prepackaged drug products; and
- Medicinal drugs and prepackaged drug products that may not be safely distributed among Class III institutional pharmacies.

Dispensing by Institutional Pharmacies

An institutional pharmacy must hold a community pharmacy permit to dispense medicinal drugs to outpatients.[20] However, an authorized prescriber may dispense up to a 24-hour supply of a medicinal drug to any patient of an emergency department of a hospital that operates a Class II or Class III institutional pharmacy, provided that the treating practitioner determines that the medicinal drug is warranted and community pharmacy services are not readily accessible.[21] If the patient needs more than a 24-hour supply of a medicinal drug, the treating practitioner must dispense a 24-hour supply of the medicinal drug and provide the patient with a prescription for use after the initial 24-hour period.[22] Such dispensing must be in accordance with the hospital's procedures.

For any drug dispensed from the emergency department of a hospital, the prescriber must create, and the consultant pharmacist of record must maintain, a patient record which includes the following:[23]

- Patient name and address;
- Drug and strength of the prescribed and/or dispensed;
- Quantity prescribed and/or dispensed;
- Directions for use;
- Prescriber/Dispenser;
- Prescriber's Drug Enforcement Administration (DEA) registration, if applicable; and
- Reason community pharmacy services were not readily accessible.

Any dispensed medications must be properly labeled and may not exceed the greater of a 24-hour supply or the minimal dispensable quantity.[24]

Effect of Proposed Changes

HB 57 expands the authorization to prescribe and dispense medicinal drugs in hospital settings. It allows all prescribers, not just physicians, to prescribe, and allows hospital pharmacies to dispense, a limited supply of medicinal drugs when community pharmacy services are unavailable.

The bill authorizes a hospital pharmacy to dispense the greater of a 24-hour supply of a medicinal drug or a supply of a medicinal drug that is sufficient to last a patient of the hospital's emergency department until the next business day. The bill also authorizes a hospital inpatient, upon discharge, to receive this limited supply of a medicinal drug if community pharmacy services are not available. The bill corrects

---

[19] Section 465.019(1)(d), F.S.
[20] Section 465.019(4), F.S.
[21] Id.
[22] Id.
[23] Rule 64B16-28.6021, F.A.C.
[24] Id.

current statutory language to reflect that it is the hospital pharmacy that dispenses the medicinal drug, rather than the prescriber.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 465.019, F.S., relating to institutional pharmacies; permits.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will incur insignificant, nonrecurring costs associated with amending adopted rules, 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:

The bill may reduce costs that may be incurred by patients who have difficulty accessing a community pharmacy after visiting an emergency department of a hospital or being discharged from inpatient care at a hospital from returning to the emergency department or hospital to obtain additional relief.

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 sufficient rulemaking authority under s. 465.005, F.S., to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to dispensing medicinal drugs;
3 amending s. 465.019, F.S.; authorizing certain
4 individuals to prescribe and dispense a limited supply
5 of medicinal drugs to a patient of an emergency
6 department of a hospital or a patient discharged from
7 a hospital under certain circumstances; providing an
8 effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Subsection (4) of section 465.019, Florida
13 Statutes, is amended to read:
14 465.019 Institutional pharmacies; permits.—
15 (4) Medicinal drugs shall be dispensed in an institutional
16 pharmacy to outpatients only when that institution has secured a
17 community pharmacy permit from the department. However, ~~an~~
18 ~~individual licensed to prescribe~~ medicinal drugs ~~in this state~~
19 may be dispensed by ~~dispense up to a 24-hour supply of a~~
20 ~~medicinal drug to any patient of an emergency department of~~ a
21 hospital that operates a Class II or Class III institutional
22 pharmacy to a patient of the hospital's emergency department or
23 a hospital inpatient upon discharge, if the prescriber ~~provided~~
24 ~~that the physician~~ treating the patient in such hospital
25 ~~hospital's emergency department~~ determines that the medicinal

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26 drug is warranted and that community pharmacy services are not
27 readily accessible, geographically or otherwise, to the patient.
28 Such prescribing and dispensing ~~from the emergency department~~
29 must be for the greater of ~~in accordance with the procedures of~~
30 ~~the hospital. For any such patient for whom a medicinal drug is~~
31 ~~warranted for a period to exceed 24 hours, an individual~~
32 ~~licensed to prescribe such drug must dispense~~ a 24-hour supply
33 of such drug or a supply of such drug which must last until the
34 next business day ~~to the patient~~ and the prescriber must provide
35 the patient with a prescription for such drug for use after such
36 ~~the~~ initial ~~24-hour~~ period. The board may adopt rules necessary
37 to carry out the provisions of this subsection.
38 Section 2. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Willhite offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Subsection (4) of section 465.019, Florida
8 Statutes, is amended to read:
9 465.019 Institutional pharmacies; permits.—
10 (4)(a) Medicinal drugs shall be dispensed in an
11 institutional pharmacy to outpatients only when that institution
12 has secured a community pharmacy permit from the department.
13 However, ~~an individual licensed to prescribe~~ medicinal drugs ~~in~~
14 ~~this state~~ may be dispensed by ~~dispense up to a 24-hour supply~~
15 ~~of a medicinal drug to any patient of an emergency department of~~
16 a hospital that operates a Class II or Class III institutional

17 pharmacy to a patient of the hospital's emergency department or
18 a hospital inpatient upon discharge, if the prescriber ~~provided~~
19 ~~that the physician~~ treating the patient in such hospital
20 ~~hospital's emergency department~~ determines that the medicinal
21 drug is warranted and that community pharmacy services are not
22 readily accessible, geographically or otherwise, to the patient.
23 Such prescribing and dispensing must be for a supply of the drug
24 that will last the greater of the following:
25 1. Up to 48 hours; or
26 2. Through the end of the next business day.
27 (b) Notwithstanding subparagraph (a)1., if a state of
28 emergency has been declared and is in effect for an area of the
29 state pursuant to s. 252.36, a supply of a medicinal drug that
30 will last up to 72 hours may be prescribed and dispensed under
31 paragraph (a) in that area. ~~from the emergency department must~~
32 ~~be in accordance with the procedures of the hospital. For any~~
33 ~~such patient for whom a medicinal drug is warranted for a period~~
34 ~~to exceed 24 hours, an individual licensed to prescribe such~~
35 ~~drug must dispense a 24-hour supply of such drug to the patient~~
36 ~~and must provide the patient with a prescription for such drug~~
37 ~~for use after the initial 24-hour period.~~
38 (c) A prescriber who prescribes medicinal drugs under this
39 subsection may provide the patient with a prescription for such
40 drug for use beyond the initial prescription period if the
41 prescriber determines that such use is warranted. Any

42 prescribing or dispensing of a controlled substance under this
43 subsection must comply with the applicable requirements of ss.
44 456.44 and 465.0276.
45 (d) The board may adopt rules ~~necessary~~ to implement ~~carry~~
46 ~~out the provisions of~~ this subsection.
47 Section 2. This act shall take effect July 1, 2020.
48
49 ---
50 **T I T L E A M E N D M E N T**
51 Remove lines 4-7 and insert:
52 hospitals to dispense a limited supply of medicinal drugs to a
53 patient of an emergency department of a hospital or a patient
54 discharged from a hospital under certain circumstances;
55 providing parameters for such prescribing and dispensing in
56 areas in which a state of emergency has been declared and is in
57 effect; authorizing prescriptions for such drugs to be issued to
58 such patients beyond the initial prescription period under
59 certain circumstances; requiring such prescribing and dispensing
60 to comply with certain statutory requirements; providing an

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 599 Consultant Pharmacists
SPONSOR(S): Health Quality Subcommittee, Rodriguez, A. M.
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	14 Y, 0 N, As CS	Siples	McElroy
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

A consultant pharmacist obtains specialized education above that which is required for licensure as a pharmacist and has a broader scope of practice. A consultant pharmacist may order and evaluate clinical and laboratory testing in addition to the services provided by a pharmacist in two situations: for a patient residing in a nursing home upon authorization by the medical director of the nursing home; and for individuals under the care of a licensed home health agency, if authorized by a licensed physician, podiatrist, or dentist.

HB 599 expands the consultant pharmacist's scope of practice by authorizing a consultant pharmacist to enter into a collaborative practice agreement to provide medication management services with a health care facility medical director or Florida-licensed allopathic physician, osteopathic physician, podiatric physician, or dentist to:

- Order and evaluate laboratory and clinical testing;
- Conduct patient assessments;
- Administer medications; and
- Modify or discontinue medicinal drugs pursuant to a patient-specific order or treatment protocol; however, a consultant pharmacist may not modify or discontinue a medicinal drug if he or she does not have a collaborative practice agreement with the prescribing health care practitioner.

The bill authorizes a consultant pharmacist to provide these services in any setting, rather than limiting such services to nursing home or home health patients. The bill also authorizes a pharmacist to make recommendations regarding the patient's health care status with the patient's prescribing health care practitioner or others specifically authorized by the patient. The bill clarifies that a consultant pharmacist is not authorized to diagnose any disease or condition.

The bill requires both the consultant pharmacist and health care practitioner to maintain a copy of the collaborative agreement and make it available upon request or during an inspection. The bill also requires the consultant pharmacist to maintain all drug, patient care, and quality assurance records.

The bill authorizes the Board of Pharmacy to establish additional education requirements for licensure as a consultant pharmacist.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

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, 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;
- Administering vaccines to adults;[9]
- Administering epinephrine injections;[10] and

---

[1] American Association of Colleges of Pharmacy, *About AACP*, available at https://www.aacp.org/about-aacp (last visited December 16, 2019).
[2] Sections 465.004 and 465.005, F.S.
[3] Section 465.007, F.S. DOH may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[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] *See* s. 465.189, F.S.
[10] Id.

- Administering antipsychotic medications by injection.[11]

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.[12]

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.[13] The formulary may only include:[14]

- Any medicinal drug 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;
- Any medicinal drug 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;
- Any medicinal drug containing any antihistamine or decongestant as a single active ingredient or in combination;
- Any medicinal drug containing fluoride in any strength;
- Any medicinal drug containing lindane in any strength;
- Any over-the-counter proprietary drug under federal law that has been approved for reimbursement by the Florida Medicaid Program; and
- Any 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:[15]

- 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 otic analgesics. Antipyrine 5.4%, benzocaine 1.4%, glycerin, if clinical signs or symptoms of tympanic membrane perforation do not exist.
- Anti-nausea preparations.
- Certain antihistamines and decongestants.
- Certain topical antifungal/antibacterials.
- Topical anti-inflammatory. Preparations containing hydrocortisone not exceeding 2.5%.
- Otic antifungal/antibacterial.
- Salicylic acid 16.7% and lactic acid 16.7% in flexible collodion, to be applied to warts, except for patients under two (2) years of age, and those with diabetes or impaired circulation.
- 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.
- Ophthalmics. Naphazoline 0.1% ophthalmic solution.
- Certain histamine H2 antagonists:
- Acne products.
- Topical Antiviral for herpes simplex infections of the lips.

---

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

Consultant Pharmacists

A consultant pharmacist is a pharmacist who provides expert advice on the use of medications to individuals or older adults, wherever they live.[16] To be licensed as a consultant pharmacist, an applicant must:[17]

- Hold a license as a pharmacist that is active and in good standing;
- Successfully complete an approved consultant pharmacist course of at least 12 hours;[18] and
- Successfully complete a 40-hour period of assessment and evaluation under the supervision of a preceptor within one year of completion of an approved consultant pharmacist course.

Education and Training Requirements for Consultant Pharmacists

In addition to the training and education received as a part of a degree program in pharmacy, a consultant pharmacist is required to complete a consultant pharmacy course and a period of assessment and evaluation under the supervision of a preceptor. The Board has general rulemaking authority to adopt rules to implement the pharmacy practice act and specific authority to adopt rules related to the licensure of consultant pharmacists.[19] The Board does not have specific authority to adopt rules related to the educational requirements for consultant pharmacists. Regardless, the Board has, by rule, established the minimum educational and training requirements for licensure as a consultant.[20]

The Board has specified the topics on which a consultant pharmacist must be trained in order to qualify for the designation. The consultant pharmacy course must provide at least 12 hours of education in the following areas:[21]

- Jurisprudence; including state and federal laws and regulations pertaining to health care facilities, institutional pharmacy, safe and controlled storage of alcohol and other related substances, and fire and health-hazard control;
- Policies and procedures outlining the medication system in effect and record-keeping for controlled substances control and record of usage, medication use evaluation, medication errors, statistical reports, etc.;
- Fiscal controls;
- Personnel management, including intra-professional relations pertaining to medication use and intra-professional relations with other members of the institutional health care team to develop formularies, review medication use and prescribing, and the provision of in-service training of other members of the institutional health care team;
- Professional responsibilities, including:
    - Drug information retrieval and methods of dispersal;
    - Development of pharmacy practice;
    - Development of an IV Admixture service;
    - Procedures to enhance medication safety, including availability of equipment and techniques to prepare special dosage forms for pediatric and geriatric patients, safety of patient self-medication and control of drugs at bedside, reporting and trending adverse drug reactions, screening for potential drug interactions, and proper writing, initiating, transcribing and/or transferring patient medication orders;

[16] American Society of Consultant Pharmacists, *What is a Senior Care Pharmacist,* available at http://www.ascp.com/page/whatisacp (last visited March 8, 2019). Consultant pharmacists are often referred to as "senior care pharmacist."
[17] Rule 64B16-26.300(3), F.A.C.
[18] Id. The course must be sponsored by an accredited college of pharmacy and approved by the Florida Board of Pharmacy Tripartite Continuing Education Committee which is based on the Statement of the Competencies Required in Institutional Pharmacy Practice and subject matter set forth in Rule 64B16-26.301, F.A.C.
[19] Section 465.005, F.S.
[20] Rule 64B16-26.300, F.A.C.
[21] Rules 64B16-26.300 and 64B16-26.301, F.A.C.

- Maintenance of drug quality and safe storage; and
- Maintenance of drug identity;

- The institutional environment, including the institution's pharmacy function and purpose, understanding the scope of service and in-patient care mission of the institution, and interpersonal relationships important to the institutional pharmacy; and
- Nuclear pharmacy, including procurement, compounding, quality control procedures, dispensing, distribution, basic radiation protection and practices, consultation and education to the nuclear medical community, record-keeping, reporting adverse reactions and medical errors, and screening for potential drug interactions.

The applicant must score a passing grade on the course examination for certification of successful completion.[22]

A consultant pharmacist must successfully complete a period of assessment and evaluation, under the supervision of a qualified preceptor, within one year of completing the consultant pharmacy educational course.[23] The period of assessment and evaluation must be completed within three consecutive months and include at least 40 hours of training in the following practice areas:[24]

- 24 hours on regimen review, documentation, and communication;
- 8 hours on facility review, including the ability to demonstrate areas that should be evaluated, documentation, and reporting procedures;
- 2 hours on committee and reports, including the review of quarterly Quality of Care committee minutes and preparation and delivery of the pharmacist quarterly report;
- 2 hours on policy and procedures, including preparation, review, and updating Policy and Methods;
- 2 hours on principles of formulary management; and
- 2 hours on professional relationships, including knowledge and interaction of facility administration and professional staff.

At least 60 percent of this training must occur on-site at an institution that holds a pharmacy license.[25]

Scope of Practice

The scope of practice for a consultant pharmacist is broader than that of a pharmacist. 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.[26] 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.[27]

Pharmacist Collaborative Practice Agreements

A collaborative practice agreement (CPA) is a formal agreement in which a licensed practitioner makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows

---

[22] Id.
[23] Rule 64B16-26.300(3)(c), F.A.C.
[24] Id. To act as a preceptor, a person must be a consultant of record at an institutional pharmacy, have a minimum of one year experience as a consultant pharmacist of record, and be licensed, in good standing, with the board. A preceptor may not supervise more than two applicants at the same time.
[25] Id.
[26] Section 465.0125(1), F.S.
[27] 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.

the pharmacist to perform specific patient care functions.[28] A CPA specifies what functions beyond the pharmacist's typical scope of practice can be delegated to the pharmacist by the collaborating health care practitioner.[29] Common tasks include initiating, modifying, or discontinuing medication therapy and ordering and evaluating tests.[30]

Forty-eight states, including Florida, permit some type of collaborative practice between a pharmacist and a prescriber.[31] However, the laws and regulations of these states vary in areas such as the functions that may be authorized, the requirements for collaborative agreements, and the qualifications for participants.[32]

Effect of Proposed Changes

Consultant Pharmacists

HB 599 authorizes a consultant pharmacist to enter into a collaborative practice agreement with a health care facility[33] medical director or a Florida-licensed allopathic physician, osteopathic physician, podiatric physician, or dentist, who is authorized to prescribe medication, to provide medication management services, which may include:

- Ordering and evaluating laboratory and clinical tests[34] to monitor medication therapy and treatment outcomes, as well as promote and evaluate patient health and wellness;
- Conducting patient assessments to evaluate and monitor drug therapy;
- Modifying or discontinuing medications as outlined in a patient-specific order or pre-approved treatment protocol; and
- Administering medication.

The bill prohibits a consultant pharmacist from modifying or discontinuing a medication if the consultant pharmacist does not have a collaborative practice agreement with the prescribing practitioner. The bill also clarifies that a consultant pharmacist is not authorized to diagnose any disease or condition.

The bill eliminates the restriction on the setting in which a consultant pharmacist's services may be offered that is in current law, and allows such services to be provided in any setting. The consultant pharmacist and the collaborating health care practitioner must maintain the collaborative practice agreement, which must be available upon request or during an inspection. The consultant pharmacist must maintain all drug, patient care, and quality assurance records as required by law.

The Board previously established, by rule, the additional training required for licensure as a consultant pharmacist under its general rulemaking authority.[35] The bill gives the Board express authority to establish additional education requirements for licensure as a consultant pharmacist.

---

[28] U.S. Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention, *Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Pharmacists*, (2013), available at https://www.cdc.gov/dhdsp/pubs/docs/translational_tools_pharmacists.pdf (last visited December 16, 2019)
[29] U.S. Center for Disease Control and Prevention, *Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team*, (2017), available at https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf (last visited March 8, 2019).
[30] *Supra* note 28.
[31] Krystalyn K. Weaver, *Collaborative Practice Agreements: Explaining the Basics*, PHARMACY TODAY, March 2018, at 55, available at https://www.pharmacytoday.org/article/S1042-0991(18)30260-3/fulltext (last visited December 16, 2019).
[32] Id.
[33] The bill defines a health care facility as an ambulatory surgery center licensed under ch. 395, F.S., an inpatient hospice licensed under part IV of ch. 400, F.S., a hospital licensed under ch. 395, F.S., an alcohol or chemical dependency center licensed under ch. 397, F.S., an ambulatory care center as defined in s. 408.07, F.S., or a nursing home component under ch. 400, F.S., within a continuing care facility licensed under ch. 651, F.S.
[34] Under current law, a consultant pharmacist may only order and evaluate laboratory and clinical tests for patients residing in a nursing home or who are under the care of a home health agency.
[35] *Supra* note 21.

The bill revises the definition of “practice of pharmacy” to authorize a pharmacist to consult with a prescribing health care practitioner or others specifically authorized by the patient on a patient’s health care status; and to authorize consultant pharmacists to:

- Order and evaluate any laboratory or clinical testing;
- Conduct patient assessments; and
- Modify or discontinue, or administer medication.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 465.003, F.S., regarding definitions.
Section 2: Amends s. 465.0125, F.S., regarding consultant pharmacist license; application, renewal, fees; responsibilities; rules.
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. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Board of Pharmacy has sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 21, 2020, the Health Quality Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment removed implementing medicinal drugs from the services a consultant pharmacist may perform.

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

1 A bill to be entitled
2 An act relating to consultant pharmacists; amending s.
3 465.003, F.S.; revising the definition of the term
4 "practice of the profession of pharmacy"; amending s.
5 465.0125, F.S.; requiring a pharmacist to complete
6 additional training to be licensed as a consultant
7 pharmacist; authorizing a consultant pharmacist to
8 perform specified services under certain conditions;
9 prohibiting a consultant pharmacist from modifying or
10 discontinuing medicinal drugs prescribed by a health
11 care practitioner under certain conditions; revising
12 the responsibilities of a consultant pharmacist;
13 requiring a consultant pharmacist and a collaborating
14 practitioner to maintain collaborative practice
15 agreements; requiring collaborative practice
16 agreements to be made available upon request from or
17 upon inspection by the Department of Health;
18 prohibiting a consultant pharmacist from diagnosing
19 any disease or condition; defining the term "health
20 care facility"; providing an effective date.
21
22 Be It Enacted by the Legislature of the State of Florida:
23
24 Section 1. Subsection (13) of section 465.003, Florida
25 Statutes, is amended to read:

26 465.003 Definitions.—As used in this chapter, the term:
27 (13) "Practice of the profession of pharmacy" includes
28 compounding, dispensing, and consulting concerning contents,
29 therapeutic values, and uses of any medicinal drug; consulting
30 concerning therapeutic values and interactions of patent or
31 proprietary preparations, whether pursuant to prescriptions or
32 in the absence and entirely independent of such prescriptions or
33 orders; and conducting other pharmaceutical services. For
34 purposes of this subsection, <u>the term</u> "other pharmaceutical
35 services" means ~~the~~ monitoring ~~of~~ the patient's drug therapy and
36 assisting the patient in the management of his or her drug
37 therapy, and includes <u>reviewing, and making recommendations</u>
38 <u>regarding,</u> ~~review of~~ the patient's drug therapy and <u>health care</u>
39 <u>status in</u> communication with the patient's prescribing health
40 care provider as licensed under chapter 458, chapter 459,
41 chapter 461, or chapter 466, or <u>a</u> similar statutory provision in
42 another jurisdiction, or such provider's agent or such other
43 persons as specifically authorized by the patient~~, regarding the~~
44 ~~drug therapy~~. However, ~~nothing in~~ this subsection may <u>not</u> be
45 interpreted to permit an alteration of a prescriber's
46 directions, the diagnosis or treatment of any disease, the
47 initiation of any drug therapy, the practice of medicine, or the
48 practice of osteopathic medicine, unless otherwise permitted by
49 law. <u>The term</u> "practice of the profession of pharmacy" also
50 includes any other act, service, operation, research, or

51 transaction incidental to, or forming a part of, any of the
52 foregoing acts, requiring, involving, or employing the science
53 or art of any branch of the pharmaceutical profession, study, or
54 training, and shall expressly permit a pharmacist to transmit
55 information from persons authorized to prescribe medicinal drugs
56 to their patients. The practice of the profession of pharmacy
57 also includes the administration of vaccines to adults pursuant
58 to s. 465.189 and the preparation of prepackaged drug products
59 in facilities holding Class III institutional pharmacy permits.
60 The term also includes the ordering and evaluating of any
61 laboratory or clinical testing; conducting patient assessments;
62 and modifying, discontinuing, or administering medicinal drugs
63 pursuant to s. 465.0125.
64 Section 2. Section 465.0125, Florida Statutes, is amended
65 to read:
66 465.0125 Consultant pharmacist license; application,
67 renewal, fees; responsibilities; rules.—
68 (1) The department shall issue or renew a consultant
69 pharmacist license upon receipt of an initial or renewal
70 application that ~~which~~ conforms to the requirements for
71 consultant pharmacist initial licensure or renewal as adopted
72 ~~promulgated~~ by the board by rule and a fee set by the board not
73 to exceed $250. To be licensed as a consultant pharmacist, a
74 pharmacist must complete additional training as required by the
75 board.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

76 (a) A consultant pharmacist may provide medication
77 management services within the framework of a collaborative
78 practice agreement between the pharmacist and a health care
79 facility medical director or a physician licensed under chapter
80 458 or chapter 459, a podiatric physician licensed under chapter
81 461, or a dentist licensed under chapter 466 who is authorized
82 to prescribe medicinal drugs.
83 (b) A collaborative practice agreement must outline the
84 circumstances under which the consultant pharmacist may:
85 1. Order and evaluate any laboratory or clinical tests to
86 promote and evaluate patient health and wellness, and monitor
87 drug therapy and treatment outcomes.
88 2. Conduct patient assessments as appropriate to evaluate
89 and monitor drug therapy.
90 3. Modify or discontinue medicinal drugs as outlined in
91 the agreed upon patient-specific order or preapproved treatment
92 protocol under the direction of a physician. However, a
93 consultant pharmacist may not modify or discontinue medicinal
94 drugs prescribed by a health care practitioner who does not have
95 a collaborative practice agreement with the consultant
96 pharmacist.
97 4. Administer medicinal drugs.
98 (c) A ~~The~~ consultant pharmacist shall maintain ~~be~~
99 ~~responsible for maintaining~~ all drug, patient care, and quality
100 assurance records as required by law and, with the collaborating

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

101 practitioner, shall maintain collaborative practice agreements
102 that must be available upon request from or upon inspection by
103 the department.
104 (d) This subsection does not authorize a consultant
105 pharmacist to diagnose any disease or condition.
106 (e) For purposes of this subsection, the term "health care
107 facility" means an ambulatory surgical center or hospital
108 licensed under chapter 395, an alcohol or chemical dependency
109 treatment center licensed under chapter 397, an inpatient
110 hospice licensed under part IV of chapter 400, a nursing home
111 licensed under part II of chapter 400, an ambulatory care center
112 as defined in s. 408.07, or a nursing home component under
113 chapter 400 within a continuing care facility licensed under
114 chapter 651 ~~for establishing drug handling procedures for the~~
115 ~~safe handling and storage of drugs. The consultant pharmacist~~
116 ~~may also be responsible for ordering and evaluating any~~
117 ~~laboratory or clinical testing when, in the judgment of the~~
118 ~~consultant pharmacist, such activity is necessary for the proper~~
119 ~~performance of the consultant pharmacist's responsibilities.~~
120 ~~Such laboratory or clinical testing may be ordered only with~~
121 ~~regard to patients residing in a nursing home facility, and then~~
122 ~~only when authorized by the medical director of the nursing home~~
123 ~~facility. The consultant pharmacist must have completed such~~
124 ~~additional training and demonstrate such additional~~
125 ~~qualifications in the practice of institutional pharmacy as~~

126 ~~shall be required by the board in addition to licensure as a~~
127 ~~registered pharmacist~~.
128 (2) Notwithstanding ~~the provisions of~~ subsection (1), a
129 consultant pharmacist or a doctor of pharmacy licensed in this
130 state may also be responsible for ordering and evaluating any
131 laboratory or clinical testing for persons under the care of a
132 licensed home health agency when, in the judgment of the
133 consultant pharmacist or doctor of pharmacy, such activity is
134 necessary for the proper performance of his or her
135 responsibilities and only when authorized by a practitioner
136 licensed under chapter 458, chapter 459, chapter 461, or chapter
137 466. In order for the consultant pharmacist or doctor of
138 pharmacy to qualify and accept this authority, he or she must
139 receive 3 hours of continuing education relating to laboratory
140 and clinical testing as established by the board.
141 (3) The board shall adopt ~~promulgate~~ rules necessary to
142 implement and administer this section.
143 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	______	

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Rodriguez, A. M. offered the following:
4
5 **Amendment**
6 Remove lines 63-82 and insert:
7 pursuant to s. 465.0125 by a consultant pharmacist.
8 Section 2. Section 465.0125, Florida Statutes, is amended
9 to read:
10 465.0125 Consultant pharmacist license; application,
11 renewal, fees; responsibilities; rules.—
12 (1) The department shall issue or renew a consultant
13 pharmacist license upon receipt of an initial or renewal
14 application that ~~which~~ conforms to the requirements for
15 consultant pharmacist initial licensure or renewal as adopted
16 ~~promulgated~~ by the board by rule and a fee set by the board not

17 to exceed $250. To be licensed as a consultant pharmacist, a
18 pharmacist must complete additional training as required by the
19 board.
20 (a) A consultant pharmacist may provide medication
21 management services in a health care facility within the
22 framework of a written collaborative practice agreement between
23 the pharmacist and a health care facility medical director or a
24 physician licensed under chapter 458 or chapter 459, a podiatric
25 physician licensed under chapter 461, or a dentist licensed
26 under chapter 466 who is authorized to prescribe medicinal
27 drugs. A consultant pharmacist may only provide medication
28 management services, patient assessments, and order and evaluate
29 laboratory or clinical testing for patients of the health care
30 practitioner with whom the consultant pharmacist has a written
31 collaborative practice agreement.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 707 Legislative Review of Occupational Regulations
SPONSOR(S): Renner
TIED BILLS: **IDEN./SIM. BILLS:** SB 1124

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Commerce Committee	22 Y, 1 N	Wright	Hamon
2) Health & Human Services Committee		Siples	Calamas
3) Appropriations Committee			

SUMMARY ANALYSIS

An occupational or professional license is a form of regulation that requires individuals who want to perform certain types of work to obtain permission from the government before performing such work. These individuals must demonstrate that they have the designated knowledge, skills, and abilities to perform the work in order to obtain the license. In Florida, such licenses are granted and regulated by state agencies and entities through various occupational regulatory programs.

A sunset review is a provision within a statute or regulation requiring the statute or regulation to expire or cease to be effective on a certain date, unless the legislature takes action to renew the statue or regulation. A sunset review allows regulations to be periodically examined to determine if they are necessary or if the need to be changed, improved, or reduced.

The bill schedules the repeal of specified professions over four years, beginning July 1, 2021, and ending July 1, 2024. The bill relates to over one-hundred professions and occupations.

The bill establishes that it is the intent of the legislature to complete a systematic review of the costs and benefits of certain occupational regulatory programs prior to the date set for repeal to determine whether the program should be allowed to expire, be fully renewed, or be renewed with modifications.

The bill has no fiscal impact on local governments and an indeterminate fiscal impact on state government.

The bill will be effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Occupational Licensing

An occupational or professional license is a form of regulation that requires individuals who want to perform certain types of work, such as contractors and cosmetologists, to obtain permission from the government to perform the work.[1] Generally, an individual obtains such permission by demonstrating that they have the designated knowledge, skills, and abilities to perform the work by meeting pre-determined criteria established by the government, such as work experience and examinations. If the individual successfully completes the pre-determined criteria, the government issues the individual a license, which allows them to perform the work.[2]

In the 1950s, less than five percent of U.S. workers were required to have an occupational license to do their jobs. Since then, the number of workers required to have a license has risen to more than one-quarter of U.S. workers.[3]

In 2015, The White House published a report on the current state of occupational licensing in the nation. The report found that when designed and implemented carefully, requiring occupational licenses offers important health and safety protections to consumers, as well as benefits to workers. However, the report also found that too often licensing requirements are inconsistent, inefficient, arbitrary, and there is evidence that the current licensing regimes in the U.S. raise the price of goods and services, restrict employment opportunities, and make it more difficult for workers to take their skills across state lines.[4]

Occupational Licensing in Florida

An estimated 28.7 percent of the workforce in Florida has an occupational license from the state.[5] Various governmental entities and agencies in Florida license and regulate such individuals practicing in a wide range of professions, including:[6]

- Department of Business and Professional Regulation (DBPR),
- Department of Health (DOH),
- Department of Financial Services (DFS),
- Department of Agriculture and Consumer Services (DACS),
- Florida Supreme Court (FSC),
- Department of Environmental Protection (DEP),
- Agency for Healthcare Administration (AHCA),
- Department of Children and Families (DCF),
- Department of Elder Affairs (DEA),
- Department of Highway Safety and Motor Vehicles (DHSMV), and
- Office of Financial Regulation (OFR).

---

[1] The White House, *Occupational Licensing: A Framework for Policymakers*, 6 (July 2015) https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf (last visited on Dec. 30, 2019).
[2] Bureau of Labor Statistics, *Frequently asked questions about data on certifications and licenses*, https://www.bls.gov/cps/certifications-and-licenses-faqs.htm, (last visited on Dec. 30, 2019).
[3] White House, *supra* note 1, at 3.
[4] *Id.* at 3-5.
[5] *Id.* at 24.
[6] Chs. 20, 25, F.S.

Sunset Reviews of Occupations and Professions

A sunset review is a clause within a statute or regulation requiring the statute or regulation to expire on a certain date unless the legislature takes action to renew the statute or regulation. A sunset review allows regulations to be periodically examined to determine if they are necessary or if the need to be changed, improved, or reduced. Sunset reviews can be useful, because even if a regulation was justified when first introduced, technological and economic advancements may have made the regulation unnecessary or overly burdensome.[7] Thirty-six states have some form of sunset process for existing occupational licensing laws, ranging from automatic program reviews and repeals, to sunset recommendations made from a commission to the state legislature.[8]

Sunset Reviews of Occupations and Professions in Florida

In 1976, the Florida Legislature enacted The Regulatory Reform Act. The Act set up a sunset review process which called for a systematic, cyclical review and repeal of statutes related to the regulatory functions of the executive branch, including statutes regulating professions, occupations, businesses, and industries.[9] In 1978, The Sundown Act was enacted as a supplement to the sunset review law to set up a review for boards of trustees, commissions, and advisory bodies which were connected to executive agency functions.[10]

The law required certain committees within the Legislature to perform an in-depth review and make a recommendation for the continuation, modification, or repeal of certain occupational regulatory programs. The recommendation needed to consider the following criteria:[11]

- Would the absence of the regulation significantly harm or endanger the public health, safety, or welfare?
- Is there a reasonable relationship between the exercise of the police power of the state and the protection of the public health, safety, and welfare?
- Is there a less restrictive method of regulation available that would adequately protect the public?
- Does the regulation have the effect of directly or indirectly increasing the costs of any goods or services involved, and, if so, to what degree?
- Is the increase in cost more harmful to the public than the harm that would result from the absence of regulation?
- Are any facets of the regulatory process designed for the purpose of benefitting, and do they have as their primary effect the benefit of, their regulated entity?

During the sunset review process, if any program was allowed to expire, the personnel positions which were responsible for carrying out the program and all unexpended balances of appropriations, allocations, or other funds for such program were to be reverted to the fund from which they were appropriated, or, if that fund was abolished, to the General Revenue Fund. Any remaining unencumbered revenue collected under a repealed occupational regulatory program were to be refunded on a pro rata basis by the Comptroller (now the Chief Financial Officer), upon request of the person or entity who paid, if such request was made within 1 year after the repeal of the program.[12]

---

[7] White, *supra* note 57 at 48-49; *Improving Occupational Licensing with Sunrise and Sunset Reviews*, National Conference of State Legislatures, (July 2018), http://www.ncsl.org/research/labor-and-employment/improving-occupational-licensing-with-sunrise-and-sunset-reviews.aspx (last visited Dec. 30, 2019); Council on Licensure & Regulation, *Sunrise, Sunset and State Agency Audits*, https://www.clearhq.org/page-486181 (last visited Dec. 30, 2019); Brian Baugus & Feler Bose, *Sunset Legislation in the States: Balancing the Legislature and the Executive*, Mercatus Center, 3 (August 2015).

[8] *Improving Occupational Licensing with Sunrise and Sunset Reviews*, National Conference of State Legislatures, (July 2018), http://www.ncsl.org/research/labor-and-employment/improving-occupational-licensing-with-sunrise-and-sunset-reviews.aspx (last visited Dec. 30, 2019).

[9] Florida Senate Committee on Government Operations, Staff Analysis of 1991 Senate Bill 28-D, p. 2 (Dec. 11, 1991).

[10] *Id.*

[11] S. 11.61(6), F.S. (1991).

[12] S. 11.61(7)-(8), F.S. (1991).

The Act also provided that any cause of action pending on the date any program was repealed, or any cause of action brought thereafter, was to be prosecuted or defended in the name of the state by the Department of Legal Affairs. All regulatory activities related to the repealed program were to cease after the date of repeal.[13]

In 1991, the Senate Government Operations Committee (SCGO) performed a review of the sunset and sundown laws. SCGO found that between 1977 and 1991, 240 program sunset reviews were completed. During that time period, an estimated 20 regulatory laws were repealed, and 50 new ones were created. Based on the mandatory nature of the in-depth review process, it was found that the costs of the sunset reviews were high in terms of legislative and executive agency staff time. The SCGO report also found that the initial reviews of regulatory programs were more useful than any second or subsequent reviews.[14]

In light of the SCGO findings, the sunset reviews for occupations, professions, businesses, and industries under the Regulatory Reform Act, and entities under The Sundown Act, were repealed in 1991. There has not been a comprehensive sunset review process specifically for occupational licensing schemes since.[15]

Effect of the Bill

The bill schedules the repeal of specified occupational regulatory programs, over four years, beginning July 1, 2021, and ending July 1, 2024. The bill relates to over one-hundred professions and occupations.

The bill establishes that it is the intent of the legislature to complete a systematic review of the costs and benefits of certain occupational regulatory programs prior to the date set for repeal to determine whether the program should be allowed to expire, be fully renewed, or be renewed with modifications.

The bill provides:

> “There is established a schedule for systematic review of the costs and benefits of occupational regulatory programs. The Legislature intends to review each program before the scheduled date on which each occupational regulatory program is set to expire through scheduled repeal to determine whether to allow the program to expire, renew the program without modifications, renew the program with modifications, or provide for other appropriate actions.”

The bill defines the following terms:

- "Occupational regulatory program" or "program" means any statutory regulatory provision or scheme which places a condition on practicing an occupation, including, but not limited to, programs that require a license, certification, registration, or credential.
- "Local government" means a county, municipality, special district, or political subdivision of the state.
- "Occupation" means a paid job, profession, work, line of work, trade, employment, position, post, career, field, vocation, or craft.

When an occupational regulatory program is allowed to expire or is repealed, the bill requires:

- the personnel positions which are responsible for carrying out the program to be abolished, and all unexpended balances of appropriations, allocations, or other funds for such program revert

[13] S. 11.61(9), F.S. (1991).
[14] SCGO, supra note 8, at 3.
[15] Ch. 91-429, Laws of Fla. Between 2006 and 2011, there was another systematic and scheduled sunset review process which included occupational regulatory programs, but that review process was applicable to every aspect of state agencies as a whole. That process was repealed in 2011. Ch. 2011-35, Laws of Fla.

to the fund from which they were appropriated, or, if that fund is abolished, to the General Revenue Fund, within 60 days;
- any remaining unencumbered revenue collected under a repealed occupational regulatory program to be refunded on a pro rata basis by the Chief Financial Officer, upon request of the person or entity who paid, if such request is made within 1 year after the repeal of the program;
- any cause of action pending on the date the occupational regulatory program was repealed, or any cause of action brought thereafter, to be prosecuted or defended in the name of the state by the Department of Legal Affairs, if prior to repeal such action would have been prosecuted or defended by the occupational regulatory program repealed by this act; and
- all regulatory activities related to the repealed program cease after the date of repeal, except as otherwise authorized.

The bill prohibits any local government from regulating any occupation or profession of any repealed occupational regulatory program, and preempts such regulation to the state, unless local regulation of such occupation is expressly authorized by law.

If after the effective date of the bill a law scheduled for review under the bill is amended or transferred, such action does not eliminate the scheduled repeal of such law, unless otherwise expressly provided in law.

The bill schedules the following occupational licenses for sunset on July 1, 2021:
- Court Reporters and Foreign Language Court Interpreters,
  - regulated by ss. 25.383 and 25.386, F.S., and FSC;
- Boiler Safety Inspectors,
  - regulated by ss. 554.104 and 554.114(1)(d), F.S., and DFS;
- Property Insurance Mediators and Neutral Evaluators,
  - regulated by ss. 627.7015(4) and 627.7074(1)(a), F.S., and DFS;
- Harbor Pilots,
  - regulated by ch. 310, F.S., and DBPR;
- Yacht and Ship Brokers,
  - regulated by ch. 326, F.S., and DBPR;
- Auctioneers and Auctioneer Apprentices,
  - regulated by pt. VI of ch. 468, F.S., and DBPR;
- Talent Agencies,
  - regulated by pt. VII of ch. 468, F.S., and DBPR.
- Community Association Managers,
  - regulated by pt. VIII of ch. 468, F.S., and DBPR;
- Athlete Agents,
  - regulated by pt. IX of ch. 468, F.S., and DBPR;
- Mobile Home Installers,
  - regulated by s. 320.8249, F.S., and DHSMV;
- Paramedics, Emergency Medical Technicians, and 911 Operators,
  - regulated by ss. 401.465, .27, and .271-273, F.S., and DOH;
- Dieticians, Nutritionists, and Nutrition Counselors,
  - regulated by pt. X of ch. 468, F.S., and DOH;
- Athlete Trainers,
  - regulated by pt. XIII of ch. 468, F.S., and DOH;
- Orthotists, Orthotic Fitters, Orthotic Fitter Assistants, Prosthetists, and Pedorthists,
  - regulated by pt. XIV of ch. 468, F.S., and DOH;
- Electrologists,
  - regulated by ch. 479, F.S., and DOH;
- Massage Therapists,
  - regulated by ch. 480, F.S., and DOH.

The bill schedules the following occupational licenses for sunset on July 1, 2022:

- Parenting Coordinators,
  - regulated by s. 61.125, F.S., and FSC;
- Funeral Directors, Embalmers, Direct Disposers, Monument Establishment Sales Agents, and Preneed Sales Agents,
  - regulated by ch. 497, F.S., and DFS;
- Service Warranty Sales Representatives, Motor Vehicle Service Agreement Salespersons, and Home Warranty Sales Representatives,
  - regulated by ss. 634.171, .318, .320, and .420, F.S., and DFS;
- Elevator Safety Professionals,
  - regulated by s. 399.01(16), F.S., and DBPR;
- Employee Leasing Companies,
  - regulated by pt. XI of ch. 468, F.S., and DBPR;
- Pugilistic Event Timekeepers and Announcers,
  - regulated by ch. 548, F.S., and DBPR;
- Home Inspectors,
  - regulated by pt. XV of ch. 468, F.S., and ;
- Mold Service Professionals,
  - regulated by pt. XVI of ch. 468, F.S., and DBPR;
- Well Water Contractors,
  - regulated by ss. 373.302-342, F.S., and DEP;
- Associated Persons of a Securities Dealer and Associated Persons of a State Registered Investment Advisor or Federal Covered Advisor,
  - regulated by s. 517.12(1),(4), F.S., and OFR;
- Acupuncturists,
  - regulated by ch. 457, F.S., and DOH;
- Medical Doctors, Physician Assistants, Anesthesiologist Assistants, and Medical Assistants,
  - regulated by ch. 458, F.S., and DOH;
- Osteopathic Doctors, Physician Assistants, and Anesthesiologist Assistants,
  - regulated by ch. 459, F.S., and DOH;
- Audiologists and Speech-language Pathologists,
  - regulated by pt. I of ch. 468, F.S., and DOH;
- Nursing Home Administrators,
  - regulated by pt. II of ch. 468, F.S., and DOH;
- Occupational Therapists and Occupational Therapist Assistants,
  - regulated by pt. III of ch. 468, F.S., and DOH;
- Radiographers, Radiological Technologists, Radiology Assistants, and X-Ray Machine Operators,
  - regulated by pt. IV of ch. 468, F.S., and DOH;
- Respiratory Therapists and Respiratory Therapy Assistants,
  - regulated by pt. V of ch. 468, F.S., and DOH;
- Commercial Telephone Sellers,
  - regulated by ch. 501, F.S., and DACS;
- Intrastate Movers and Brokers,
  - regulated by ch. 507, F.S., and DACS.

The bills schedules the following occupational licenses for sunset on July 1, 2023:

- Mediators and Arbitrators,
  - regulated by ch. 44.106, F.S., and FSC;
- Firefighters, Fire Protection Systems Contractors, Fire Equipment Dealers, Firesafety Inspectors, and Volunteer Firefighters,
  - regulated by ch. 633, F.S., and DFS;
- Professional Bail Bond Agents and Limited Surety Bail Bond Agents,
  - regulated by ch. 648, F.S., and DFS;

- Farm Labor Contractors,
  - regulated by s. 450.30, F.S., and DBPR;
- Certified Public Accountants,
  - regulated by ch. 473, F.S., and DBPR;
- Veterinarians,
  - regulated by ch. 474, F.S., and DBPR;
- Real Estate Brokers and Salespersons,
  - regulated by pt. I of ch. 475, F.S., and DBPR;
- Barbers,
  - regulated by ch. 476, F.S., and DBPR;
- Cosmetologists and Specialists,
  - regulated by ch. 477, F.S., and DBPR;
- Chiropractic Physicians, Physician Assistants, and Registered Chiropractic Assistants,
  - regulated by ch. 460, F.S., and DOH;
- Podiatric Physicians and Certified Podiatric X-Ray Assistants,
  - regulated by ch. 461, F.S., and DOH;
- Naturopaths,
  - regulated by ch. 462, F.S., and DOH;
- Certified Optometrists and Licensed Optometric Professionals,
  - regulated by ch. 463, F.S., and DOH;
- Clinical Laboratory Personnel and Medical Physicists,
  - regulated by ss. 483.800-828 and .901, F.S., and DOH;
- Opticians and Hearing Aid Specialists,
  - regulated by s. 484.002, .007(3)-(4), .013-.015, and .018(3), F.S., and DOH;
- Physical Therapists and Physical Therapist Assistants,
  - regulated by ch. 486, F.S., and DOH;
- Motor Vehicle Repair Shops,
  - regulated by pt. IX of ch. 559, F.S., and DACS;
- Sellers of Travel,
  - regulated by pt. XI of ch. 559, F.S., and DACS;
- Charitable Solicitors,
  - regulated by s. 496.4101, F.S. and DACS.

The bill schedules the following occupational licenses for sunset on July 1, 2024:

- Property and Casualty Agents, Health and Life Insurance Agents, Title Agents, Portable Electronic Agents, Credit Insurance Agents, In-Transit and Storage Personal Property Insurance Agents, Legal Expense Sales Representatives, Managing General Agents, Motor Vehicle Rental Insurance Agents, Individual Reinsurance Brokers and Managers, Service Representatives, Travel Insurance Agents, All-lines Adjusters, Emergency Adjusters, Public Adjusters and Apprentices, Health Agents, Viatical Settlement Providers and Brokers, ACA Navigators, and Motor Vehicle Physical Damage and Mechanical Breakdown Agents,
  - regulated by ch. 626, F.S., and DFS;
- Engineers,
  - regulated by ch. 471, F.S., and DBPR;
- Professional Geologists,
  - regulated by ch. 492, F.S., and DBPR;
- Architects and Interior Designers,
  - regulated by pt. I of ch. 481, F.S., and DBPR;
- Landscape Architects,
  - regulated by pt. II of ch. 481, F.S., and DBPR;
- Construction Contractors,
  - regulated by pt. I of ch. 489, F.S., and DBPR;
- Electrical Contractors,
  - regulated by pt. II of ch. 489, F.S., and DBPR;

- Septic Tank Contractors,
  - regulated by pt. III of ch. 489, F.S., and DOH;
- Building Code Administrators, Inspectors, and Plans Examiniers,
  - regulated by pt. XII of ch. 468, F.S., and DBPR;
- Registered Core Trainers,
  - regulated by s. 429.52(11)-(12), F.S., and DEA;
- Health Care Risk Manager,
  - regulated by ss. 395.10971-10975, F.S., and AHCA;
- Recovery Residence Administrators,
  - regulated by s. 397.4871, F.S., and DCF;
- Child and Family Care Personnel Operators and Employees,
  - regulated by s. 402.305, F.S., and DCF;
- Registered Nurses, Advanced Registered Nurse Practitioners, and Certified Nurse Assistants,
  - regulated by ch. 464, F.S., and DOH;
- Pharmacists, Pharmacist Interns, and Pharmacist Technicians,
  - regulated by ch. 465, F.S., and DOH;
- Dentists and Dental Hygienists,
  - regulated by ch. 466, F.S., and DOH;
- Licensed Midwives,
  - regulated by ch. 467, F.S., and DOH;
- Psychologists and School Psychologists,
  - regulated by ch. 490, F.S., and DOH;
- Licensed Clinical Social Workers, Marriage and Family Therapists, Mental Health Counselors, Psychotherapists, and Certified Master Social Workers,
  - regulated by ch. 491, F.S., and DOH;
- Surveyors and Mappers,
  - regulated by ch. 472, F.S., and DACS;
- Hypnotists,
  - regulated by ch. 485, F.S., and DOH;
- Pest Control Professionals,
  - regulated by ch. 482, F.S., and DACS;
- Pesticide Application Professionals,
  - regulated by pt. I of ch. 487, F.S., and DACS;
- Body Piercing Salons, Tattoo Artists, Tattoo Establishments, and Certified Environmental Health Professionals,
  - regulated by ss. 381.0101, .0075-.00777, and .00781-00791, F.S., and DOH.

At the time of a scheduled repeal, if an occupational regulatory programs is allowed to expire or is amended, there will also need to be conforming changes made to related statutes and cross-references.

The bill is effective upon becoming law.

B. SECTION DIRECTORY:

Section 1: Creates a process for a legislative sunset review for certain occupational regulatory programs.
Section 2: Schedules certain statutes for sunset on July 1, 2021.
Section 3: Schedules certain statutes for sunset on July 1, 2022.
Section 4: Schedules certain statutes for sunset on July 1, 2023.
Section 5: Schedules certain statutes for sunset on July 1, 2024.
Section 6: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   If the regulatory authority is not reenacted, affected regulatory agencies will experience a significant loss of fee revenue.

2. Expenditures:

   If the regulatory authority is not reenacted, affected regulatory agencies will experience a significant reduction of workload to regulate and enforce regulatory requirements for professions and occupations.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For any occupational regulatory program that is repealed as a result of the sunset review process, the bill may have a positive impact on individuals who would have otherwise been required to pay licensing fees and comply with extensive licensing requirements. The impact on consumers is indeterminate.

D. FISCAL COMMENTS:

To the extent certain occupational regulatory programs are allowed to expire, state revenues and expenditures related to such programs will decline or be eliminated.

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:

Rule-making is not required to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to legislative review of occupational
3 regulations; creating s. 11.65, F.S.; providing
4 definitions; establishing a schedule for the
5 systematic review of occupational regulatory programs;
6 authorizing the Legislature to take certain actions
7 before the scheduled repeal of an occupational
8 regulatory program; providing that amending or
9 transferring Florida Statutes does not affect a
10 scheduled repeal; providing for the abolition of units
11 or subunits of government and personnel positions
12 responsible for repealed programs; providing for the
13 reversion of certain unexpended funds and the refund
14 of certain unencumbered revenue of a repealed program;
15 providing for cause of action by or against specified
16 units of government under certain circumstances;
17 providing for certain actions for acts committed
18 before a certain time; preempting the regulation of an
19 occupation to the state if such occupation's
20 regulatory program has been repealed through this act;
21 providing a schedule of repeal for occupational
22 regulatory programs; providing contingent effective
23 dates.
24
25 Be It Enacted by the Legislature of the State of Florida:

26
27 Section 1. Section 11.65, Florida Statutes, is created to
28 read:
29 11.65 Legislative review of occupational regulation.—
30 (1) As used in this section:
31 (a) "Occupational regulatory program" or "program" means
32 any statutory regulatory provision or scheme which places a
33 condition on practicing an occupation, including, but not
34 limited to, programs that require a license, certification,
35 registration, or credential.
36 (b) "Local government" means a county, municipality,
37 special district, or political subdivision of the state.
38 (c) "Occupation" means a paid job, profession, work, line
39 of work, trade, employment, position, post, career, field,
40 vocation, or craft.
41 (2) There is established a schedule for systematic review
42 of the costs and benefits of occupational regulatory programs.
43 The Legislature intends to review each program before the
44 scheduled date on which each occupational regulatory program is
45 set to expire through scheduled repeal to determine whether to
46 allow the program to expire, renew the program without
47 modifications, renew the program with modifications, or provide
48 for other appropriate actions.
49 (3) If a chapter or section of the Florida Statutes
50 scheduled for review by this act is subsequently amended or

51 transferred, such subsequent amendment or transfer, unless
52 otherwise expressly provided in the act amending or transferring
53 such chapter or section, shall not eliminate the scheduled
54 repeal of such chapter or section.
55 (4) Within 60 days after the date on which any
56 occupational regulatory program is allowed to expire through
57 scheduled repeal under this act, the personnel positions which
58 are responsible for carrying out the program shall be abolished,
59 and all unexpended balances of appropriations, allocations, or
60 other funds for such program shall revert to the fund from which
61 they were appropriated or, if that fund is abolished, to the
62 General Revenue Fund. Except as authorized under this section,
63 all regulatory activities related to the repealed program shall
64 cease after the date of repeal.
65 (5) Any remaining unencumbered revenue collected under an
66 occupational regulatory program allowed to expire through repeal
67 shall be refunded on a pro rata basis by the Chief Financial
68 Officer pursuant to s. 215.26, upon request of the person or
69 entity who paid, if such request is made within 1 year after the
70 repeal of the program.
71 (6) Any cause of action pending on the date the
72 occupational regulatory program was repealed, or any cause of
73 action brought thereafter, shall be prosecuted or defended in
74 the name of the state by the Department of Legal Affairs, if
75 prior to repeal such action would have been prosecuted or

76 defended by the occupational regulatory program repealed by this
77 act.
78 (7) Any occupational regulatory program that expires
79 through scheduled repeal in accordance with this act may not be
80 subsequently regulated by a local government. The regulation of
81 any occupation repealed by this act is preempted to the state
82 unless local regulation of such occupation is expressly
83 authorized by law.
84 Section 2. Pursuant to the Occupational Regulation Sunset
85 Act, the following statutes are repealed effective July 1, 2021:
86 ss. 25.383, 25.386, 310.001, 310.0015, 310.002, 310.011,
87 310.032, 310.042, 310.051, 310.061, 310.071, 310.073, 310.075,
88 310.081, 310.091, 310.101, 310.102, 310.111, 310.1112, 310.1115,
89 310.121, 310.131, 310.141, 310.142, 310.146, 310.151, 310.161,
90 310.171, 310.181, 310.183, 310.185, 320.8249, 326.001, 326.002,
91 326.003, 326.004, 326.005, 326.006, 401.27, 401.271, 401.2715,
92 401.272, 401.273, 401.465, 468.381, 468.382, 468.383, 468.384,
93 468.385, 468.3851, 468.3852, 468.3855, 468.386, 468.387,
94 468.388, 468.389, 468.391, 468.392, 468.393, 468.394, 468.395,
95 468.396, 468.397, 468.398, 468.399, 468.401, 468.402, 468.403,
96 468.404, 468.405, 468.406, 468.407, 468.408, 468.409, 468.410,
97 468.411, 468.412, 468.413, 468.414, 468.415, 468.431, 468.4315,
98 468.432, 468.433, 468.4334, 468.4336, 468.4337, 468.4338,
99 468.435, 468.436, 468.4365, 468.437, 468.438, 468.451, 468.452,
100 468.453, 468.4535, 468.4536, 468.454, 468.456, 468.4561,

101 468.45615, 468.4562, 468.4565, 468.457, 468.501, 468.502,
102 468.503, 468.504, 468.505, 468.506, 468.507, 468.508, 468.509,
103 468.51, 468.511, 468.512, 468.513, 468.514, 468.515, 468.516,
104 468.517, 468.518, 468.70, 468.701, 468.703, 468.705, 468.707,
105 468.709, 468.711, 468.713, 468.715, 468.717, 468.719, 468.723,
106 468.80, 468.801, 468.802, 468.803, 468.806, 468.808, 468.809,
107 468.8095, 468.811, 468.812, 468.813, 478.40, 478.41, 478.42,
108 478.43, 478.44, 478.45, 478.46, 478.47, 478.48, 478.49, 478.50,
109 478.54, 480.031, 480.032, 480.033, 480.034, 480.035, 480.036,
110 480.039, 480.041, 480.0415, 480.042, 480.043, 480.044, 480.046,
111 480.0465, 480.047, 480.0475, 480.0485, 480.049, 480.052,
112 480.0535, 488.01, 488.02, 488.03, 488.04, 488.045, 488.05,
113 488.06, 488.07, 488.08, 554.104, 554.114(1)(d), 627.7015(4), and
114 627.7074(1)(a).
115 Section 3. Pursuant to the Occupational Regulation Sunset
116 Act, the following statutes are repealed effective July 1, 2022:
117 ss. 61.125, 373.302, 373.303, 373.306, 373.308, 373.309,
118 373.313, 373.314, 373.316, 373.319, 373.323, 373.324, 373.325,
119 373.326, 373.329, 373.333, 373.335, 373.336, 373.337, 373.342,
120 399.01(16), 457.101, 457.102, 457.103, 457.104, 457.105,
121 457.107, 457.108, 457.1085, 457.109, 457.116, 457.118, 458.301,
122 458.303, 458.305, 458.307, 458.309, 458.310, 458.311, 458.3115,
123 458.3124, 458.313, 458.3135, 458.3137, 458.314, 458.3145,
124 458.3147, 458.315, 458.3151, 458.316, 458.3165, 458.317,
125 458.3175, 458.319, 458.3191, 458.3192, 458.3193, 458.320,

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

126 458.321, 458.323, 458.324, 458.325, 458.3255, 458.326, 458.327,
127 458.328, 458.329, 458.3295, 458.331, 458.3311, 458.3312,
128 458.335, 458.336, 458.337, 458.339, 458.341, 458.343, 458.345,
129 458.347, 458.3475, 458.348, 458.3485, 458.351, 459.001, 459.002,
130 459.003, 459.004, 459.005, 459.0055, 459.0066, 459.0075,
131 459.0076, 459.00761, 459.0077, 459.008, 459.0081, 459.0082,
132 459.0083, 459.0085, 459.009, 459.0092, 459.011, 459.012,
133 459.0122, 459.0125, 459.013, 459.0135, 459.0138, 459.0141,
134 459.0145, 459.015, 459.0151, 459.0152, 459.016, 459.017,
135 459.018, 459.019, 459.021, 459.022, 459.023, 459.025, 459.026,
136 468.1105, 468.1115, 468.1125, 468.1135, 468.1145, 468.1155,
137 468.1165, 468.1175, 468.1185, 468.1195, 468.1205, 468.1215,
138 468.1225, 468.1245, 468.1246, 468.1255, 468.1265, 468.1275,
139 468.1285, 468.1295, 468.1296, 468.1315, 468.1635, 468.1645,
140 468.1655, 468.1665, 468.1675, 468.1685, 468.1695, 468.1705,
141 468.1715, 468.1725, 468.1735, 468.1745, 468.1755, 468.1756,
142 468.201, 468.203, 468.204, 468.205, 468.207, 468.209, 468.211,
143 468.213, 468.215, 468.217, 468.219, 468.221, 468.223, 468.225,
144 468.3001, 468.3003, 468.301, 468.302, 468.303, 468.304, 468.305,
145 468.306, 468.3065, 468.307, 468.309, 468.3095, 468.3101,
146 468.311, 468.3115, 468.312, 468.314, 468.315, 468.35, 468.351,
147 468.352, 468.353, 468.354, 468.355, 468.358, 468.359, 468.36,
148 468.361, 468.363, 468.364, 468.365, 468.366, 468.367, 468.368,
149 468.369, 468.520, 468.521, 468.522, 468.523, 468.524, 468.5245,
150 468.525, 468.526, 468.527, 468.5275, 468.528, 468.529, 468.530,

151 468.531, 468.532, 468.533, 468.534, 468.535, 468.83, 468.831,
152 468.8311, 468.8312, 468.8313, 468.8314, 468.8315, 468.8316,
153 468.8317, 468.8318, 468.8319, 468.832, 468.8321, 468.8322,
154 468.8323, 468.8324, 468.8325, 468.84, 468.841, 468.8411,
155 468.8412, 468.8413, 468.8414, 468.8415, 468.8416, 468.8417,
156 468.8418, 468.8419, 468.42, 468.8421, 468.8422, 468.8423,
157 468.8424, 497.144, 497.145, 497.147, 497.148, 497.168, 497.365,
158 497.366, 497.368, 497.369, 497.370, 497.371, 497.372, 497.373,
159 497.374, 497.375, 497.376, 497.377, 497.378, 497.379, 497.390,
160 497.554, 497.602, 497.603, 497.605, 501.605, 501.607, 501.608,
161 501.609, 501.612, 501.616(2) and (4), 507.01, 507.02, 507.03,
162 507.04, 507.05, 507.06, 507.07, 507.08, 507.09, 507.10, 507.11,
163 507.12, 507.13, 517.12(1) and (4), 548.003, 548.017, 634.171,
164 634.318, 634.320, and 634.420.
165 Section 4. Pursuant to the Occupational Regulation Sunset
166 Act, the following statutes are repealed effective July 1, 2023:
167 s. 44.106, 450.30, 460.401, 460.402, 460.403, 460.404, 460.405,
168 460.406, 460.4061, 460.4062, 460.407, 460.408, 460.41, 460.411,
169 460.412, 460.413, 460.414, 460.4165, 460.4166, 460.4167,
170 461.001, 461.002, 461.003, 461.004, 461.005, 461.006, 461.007,
171 461.008, 461.009, 461.012, 461.013, 461.0131, 461.0134,
172 461.0135, 461.014, 461.018, 462.01, 462.023, 462.08, 462.09,
173 462.11, 462.13, 462.14, 462.16, 462.17, 462.18, 462.19,
174 462.2001, 463.0001, 463.001, 463.002, 463.003, 463.004, 463.005,
175 463.0055, 463.0057, 463.006, 463.007, 463.008, 463.009, 463.011,

176 463.012, 463.013, 463.0135, 463.014, 463.0141, 463.015, 463.016,
177 463.018, 473.301, 473.302, 473.303, 473.3035, 473.304, 473.305,
178 473.306, 473.3065, 473.308, 473.309, 473.3101, 473.311, 473.312,
179 473.3125, 473.313, 473.314, 473.3141, 473.315, 473.316, 473.318,
180 473.319, 473.3205, 473.321, 473.322, 473.323, 474.201, 474.202,
181 474.203, 474.204, 474.205, 474.206, 474.2065, 474.207, 474.211,
182 474.2125, 474.213, 474.214, 474.2145, 474.215, 474.216,
183 474.2165, 474.2167, 474.217, 474.2185, 474.221, 475.001, 475.01,
184 475.011, 475.02, 475.021, 475.03, 475.04, 475.045, 475.05,
185 475.10, 475.125, 475.15, 475.161, 475.17, 475.175, 475.180,
186 475.181, 475.182, 475.183, 475.215, 475.22, 475.23, 475.24,
187 475.25, 475.255, 475.2701, 475.272, 475.274, 475.2755, 475.278,
188 475.28, 475.2801, 475.31, 475.37, 475.38, 475.41, 475.42,
189 475.43, 475.451, 475.4511, 475.453, 475.455, 475.482, 475.483,
190 475.4835, 475.484, 475.485, 475.486, 475.5015, 475.5016,
191 475.5017, 475.5018, 476.014, 476.024, 476.034, 476.044, 476.054,
192 476.064, 476.074, 476.114, 476.134, 476.144, 476.154, 476.155,
193 476.178, 476.184, 476.188, 476.192, 476.194, 476.204, 476.214,
194 476.234, 476.244, 476.254, 477.011, 477.012, 477.013, 477.0132,
195 477.0135, 477.014, 477.015, 477.016, 477.017, 477.018, 477.019,
196 477.0201, 477.0212, 477.0213, 477.022, 477.023, 477.025,
197 477.026, 477.0263, 477.0265, 477.028, 477.029, 477.031, 483.800,
198 483.801, 483.803, 483.805, 483.807, 483.809, 483.811, 483.812,
199 483.813, 483.815, 483.817, 483.819, 483.821, 483.823, 483.824,
200 483.825, 483.828, 483.901, 484.002, 484.007(3) and (4), 484.013,

201 484.014, 484.015, 484.018(3), 486.011, 486.015, 486.021,
202 486.023, 486.025, 486.028, 486.031, 486.041, 486.051, 486.061,
203 486.0715, 486.081, 486.085, 486.102, 486.103, 486.104, 486.106,
204 486.1065, 486.107, 486.108, 486.109, 486.115, 486.123, 486.125,
205 486.135, 486.151, 486.153, 486.161, 486.171, 486.172, 496.4101,
206 559.901, 559.902, 559.903, 559.904, 559.905, 559.907, 559.909,
207 559.911, 559.915, 559.916, 559.917, 559.919, 559.920, 559.921,
208 559.9215, 559.92201, 559.9221, 559.926, 559.927, 559.928,
209 559.9281, 559.9285, 559.929, 559.9295, 559.931, 559.932,
210 559.933, 559.9335, 559.934, 559.935, 559.9355, 559.936, 559.937,
211 559.938, 559.939, 633.132, 633.216, 633.304, 633.316, 633.318,
212 633.324, 633.328, 633.332, 633.336, 633.338, 633.406, 633.408,
213 633.412, 633.414, 633.416, 633.418, 633.424, 633.426, 648.24,
214 648.25, 648.26, 648.27, 648.279, 648.285, 648.29, 648.295,
215 648.30, 648.31, 648.315, 648.33, 648.34, 648.35, 648.355,
216 648.36, 648.365, 648.38, 648.381, 648.382, 648.383, 648.384,
217 648.385, 648.386, 648.387, 648.388, 648.39, 648.40, 648.41,
218 648.42, 648.421, 648.43, 648.44, 648.441, 648.442, 648.4425,
219 648.45, 648.46, 648.48, 648.49, 648.50, 648.51, 648.52, 648.525,
220 648.53, 648.55, 648.57, 648.571, and 648.58.
221 Section 5. Pursuant to the Occupational Regulation Sunset
222 Act, the following statutes are repealed effective July 1, 2024:
223 381.0075, 381.00771, 381.00773, 381.00775, 381.00777, 381.00781,
224 381.00783, 381.00785, 381.00787, 381.00789, 381.00791, 381.0101,
225 395.10973, 397.4871, 402.305, 429.52(11) and (12), 464.001,

226 464.002, 464.003, 464.004, 464.005, 464.006, 464.008, 464.009,
227 464.0095, 464.0096, 464.012, 464.013, 464.014, 464.015, 464.016,
228 464.017, 464.018, 464.019, 464.0195, 464.0196, 464.0205,
229 464.022, 464.027, 464.201, 464.202, 464.203, 464.204, 464.205,
230 464.206, 464.207, 464.208, 465.002, 465.007, 465.0075, 465.008,
231 465.009, 465.012, 465.0125, 465.0126, 465.013, 465.014,
232 465.0155, 465.0252, 465.0255(2), (3), and (4), 465.026,
233 465.0275, 465.0276, 465.186, 465.187, 465.188, 465.189,
234 465.1893, 465.1901, 466.001, 466.002, 466.003, 466.004, 466.005,
235 466.006, 466.0065, 466.0067, 466.00671, 466.00672, 466.00673,
236 466.007, 466.0075, 466.008, 466.009, 466.011, 466.013, 466.0135,
237 466.014, 466.015, 466.016, 466.017, 466.018, 466.019, 466.021,
238 466.022, 466.023, 466.0235, 466.024, 466.025, 466.026, 466.027,
239 466.0275, 466.02751, 466.028, 466.0282, 466.0285, 466.041,
240 466.051, 467.001, 467.002, 467.003, 467.004, 467.005, 467.006,
241 467.009, 467.011, 467.012, 467.0125, 467.013, 467.0135, 467.014,
242 467.015, 467.016, 467.017, 467.019, 467.201, 467.203, 467.205,
243 467.207, 468.601, 468.602, 468.603, 468.604, 468.605, 468.606,
244 468.607, 468.609, 468.613, 468.617, 468.619, 468.621, 468.627,
245 468.629, 468.631, 468.632, 468.633, 471.001, 471.003, 471.0035,
246 471.005, 471.007, 471.008, 471.009, 471.011, 471.013, 471.015,
247 471.017, 471.019, 471.0195, 471.021, 471.023, 471.025, 471.027,
248 471.031, 471.033, 471.037, 471.038, 471.0385, 471.045, 472.001,
249 472.003, 472.005, 472.006, 472.007, 472.0075, 472.008, 472.009,
250 472.0101, 472.011, 472.013, 472.0131, 472.0132, 472.0135,

251 472.015, 472.016, 472.0165, 472.017, 472.018, 472.019, 472.0201,
252 472.02011, 472.0202, 472.0203, 472.0204, 472.021, 472.023,
253 472.025, 472.027, 472.029, 472.031, 472.033, 472.0335, 472.0337,
254 472.034, 472.0345, 472.0351, 472.0355, 472.036, 472.0365,
255 472.0366, 472.037, 481.201, 481.203, 481.205, 481.2055, 481.207,
256 481.209, 481.211, 481.213, 481.2131, 481.215, 481.217, 481.219,
257 481.221, 481.222, 481.223, 481.225, 481.2251, 481.229, 481.231,
258 481.301, 481.303, 481.305, 481.306, 481.307, 481.309, 481.310,
259 481.311, 481.313, 481.315, 481.317, 481.319, 481.321, 481.323,
260 481.325, 481.329, 482.011, 482.021, 482.032, 482.051, 482.061,
261 482.071, 482.072, 482.0815, 482.091, 482.111, 482.121, 482.132,
262 482.141, 482.151, 482.152, 482.155, 482.156, 482.1562, 482.157,
263 482.161, 482.163, 482.165, 482.1821, 482.183, 482.191, 482.211,
264 482.226, 482.2265, 482.2267, 482.227, 482.231, 482.2401,
265 482.241, 482.242, 482.243, 485.001, 485.002, 485.003, 485.004,
266 485.005, 487.011, 487.012, 487.021, 487.025, 487.031, 487.041,
267 487.042, 487.0435, 487.0437, 487.044, 487.045, 487.046, 487.047,
268 487.048, 487.049, 487.051, 487.064, 487.071, 487.081, 487.091,
269 487.101, 487.111, 487.13, 487.15, 487.156, 487.1585, 487.159,
270 487.160, 487.161, 487.163, 487.171, 487.175, 489.101, 489.103,
271 489.105, 489.107, 489.108, 489.109, 489.111, 489.113, 489.1131,
272 489.1136, 489.114, 489.115, 489.116, 489.117, 489.118, 489.119,
273 489.1195, 489.121, 489.124, 489.125, 489.126, 489.127, 489.128,
274 489.129, 489.13, 489.131, 489.132, 489.133, 489.134, 489.140,
275 489.1401, 489.1402, 489.141, 489.142, 489.1425, 489.143,

276 489.144, 489.145, 489.1455, 489.146, 489.501, 489.503, 489.505,
277 489.507, 489.509, 489.510, 489.511, 489.513, 489.514, 489.515,
278 489.516, 489.5161, 489.517, 489.518, 489.5185, 489.519, 489.520,
279 489.521, 489.522, 489.523, 489.525, 489.529, 489.530, 489.531,
280 489.5315, 489.532, 489.533, 489.5335, 489.537, 489.538, 489.551,
281 489.552, 489.553, 489.554, 489.555, 489.556, 489.557, 489.558,
282 490.001, 490.002, 490.003, 490.004, 490.005, 490.0051, 490.006,
283 490.007, 490.0085, 490.009, 490.0111, 490.012, 490.0121,
284 490.014, 490.0141, 490.0143, 490.0145, 490.0147, 490.0148,
285 490.0149, 490.015, 491.002, 491.003, 491.004, 491.0045,
286 491.0046, 491.005, 491.0057, 491.006, 491.0065, 491.007,
287 491.008, 491.0085, 491.009, 491.0111, 491.0112, 491.012,
288 491.014, 491.0141, 491.0143, 491.0144, 491.0145, 491.0147,
289 491.0148, 491.0149, 491.015, 491.016, 492.101, 492.102, 492.103,
290 492.104, 492.105, 492.1051, 492.106, 492.107, 492.108, 492.109,
291 492.1101, 492.111, 492.112, 492.113, 492.114, 492.115, 492.116,
292 492.1165, 626.011, 626.015, 626.016, 626.022, 626.025, 626.0428,
293 626.112, 626.141, 626.161, 626.171, 626.172, 626.175, 626.181,
294 626.191, 626.201, 626.202, 626.207, 626.211, 626.221, 626.231,
295 626.241, 626.2415, 626.251, 626.261, 626.266, 626.271, 626.281,
296 626.2815, 626.2816, 626.2817, 626.291, 626.292, 626.301,
297 626.311, 626.321, 626.322, 626.331, 626.341, 626.342, 626.371,
298 626.381, 626.382, 626.431, 626.441, 626.451, 626.461, 626.471,
299 626.511, 626.536, 626.541, 626.551, 626.561, 626.571, 626.5715,
300 626.572, 626.593, 626.601, 626.602, 626.611, 626.6115, 626.621,

301 626.6215, 626.631, 626.641, 626.651, 626.6515, 626.661, 626.681,
302 626.691, 626.692, 626.711, 626.726, 626.727, 626.728, 626.729,
303 626.730, 626.731, 626.7315, 626.732, 626.733, 626.734, 626.7351,
304 626.7352, 626.7353, 626.7354, 626.741, 626.742, 626.743,
305 626.744, 626.745, 626.7451, 626.7452, 626.7453, 626.7454,
306 626.7455, 626.748, 626.7491, 626.7492, 626.752, 626.753,
307 626.754, 626.776, 626.777, 626.778, 626.779, 626.780, 626.781,
308 626.782, 626.783, 626.784, 626.7845, 626.785, 626.7851, 626.788,
309 626.789, 626.792, 626.793, 626.794, 626.795, 626.796, 626.797,
310 626.798, 626.826, 626.827, 626.828, 626.829, 626.830, 626.8305,
311 626.831, 626.8311, 626.833, 626.834, 626.835, 626.836, 626.837,
312 626.8373, 626.838, 626.839, 626.841, 626.8411, 626.8412,
313 626.8413, 626.8414, 626.8417, 626.8418, 626.8419, 626.84195,
314 626.842, 626.84201, 626.8421, 626.8423, 626.8427, 626.843,
315 626.8433, 626.8437, 626.844, 626.8443, 626.8447, 626.845,
316 626.8453, 626.8457, 626.846, 626.8463, 626.8467, 626.847,
317 626.8473, 626.851, 626.852, 626.853, 626.854, 626.8548, 626.855,
318 626.856, 626.8561, 626.8582, 626.8584, 626.859, 626.860,
319 626.861, 626.862, 626.863, 626.864, 626.865, 626.8651, 626.866,
320 626.8685, 626.869, 626.8695, 626.8696, 626.8697, 626.8698,
321 626.870, 626.871, 626.8732, 626.8734, 626.8736, 626.8737,
322 626.8738, 626.874, 626.875, 626.876, 626.877, 626.878, 626.8795,
323 626.8796, 626.8797, 626.927, 626.9271, 626.9272, 626.9912,
324 626.9916, 626.995, 626.9951, 626.9952, 626.9953, 626.9954,
325 626.9955, 626.9956, 626.9957, and 626.9958.

CODING: Words stricken are deletions; words underlined are additions.

326 Section 6. Except as otherwise expressly provided in this
327 act, 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 ____

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Renner offered the following:
4
5 **Amendment**
6 Remove lines 84-85 and insert:
7 Section 2. Pursuant to s. 11.65, the following statutes
8 are repealed effective July 1, 2021:
9 Remove lines 115-116 and insert:
10 Section 3. Pursuant to s. 11.65, the following statutes
11 are repealed effective July 1, 2022:
12 Remove lines 165-166 and insert:
13 Section 4. Pursuant to s. 11.65, the following statutes
14 are repealed effective July 1, 2023:
15 Remove lines 221-222 and insert:

16 Section 5. Pursuant to s. 11.65, the following statutes
17 are repealed effective July 1, 2024:

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 743 Nonopioid Alternatives
SPONSOR(S): Plakon
TIED BILLS: **IDEN./SIM. BILLS:** SB 1080

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	14 Y, 0 N	Siples	McElroy
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Mielke	Clark
3) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Substance abuse affects millions of people in the U.S. each year. Drug overdoses have steadily increased and now represent the leading cause of accidental death in the U.S., the majority of which involve an opioid. In Florida, opioids (licit and illicit) were responsible for more than 5,000 deaths in 2018. The National Institute of Health reports that the majority of heroin users first misused a prescription opioid.

The Department of Health (DOH) publishes an educational pamphlet regarding the use of non-opioid alternatives to treat pain on its website. Current law requires that health care practitioners, except pharmacists, discuss non-opioid alternatives with patients prior to prescribing, ordering, dispensing, or administering opioids. A health care practitioner must also provide a copy of the DOH-developed pamphlet to a patient and document the discussion in the patient's medical record. The only exception to these requirements is when a health care practitioner is providing emergency care and services.

HB 743 revises these requirements by:

- Exempting hospice services and any care provided in a hospital critical care unit or emergency department from the requirement to discuss non-opioid alternatives with a patient;
- Removing the requirement to address non-opioid alternatives when a drug is dispensed or administered;
- Authorizing a health care practitioner to discuss non-opioid alternatives with the patient's representative rather than the patient; and
- Requiring that the pamphlet provided to the patient be printed and authorizing a health care practitioner to provide the pamphlet to the patient's representative in lieu of the patient.

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

Substance Abuse

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

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

Opioid Abuse

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues.[7] They are commonly used as pain relievers to treat acute and chronic pain. An individual experiences pain as a result of a series of electrical and chemical exchanges among his or her peripheral nerves, spinal cord, and brain.[8] Opioid receptors occur naturally and are distributed widely throughout the central nervous system and in peripheral sensory and autonomic nerves.[9] When an individual experiences pain, the body releases hormones, such as endorphins, which bind with targeted opioid receptors.[10] This disrupts the transmission of pain signals through the central nervous system and reduces the perception of pain.[11] Opioids function in the same way by binding to specific opioid

[1] World Health Organization, *Substance Abuse*, available at http://www.who.int/topics/substance_abuse/en/ (last visited December 17, 2019).
[2] Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders,* (last rev. April 2019), available at http://www.samhsa.gov/disorders/substance-use (last visited December 17, 2019).
[3] National Institute on Drug Abuse*, Drugs, Brains, and Behavior: The Science of Addiction*, available at https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited December 17, 2019).
[4] Id.
[5] *Supra* note 2.
[6] Id.
[7] World Health Organization, *Information Sheet on Opioid Overdose*, (Aug. 2018), available at http://www.who.int/substance_abuse/information-sheet/en/ (last visited December 17, 2019).
[8] National Institute of Neurological Disorders and Stroke, *Pain: Hope through Research*, (last rev. Aug. 13, 2019), available at https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Hope-Through-Research/Pain-Hope-Through-Research (last visited December 17, 2019).
[9] Gjermund Henriksen, Frode Willoch; *Brain Imaging of Opioid Receptors in the Central Nervous System,* 131 BRAIN 1171-1196 (2007), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367693/ (last visited December 17, 2019).
[10] Id.
[11] Id.

receptors in the brain, spinal cord, and gastrointestinal tract, thereby reducing the perception of pain.[12] Opioids include:[13]

- Buprenorphine (Subutex, Suboxone);
- Codeine;
- Fentanyl (Duragesic, Fentora);
- Fentanyl Analogs;
- Heroin;
- Hydrocodone (Vicodin, Lortab, Norco);
- Hydromorphone (Dilaudid, Exalgo);
- Meperidine;
- Methadone;
- Morphine;
- Oxycodone (OxyContin, Percodan, Percocet);
- Oxymorphone;
- Tramadol; and
- U-47700.

Opioids are commonly abused, with an estimated 15 million people worldwide suffering from opioid dependence.[14] Opioids can create a euphoric feeling because they affect the regions of the brain involved with pleasure and reward, which can lead to abuse.[15] Continued use of these drugs can lead to the development of tolerance and psychological and physical dependence.[16] This dependence is characterized by a strong desire to take opioids, impaired control over opioid use, persistent opioid use despite harmful consequences, a higher priority given to opioid use than to other activities and obligations, and a physical withdrawal reaction when opioids are discontinued.[17] Nearly 80 percent of people who use heroin first misused prescription opioids.[18]

An overabundance of opioids in the body can lead to a fatal overdose. In addition to their presence in major pain pathways, opioid receptors are also located in the respiratory control centers of the brain.[19] Opioids disrupt the transmission of signals for respiration in the identical manner that they disrupt the transmission of pain signals. This leads to a reduction, and potentially cessation, of an individual's respiration. Oxygen starvation will eventually stop vital organs like the heart, then the brain, and can lead to unconsciousness, coma, and possibly death.[20] Within three to five minutes without oxygen, brain damage starts to occur, soon followed by death.[21] However, this does not occur instantaneously as people will commonly stop breathing slowly, minutes to hours after the drug or drugs were used.[22]

---

[12] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA Opioid Overdose Prevention Toolkit: Facts for Community Members* (2013, rev. 2014) 3, available at https://www.integration.samhsa.gov/Opioid_Toolkit_Community_Members.pdf (last visited December 17, 2019).
[13] Florida Department of Law Enforcement, Medical Examiners Commission, *Drugs Identified in Deceased Persons by Florida Medical Examiners 2018 Annual Report*, (Nov. 2019), available at https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Annual-Drug-Report.aspx (last visited December 18, 2019).
[14] *Supra* note 7.
[15] National Institute on Health, National Institute on Drug Abuse, *Misuse of Prescription Drugs: What Classes of Prescription Drugs Are Commonly Misused?*, (rev. Dec. 2018), available at https://www.drugabuse.gov/publications/research-reports/misuse-prescription-drugs/which-classes-prescription-drugs-are-commonly-misused (last visited December 18, 2019).
[16] *Supra* note 9.
[17] *Supra* note 7.
[18] National Institute on Health, National Institute on Drug Abuse, *Prescription Opioids and Heroin: Prescription Opioid Use Is a Risk Factor for Heroin Use*, (rev. Jan. 2018), available at https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use (last December 18, 2019).
[19] K.T.S. Pattinson, *Opioids and the Control of Respiration*, BRITISH JOURNAL OF ANAESTHESIA, Volume 100, Issue 6, pp. 747-758, available at http://bja.oxfordjournals.org/content/100/6/747.full (last visited December 18, 2019).
[20] Harm Reduction Coalition, *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects* (Fall 2012), http://harmreduction.org/wp-content/uploads/2012/11/od-manual-final-links.pdf (last visited December 18, 2019).
[21] Id. at 9.
[22] Id. at 9.

An opioid overdose can be identified by a combination of three signs and symptoms referred to as the "opioid overdose triad": pinpoint pupils, unconsciousness, and respiratory depression.[23]

The drug overdose death rate involving opioids has increased by 200% since 2000 and has now become the leading cause of accidental deaths in the United States.[24] Opioid-involved overdoses accounted for 68 percent of drug overdose deaths in 2017.[25] Nationwide, in 2017, there were 47,600 deaths that involved an opioid (licit or illicit), and 17,029 people died from overdoses involving prescription opioids.[26] The most common drugs involved in prescription opioid overdose deaths were methadone, oxycodone, and hydrocodone.[27] In 2018, Florida had the following opioid-involved deaths:[28]

Opioid	Caused Death	Present at Death
Oxycodone	535	646
Hydrocodone	168	425
Methadone	228	173
Morphine	1,102	761
Fentanyl	2,348	355
Fentanyl Analogs	874	178
Heroin	806	134

Controlled Substance Prescribing in Florida: Chronic Pain

Every physician, podiatrist, or dentist, who prescribes controlled substances in the state to treat chronic nonmalignant pain,[29] must register as a controlled substance prescribing practitioner and comply with certain practice standards specified in statute and rule.[30] Before prescribing controlled substances to treat chronic nonmalignant pain, a practitioner must:[31]

- Complete a medical history and a physical examination of the patient which must be documented in the patient's medical record and include:
    - The nature and intensity of the pain;
    - Current and past treatments for pain;
    - Underlying or coexisting diseases or conditions;
    - The effect of the pain on physical and psychological function;
    - A review of previous medical records and diagnostic studies;
    - A history of alcohol and substance abuse; and
    - Documentation of the presence of one or recognized medical indications for the use of a controlled substance.
- Develop a written plan for assessing the patient's risk for aberrant drug-related behavior and monitor such behavior throughout the course of controlled substance treatment;

---

[23] *Supra* note 7.
[24] Rose Rudd, MSPH, et. al., *Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014,* Morbidity and Mortality Weekly Report (MMWR) 64(50); Jan. 1, 2016, at 1378-82, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w (last visited December 18, 2019).
[25] Centers for Disease Control and Prevention, *Drug Overdose Deaths*, (last rev. June 27, 2019), available at https://www.cdc.gov/drugoverdose/data/statedeaths.html (last visited December 18, 2019).
[26] L. Scholl, et. al. *Drug and Opioid-Involved Overdose Deaths – United States, 2013-2017*, Morbidity and Mortality Weekly Report (MMWR) 64(50); Jan. 4, 2019, at 1378-82, available at https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm?s_cid=mm675152e1_w (last visited December 18, 2019).
[27] Centers for Disease Control and Prevention, *Overdose Death Maps: Overdose Deaths Involving Prescription Opioids*, (last rev. Aug. 13, 2019), available at https://www.cdc.gov/drugoverdose/data/prescribing/overdose-death-maps.html (last visited December 18, 2019).
[28] *Supra* note 13. "Caused death" means that the medical examiner determined the drug played a causal role in the death. "Present at death" means the medical examiner determine that the drug is present or identifiable but may not have played a causal role in the death.
[29] "Chronic nonmalignant pain" is defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery. Section 456.44(1)(e), F.S.
[30] Chapter 2011-141, s. 3, Laws of Fla. (creating s. 456.44, F.S., effective July 1, 2011).
[31] Section 456.44(3), F.S.

- Develop a written individualized treatment plan for each patient stating the objectives that will be used to determine treatment success;
- Discuss the risks and benefits of using controlled substances, including the risks of abuse and addiction, as well as the physical dependence and its consequences with the patient; and
- Enter into a controlled substance agreement with each patient that must be signed by the patient or legal representative and by the prescribing practitioner and include:
    - The number and frequency of prescriptions and refills;
    - A statement outlining expectations for patient's compliance and reasons for which the drug therapy may be discontinued; and
    - An agreement that the patient's chronic nonmalignant pain only be treated by a single treating practitioner unless otherwise authorized and documented in the medical record.

A prescribing practitioner must see a patient being treated with controlled substances for chronic nonmalignant pain at least once every three months and must maintain detailed medical records relating to such treatment.[32] Patients at special risk for drug abuse or diversion may require consultation with or a referral to an addiction medicine physician or a psychiatrist.[33] The prescribing practitioner must immediately refer a patient exhibiting signs or symptoms of substance abuse to a pain management physician, an addiction medicine specialist, or an addiction medicine facility.[34]

Controlled Substance Prescribing in Florida: Acute Pain

The Boards of Dentistry, Medicine, Nursing, Optometry, Osteopathic Medicine, and Podiatric Medicine, have adopted rules establishing guidelines for prescribing a controlled substance to treat acute pain.[35] Under these guidelines, a health care practitioner must:[36]

- Conduct a medical history and physical examination of the patient and document the patient's medical record, including the presence of one or more recognized medical indications for the use of a controlled substance;
- Create and maintain a written treatment plan, including any further diagnostic evaluations or other treatments planned including non-opioid medications and treatments;
- Obtain informed consent and agreement for treatment, including discussing the risks and benefits of using a controlled substance; expected pain intensity, duration, options; and use of pain medications, non-medication therapies, and common side effects;
- Periodically review the treatment plan;
- Refer the patient, as necessary, for additional evaluation and treatment in order to meet treatment goals;
- Maintain accurate and complete medical records; and
- Comply with all controlled substance laws and regulations.

A health care practitioner who fails to follow the guidelines established by the appropriate regulatory board is subject to disciplinary action against his or her license.

Continuing Education on Controlled Substance Prescribing

All health care practitioners who are authorized to prescribe controlled substances must complete a board-approved 2-hour continuing education course, if not already required to complete such a course under his or her practice act.[37] The course must address:

---

[32] Section 456.44(3)(d), F.S.
[33] Section 456.44(3)(e), F.S.
[34] Section 456.44(3)(g), F.S.
[35] Rules 64B5-17.0045, 64B8-9.013, 64B9-4.017, 64B13-3.100, 64B15-14.005, 64B18-23.002, F.A.C., respectively. *See also* s. 456.44(4), F.S.
[36] Id.
[37] Section 456.0301, F.S. Pursuant to s. 464.013(3)(b), F.S., an advanced registered nurse practitioner must complete at least 3 hours of continuing education hours on the safe and effective prescribing of controlled substances each biennial renewal cycle. Section

- Current standards on prescribing controlled substances, particularly opiates;
- Alternatives to the current standards on controlled substance prescribing;
- Nonpharmacological therapies;
- Prescribing emergency opioid antagonists; and
- Information on the risks of opioid addiction following all stages of treatment in the management of acute pain.

The course may be taken in a long-distance format and must be included in the continuing education required for the biennial renewal of a health care practitioner's license. The Department of Health (DOH) may not renew the license of a prescriber who fails to complete this continuing education requirement.

Non-Opioid Alternatives

Using a non-opioid treatment option may eliminate the need for an opioid or reduce the amount of opioids used. The Center for Disease Control and Prevention's (CDC) guidelines for treating chronic pain indicate that non-pharmacologic therapy and non-opioid pharmacologic therapy are the preferred manners of treatment for chronic pain.[38] Examples of non-opioid treatments include:[39]

- Non-opioid medications, such as non-steroidal anti-inflammatory agents (NSAIDs), acetaminophen, corticosteroids, and topical products;
- Behavioral interventions, such as meditation;
- Environmental-based interventions, such as lighting alterations and music therapy; and
- Physical interventions, such as surgery, chiropractic care, acupuncture, physical therapy, and massage therapy.

The CDC also advises that opioid therapy should only be considered if the expected benefit to the patient outweighs the risk, and if used, should be combined with non-pharmacologic and non-opioid pharmacologic therapy.[40]

Florida Law on Non-Opioid Alternatives

In 2019, the Legislature enacted a law that requires DOH to develop and publish on its website, an educational pamphlet regarding the use of non-opioid alternatives to treat pain.[41] The pamphlet addresses:[42]

- Nonopioid alternatives, including non-opioid medications and non-pharmacological therapies; and
- Advantages and disadvantages of using each of the non-opioid alternatives.

All health care practitioners, except pharmacists, must discuss non-opioid alternatives for treating pain with their patients prior to providing anesthesia or prescribing, ordering, dispensing, or administering an opioid.[43] The health care practitioner must discuss the advantages and disadvantages of using a non-

---

466.0135, F.S., requires dentists to complete at least 2 continuing education hours on the safe and effective prescribing of controlled substances for license renewal. Rules 64B8-30.005(6) and 64B15-6.0035(6), F.A.C., requires physician assistants who prescribe controlled substances to complete 3 hours of continuing education on the safe and effective prescribing of controlled substance medications.

[38] Centers for Disease Control and Prevention, *Nonopioid Treatments for Chronic Pain,* available at https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf (last visited December 18, 2019).

[39] The Joint Commission, *Non-Pharmacologic and Non-Opioid Solutions for Pain Management*, QUICK SAFETY 44 (Aug. 2018), available at https://www.jointcommission.org/assets/1/23/QS_Nonopioid_pain_mgmt_8_15_18_FINAL1.PDF (last visited December 18, 2019).

[40] *Supra* note 38.

[41] Chapter 2019-123, L.O.F., codified at s. 456.44(7), F.S. The website and pamphlet may be accessed at http://www.floridahealth.gov/programs-and-services/non-opioid-pain-management/index.html (last visited December 17, 2019).

[42] Id.

[43] Section 456.44(7)(c), F.S.

opioid alternative, document the discussion in the patient's record, and provide the patient with the DOH-developed pamphlet.[44] The only exception to this requirement is when a health care practitioner is providing emergency care or services.[45]

There is currently no requirement that the patient must receive a printed copy of the pamphlet. Current law does not authorize a health care practitioner to provide the information to the patient's representative instead of the patient.

Effect of the Proposed Changes

HB 743 revises the circumstances under which a health care practitioner must counsel a patient about non-opioid alternatives. The bill exempts health care practitioners providing hospice services[46] and those providing care in a hospital critical care unit or emergency department from the requirement to provide information about non-opioid alternatives.

The bill authorizes a health care practitioner to inform the patient's representative, instead of the patient, of non-opioid alternatives for treating pain and discuss the advantages and disadvantages of using such alternatives, prior to administering anesthesia that involves the use of an opioid drug or prescribing or ordering an opioid drug. A health care practitioner must document the discussion in the patient's medical record and provide a printed copy of the pamphlet produced by DOH to the patient or the patient's representative.

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

B. SECTION DIRECTORY:

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH may incur insignificant costs associated with printing the non-opioid alternatives brochure to provide to appropriate patients in county health departments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

---

[44] Id.

[45] "Emergency care and services" means medical screening, examination, and evaluation by a physician or other authorized personnel under the supervision of a physician to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relive or eliminate the emergency medical condition, within the service capability of the facility (s. 395.002, F.S.).

[46] "Hospice services are provided to individuals who have been admitted to a hospice program after or upon a diagnosis and prognosis of terminal illness by a licensed physician. Hospice services may include physician care, nursing services, social work services, pastoral or counseling services, dietary counseling, bereavement counseling, and other palliative and support services needed by the patients. *See* ss. 400.609 and 400.6095, F.S.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   Health care practitioners may incur costs associated with purchasing or printing the DOH-developed pamphlet on non-opioid alternatives.

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:

   Rulemaking is not necessary to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to nonopioid alternatives; amending s.
3 456.44, F.S.; revising a requirement for certain
4 health care practitioners to inform a patient or the
5 patient's representative of nonopioid alternatives
6 before prescribing or ordering an opioid drug;
7 providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Paragraph (c) of subsection (7) of section
12 456.44, Florida Statutes, is amended to read:
13 456.44 Controlled substance prescribing.—
14 (7) NONOPIOID ALTERNATIVES.—
15 (c) Except when ~~in the provision of~~ a patient is receiving
16 care in a hospital critical care unit or emergency department or
17 a patient is receiving hospice services under s. 400.6095
18 ~~services and care, as defined in s. 395.002~~, before providing
19 care requiring the administration of anesthesia involving the
20 use of an opioid drug listed as a Schedule II controlled
21 substance in s. 893.03 or 21 U.S.C. s. 812, or prescribing or
22 ordering ~~or prescribing, ordering, dispensing, or administering~~
23 an opioid drug listed as a Schedule II controlled substance in
24 s. 893.03 or 21 U.S.C. s. 812 for the treatment of pain, a
25 health care practitioner who prescribes or orders an opioid

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26 drug~~, excluding those licensed under chapter 465,~~ must:
27 1. Inform the patient or the patient's representative of
28 available nonopioid alternatives for the treatment of pain,
29 which may include nonopioid medicinal drugs or drug products,
30 interventional procedures or treatments, acupuncture,
31 chiropractic treatments, massage therapy, physical therapy,
32 occupational therapy, or any other appropriate therapy as
33 determined by the health care practitioner.
34 2. Discuss with the patient or the patient's
35 representative the advantages and disadvantages of the use of
36 nonopioid alternatives, including whether the patient is at a
37 high risk of, or has a history of, controlled substance abuse or
38 misuse and the patient's personal preferences.
39 3. Provide the patient or the patient's representative
40 with a printed copy of the educational pamphlet described in
41 paragraph (b).
42 4. Document the nonopioid alternatives considered in the
43 patient's record.
44 Section 2. This act shall take effect July 1, 2020.

COMMITTEE/SUBCOMMITTEE ACTION

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

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Plakon offered the following:
4
5 **Amendment**
6 Remove everything after the enacting clause and insert:
7 Section 1. Paragraph (c) of subsection (7) of section
8 456.44, Florida Statutes, is amended to read:
9 456.44 Controlled substance prescribing.—
10 (7) NONOPIOID ALTERNATIVES.—
11 (c) ~~Except in the provision of emergency services and~~
12 ~~care, as defined in s. 395.002,~~ Before providing care requiring
13 the administration of anesthesia involving the use of an opioid
14 drug listed as a Schedule II controlled substance in s. 893.03
15 or 21 U.S.C. s. 812, or prescribing or ordering ~~or prescribing,~~
16 ~~ordering, dispensing, or administering~~ an opioid drug listed as

17 a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s.
18 812 for the treatment of pain, a health care practitioner who
19 prescribers or orders an opioid drug, excluding those licensed
20 under chapter 465, must:
21 1. Inform the patient or the patient’s represenative of
22 available nonopioid alternatives for the treatment of pain,
23 which may include nonopioid medicinal drugs or drug products,
24 interventional procedures or treatments, acupuncture,
25 chiropractic treatments, massage therapy, physical therapy,
26 occupational therapy, or any other appropriate therapy as
27 determined by the health care practitioner.
28 2. Discuss with the patient or the patient’s
29 representative the advantages and disadvantages of the use of
30 nonopioid alternatives, including whether the patient is at a
31 high risk of, or has a history of, controlled substance abuse or
32 misuse and the patient's personal preferences.
33 3. Provide the patient or the patient’s representative
34 with a printed copy of the educational pamphlet described in
35 paragraph (b).
36 4. Document the nonopioid alternatives considered in the
37 patient's record.
38 (d) The requirements of paragraph (c) do not apply to:
39 1. A patient receiving care in a hospital critical care
40 unit or emergency department.

41 2. A patient receiving hospice care services under s.
42 400.6095.
43 3. A patient receiving care for cancer or a terminal
44 condition as defined in subsection (1).
45 Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 747 Coverage for Air Ambulance Services
SPONSOR(S): Health Market Reform Subcommittee, Williamson
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 736

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 1 N, As CS	Grabowski	Calamas
2) Appropriations Committee	29 Y, 0 N	Keith	Pridgeon
3) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

Providers of air ambulance services use both helicopter and fixed-wing aircraft to transport patients with time-sensitive medical needs. Air ambulance services can dramatically reduce transport times for critically ill patients during life-threatening emergencies.

The infrequent and unpredictable nature of most air ambulance transports, as well as high prices, reduce the incentives of both air ambulance providers and insurers to enter into contracts with agreed-upon payment rates. This means air ambulance providers are more likely to be out-of-network when compared with other types of providers, and may be more likely to seek reimbursement by balance billing the patient. While Florida law prohibits balance billing in many circumstances, air ambulance services are largely exempt from those prohibitions.

HB 747 requires a commercial health insurer or HMO to provide reasonable reimbursement to an air ambulance service for emergency and nonemergency transport services provided to a covered individual in accordance with the terms of the insurance policy or HMO contract. The bill defines “reasonable reimbursement” as payment that considers the direct cost of services provided, costs incurred by the operation of an air ambulance service by a county which operates entirely within a designated area of critical state concern as determined by the Department of Economic Opportunity, and in-network reimbursement for comparable services.

The bill specifies that reasonable reimbursement to air ambulance service providers may be reduced only by applicable copayments, coinsurance, and deductibles, unless a covered individual has contracted to pay a different amount. The reasonable reimbursement must serve as full and final payment to the air ambulance service provider. Accordingly, the bill would prohibit air ambulance service providers from balance billing insured patients.

The bill has no fiscal impact to the state and an indeterminate impact to local governments.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

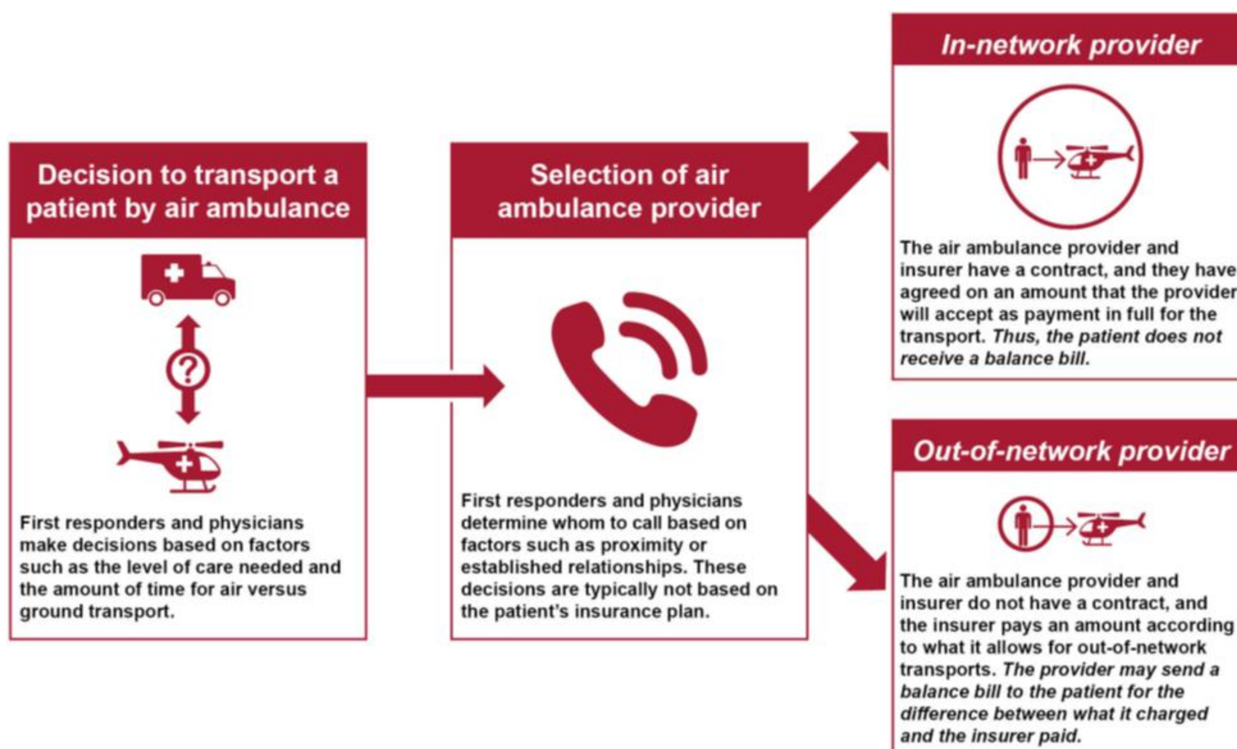
Background

Air Ambulance Services

Providers of air ambulance services use both helicopter and fixed-wing aircraft to transport patients with time-sensitive medical needs. These two types of aircraft are generally used on different types of missions:

- Helicopters are often used for transports from the scene of the accident or injury to the hospital or for shorter-distance transports between hospitals. Helicopter bases may be at hospitals, airports, or other types of helipads, and a provider may need to fly from its base to the scene or a hospital to pick up the patient being transported.
- Fixed-wing aircraft may be used for longer-distance transports between hospitals. Fixed-wing bases are at airports, and the patient is usually transported by ground ambulance to and from the airports.[1]

Relatively few patients receive air ambulance transports, but those who do generally have no control over the decision to be transported via air ambulance or in the selection of an air ambulance provider.[2]



[1] U.S. Government Accountability Office, *AIR AMBULANCE – Available Data Show Privately-Insured Patients are at Financial Risk*, GAO-19-292, March 2019, available at https://www.gao.gov/assets/700/697684.pdf (last accessed January 24, 2020).
[2] Id.

Air ambulance services can dramatically reduce transport times for critically ill patients during life-threatening emergencies.[3] In the case of on-scene response transports, first responders decide when air ambulance service is needed, while hospital staff primarily make decisions regarding the need for interfacility transports. However, the on-demand nature of air ambulance services, combined with the high fixed costs associated with the transport vehicles, leads to the high cost of air ambulance services.[4] Those costs can vary widely; one source indicates the average air ambulance flight covers 52 miles and costs between $12,000 and $25,000.[5] Another source indicates that the median price charged by air ambulance providers was just under $30,000 per transport in 2014.[6] A study commissioned by the Association of Air Medical Services and Members, an industry trade group, indicates that air ambulance providers earned approximately $23,500 in median revenue per transport for flights reimbursed under commercial health insurance during fiscal year 2015.[7]

There have been numerous reports of cases where patients have received substantial balance bills from air ambulance providers for services rendered.[8] Balance billing describes a situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that the insurer or HMO paid on the claim. The infrequent and unpredictable nature of most air ambulance transports, as well as high prices, reduces the incentives of both air ambulance providers and insurers to enter into contracts with agreed-upon payment rates. This means air ambulance providers are more likely to be out-of-network when compared with other types of providers, and may be more likely to seek reimbursement through balance billing.[9]

Regulation of Air Ambulance Services

Federal Regulation

States generally have the right to regulate the business of insurance.[10] Absent federal intervention, states are responsible for regulating both health plans and service providers. In the case of air ambulance, however, federal law has effectively prevented states from regulating air ambulance services.

The federal Airline Deregulation Act of 1978[11] prohibits states from regulating the price, route, or service of an air carrier for the purposes of keeping national commercial air travel competitive. While the law was intended to shield commercial airlines from state price regulations, it also had the effect of preempting any state regulation of air medical transportation.[12]

---

[3] U.S. Government Accountability Office, *AIR AMBULANCE – Data Collection and Transparency Needed to Enhance DOT Oversight*, GAO-17-637, July 2017, available at https://www.gao.gov/assets/690/686167.pdf (last accessed January 24, 2020).
[4] Supra note 1.
[5] National Association of Insurance Commissioners, *Understanding Air Ambulance Insurance Coverage*, May 2018, available at https://www.naic.org/documents/consumer_alert_understanding_air_ambulance_insurance.htm (last accessed January 24, 2020).
[6] Supra note 3.
[7] Association of Air Medical Services and Members, *Air Medical Services Cost Study Report*, March 24, 2017, available at http://aams.org/wp-content/uploads/2017/04/Air-Medical-Services-Cost-Study-Report.pdf (last accessed January 24, 2020).
[8] See, for example, *New York Times*, "Air Ambulances Offer a Lifeline, and Then a Sky-High Bill", May 5, 2015, available at https://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html (last accessed January 25, 2020); *Kaiser Health News*, "Loopholes Limit New California Law To Guard Against Lofty Air Ambulance Bills," January 14, 2020, available at https://khn.org/news/loopholes-limit-new-california-law-to-guard-against-lofty-air-ambulance-bills/?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=81882222&_hsenc=p2ANqtz-_xOXkiliKqycwboslv-ok9ZzPwE0kaWIcuR0C89EQT-lM6DClHRVyXBUUcRr4Nk_Flh6H2L5j_boZBH9EpSPpIKcsGeCRPTqKN5nw13yXMsU_VTOo&_hsmi=81882222 (last accessed January 25, 2020).
[9] Supra note 1.
[10] See the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011-1015
[11] P.L. 95-504, 49 U.S.C. § 1301 et seq.
[12] National Association of Insurance Commissioners, *Issue Brief: Air Ambulance Regulation*, January 2019, available at https://www.naic.org/documents/government_relations_air_ambulance_regulation_issue_brief.pdf (last accessed January 25, 2020).

Several states have tried to prevent air ambulances from collecting inflated charges by setting maximum prices, prohibiting air ambulances from balance billing, setting reasonable air ambulance rates in workers' compensation claims (which states do for nearly every health care service for workplace injuries), or even requiring air ambulance providers to provide fee schedules upon request.[13] In some states, air ambulance providers have successfully challenged state law by relying on the Airline Deregulation Act. For example, A 2017 North Dakota law requires insurers to pay for out-of-network air ambulance transports at the average of the insurer's in-network rate for air ambulance providers in the state. This payment is deemed full and final payment for the services provided.[14] In January 2019, a federal district court concluded that this payment provision is preempted by the ADA, as it has the effect of setting rates for air services.[15]

Alternatively, states have also used coverage mandates on insurers as a vehicle to prevent balance billing by service providers. In Montana, a 2017 law requires insurers and health plans to assume responsibility for amounts charged to a covered individual in excess of both allowed amounts and applicable cost-sharing amounts for air ambulance services. It also requires the use of a nonbinding dispute resolution process to determine the fair market price of services provided before a party may seek any remedy in court.[16] In New Mexico, managed health care plans are required to make emergency care services available to covered individuals without restriction and to ensure the provision of appropriate out-of-network services without additional costs. The Superintendent of Insurance began applying these requirements to air ambulance services in 2017.[17] Laws such as these appear to skirt the Airline Deregulation Act by imposing regulatory requirements on the insurer, rather than the provider.

Florida Regulation

In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[18]

All health insurance policies issued in Florida, with the exception of certain self-insured policies,[19] must meet certain requirements that are detailed throughout the Florida Insurance Code. Chapter 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for health plans issued by health maintenance organizations (HMOs). At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[20]

There have been numerous reports of cases where patients have received substantial balance bills from air ambulance providers for services rendered.[21] While Florida law prohibits balance billing in many circumstances, air ambulance services are generally exempt from those prohibitions.

---

[13] Are Air Ambulances Truly Flying Out Of Reach? Surprise-Billing Policy And The Airline Deregulation Act, " *Health Affairs* Blog, October 17, 2019, available at https://www.healthaffairs.org/do/10.1377/hblog20191016.235396/full/ (last accessed January 25, 2020).
[14] N.D. Cent. Code S 26.1-47-09.
[15] *Guardian Flight LLV v. Godfread*, No. 1:18-cv-007.
[16] Mont. Code Ann. Ss. 33-2-2302 and 33-2-2305.
[17] N.M. Stat. Ann. S. 59A-57-4; N.M. Code R. S. 13.10.21.8.
[18] S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[19] 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[20] S. 627.413(1)(d), F.S.
[21] See, for example, *New York Times*, "Air Ambulances Offer a Lifeline, and Then a Sky-High Bill", May 5, 2015, available at https://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html (last accessed January 25, 2020).

Under current law, balance billing is prohibited for services provided by Medicaid;[22] workers' compensation insurance;[23] an exclusive provider who is part of an EPO; [24] or a provider who is under contract with a prepaid limited service organization.[25] In addition, the law provides that an HMO is liable to pay, and may not balance bill, for covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[26] Balance billing is also prohibited under commercial insurance in cases when emergency services are provided by an out-of-network provider, and when nonemergency services are provided by an out-of-network provider and the covered individual does not have the ability and opportunity to choose a participating provider at the facility who is available to treat that patient.[27]

Florida law does not address balance billing by air ambulance providers in cases when an air ambulance provider has not contracted with an insurer for reimbursement rates.

Effect of Proposed Changes

HB 747 requires a commercial health insurer or HMO to provide reasonable reimbursement to an air ambulance service for covered emergency and nonemergency transport services provided to a covered individual in accordance with the terms of the insurance policy or HMO contract. The bill defines "reasonable reimbursement" as payment that considers the direct cost of services provided, costs incurred by the operation of an air ambulance service by a county which operates entirely within a designated area of critical state concern as determined by the Department of Economic Opportunity[28], and in-network reimbursement for comparable services.

The bill specifies that reasonable reimbursement to air ambulance service providers may be reduced only by applicable copayments, coinsurance, and deductibles, unless a covered individual has contracted to pay a different amount. The reasonable reimbursement must serve as full and final payment to the air ambulance service provider.

The bill would prohibit air ambulance service providers from seeking reimbursement from commercially insured recipients of services, and would thus prohibit balance billing. In cases where an air ambulance provider and an insurer have not contractually agreed to reimbursement rates, the air ambulance provider would be required to accept "reasonable reimbursement" from the insurer. In preventing the use of balance billing practices by air ambulance providers, the bill would reduce the number of insured patients who receive unexpected bills resulting from air medical transport, while changing the balance of contract negotiation between payers and these providers.

The bill also indicates that these provisions are not severable. In other words, if one provision in the bill is invalidated for any reason, the entirely of the bill shall be void.

The bill takes effect upon becoming law.

---

[22] S. 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with the Provider General Handbook, which expressly prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (CORE contract) establishes minimum requirements for contracts between plans and providers. The CORE contract requires those contracts to prohibit balance billing, except for any applicable cost sharing.
[23] S. 440.13(13)(a), F.S.
[24] S. 627.6472(4)(e), F.S.
[25] S. 636.035(3) - (4), F.S.
[26] Ss. 641.315(1) and 641.3154(1), F.S.
[27] S. 627.64194, F.S.
[28] The Areas of Critical State Concern Program was created by the Florida Environmental Land and Water Management Act of 1972. The program is intended to protect resources and public facilities of major statewide significance, within designated geographic areas, from uncontrolled development that would cause substantial deterioration of such resources.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.42397, F.S., relating to coverage for air ambulance services.
Section 2: Establishes that the bill's requirements are not severable.
Section 3: Provides that the bill takes effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   There is no additional cost to the Office of Insurance Regulation associated with the need to amend its form review procedures to account for new requirements in the bill.[29] Additionally, provisions of the bill have no impact on the Department of Management Services' Division of State Group Insurance PPO and HMO health plans.[30]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   At least one county (Monroe) operates an air ambulance service program, and is within a designated area of critical state concern. The bill may have an indeterminate fiscal impact on any county or municipal government operating such a program.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

By preventing the use of balance billing practices by air ambulance service providers, the bill will likely have a negative, indeterminate fiscal impact on those providers. Oppositely, the bill may have a positive fiscal impact on insurers, HMOs, and insureds by limiting payments to air ambulance service providers to "reasonable reimbursement" for services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have

[29] Florida Office of Insurance Regulation, Agency Analysis of 2020 HB 747, pp. 2-3 (Dec. 10, 2019).
[30] Florida Department of Management Services, Agency Analysis of 2020 HB 747, p.5 (Jan. 23, 2020).

to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Office of Insurance Regulation has sufficient authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 21, 2020, the Health Market Reform Subcommittee adopted a strike-all amendment to the bill. The strike-all creates equivalent language in both chapters 627 and 641, so that the regulation of air ambulance billing will apply to both insurance carriers and HMOs. The bill as introduced included regulation only in chapter 627.

The strike-all also modifies the set of factors that must be considered when insurers and HMOs determine "reasonable reimbursement" to providers of air ambulance services. Insurers and HMOs are required to consider the "direct" cost of services provided, rather than "actual" cost.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

1 A bill to be entitled
2 An act relating to coverage for air ambulance
3 services; creating ss. 627.42397 and 641.514, F.S.;
4 providing definitions; requiring health insurers and
5 health maintenance organizations, respectively, to
6 provide reasonable reimbursement to air ambulance
7 services for certain covered services; providing that
8 such reimbursement may be reduced only by certain
9 amounts; providing that reasonable reimbursement must
10 serve as full and final payment to air ambulance
11 services; providing nonseverability; providing an
12 effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Section 627.42397, Florida Statutes, is created
17 to read:
18 627.42397 Coverage for air ambulance services.—
19 (1) As used in this section, the term:
20 (a) "Air ambulance service" has the same meaning as
21 provided in s. 401.23.
22 (b) "Health insurer" means an authorized insurer offering
23 health insurance as defined in s. 624.603.
24 (c) "Reasonable reimbursement" means reimbursement that
25 considers the direct cost to provide the air ambulance

26 transportation service to the insured, the operation of an air
27 ambulance service by a county which operates entirely within a
28 designated area of critical state concern as determined by the
29 Department of Economic Opportunity, and in-network reimbursement
30 established by the health insurer for the specific policy. The
31 term does not include billed charges for the cost of services
32 rendered.
33 (2) A health insurance policy must require a health
34 insurer to provide reasonable reimbursement to an air ambulance
35 service for covered nonemergency and emergency services provided
36 to an insured in accordance with the coverage terms of the
37 policy. Such reasonable reimbursement may be reduced only by
38 applicable copayments, coinsurance, and deductibles. The
39 reasonable reimbursement must serve as full and final payment to
40 the air ambulance service.
41 Section 2. Section 641.514, Florida Statutes, is created
42 to read:
43 641.514 Coverage for air ambulance services.—
44 (1) As used in this section, the term:
45 (a) "Air ambulance service" has the same meaning as
46 provided in s. 401.23.
47 (b) "Health maintenance organization" has the same meaning
48 as provided in s. 641.19(12).
49 (c) "Reasonable reimbursement" means reimbursement that
50 considers the direct cost to provide the air ambulance

51 transportation service to the subscriber, the operation of an
52 air ambulance service by a county which operates entirely within
53 a designated area of critical state concern as determined by the
54 Department of Economic Opportunity, and in-network reimbursement
55 established by the health maintenance organization for the
56 specific contract. The term does not include billed charges for
57 the cost of services rendered.
58 (2) A health maintenance contract must require a health
59 maintenance organization to provide reasonable reimbursement to
60 an air ambulance service for covered nonemergency and emergency
61 services provided to a subscriber in accordance with the
62 coverage terms of the contract. Such reasonable reimbursement
63 may be reduced only by applicable copayments, coinsurance, and
64 deductibles. The reasonable reimbursement must serve as full and
65 final payment to the air ambulance service.
66 Section 3. If any provision of section 627.42397, Florida
67 Statutes, or section 641.514, Florida Statutes, as created by
68 this act, is determined to be invalid or inoperative for any
69 reason, the remaining provisions thereof shall be deemed to be
70 void and of no effect. To this end, the Legislature declares
71 that it would not have enacted any of the provisions of section
72 627.42397, Florida Statutes, or section 641.514, Florida
73 Statutes, individually and expressly finds them not to be
74 severable.
75 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

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Williamson offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 33-65 and insert:
7 (2) A health insurance policy must require a health
8 insurer to provide reasonable reimbursement to an air ambulance
9 service for covered nonemergency and emergency services provided
10 to an insured in accordance with the coverage terms of the
11 policy. Such reasonable reimbursement may be reduced only by
12 applicable copayments, coinsurance, and deductibles. Payment in
13 full of applicable copayments, coinsurance, and deductibles by
14 the insured shall constitute an accord and satisfaction, and
15 otherwise constitute a release, of any claim for additional
16 moneys owed by the insured in connection with the air ambulance

17 service to the health insurer or to any person or entity to whom
18 such payment, or the right to receive such payment, is
19 transferred or assigned.
20 Section 2. Section 641.514, Florida Statutes, is created
21 to read:
22 641.514 Coverage for air ambulance services.—
23 (1) As used in this section, the term:
24 (a) "Air ambulance service" has the same meaning as
25 provided in s. 401.23.
26 (b) "Health maintenance organization" has the same meaning
27 as provided in s. 641.19(12).
28 (c) "Reasonable reimbursement" means reimbursement that
29 considers the direct cost to provide the air ambulance
30 transportation service to the subscriber, the operation of an
31 air ambulance service by a county which operates entirely within
32 a designated area of critical state concern as determined by the
33 Department of Economic Opportunity, and in-network reimbursement
34 established by the health maintenance organization for the
35 specific contract. The term does not include billed charges for
36 the cost of services rendered.
37 (2) A health maintenance contract must require a health
38 maintenance organization to provide reasonable reimbursement to
39 an air ambulance service for covered nonemergency and emergency
40 services provided to a subscriber in accordance with the
41 coverage terms of the contract. Such reasonable reimbursement

42 may be reduced only by applicable copayments, coinsurance, and
43 deductibles. Payment in full of applicable copayments,
44 coinsurance, and deductibles by the subscriber shall constitute
45 an accord and satisfaction, and otherwise constitute a release,
46 of any claim for additional moneys owed by the subscriber in
47 connection with the air ambulance service to the health
48 maintenance organization or to any person or entity to whom such
49 payment, or the right to receive such payment, is transferred or
50 assigned.
51
52 ---
53 **T I T L E A M E N D M E N T**
54 Remove lines 9-10 and insert:
55 amounts; providing that payment in full of copayments,
56 coinsurance, and deductibles by insureds and
57 subscribers, respectively, constitutes accord and
58 satisfaction and release of specified claims in
59 connection with air ambulance

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 827 Recovery Care Services
SPONSOR(S): Stevenson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 1 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	10 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

The bill creates a new licensure category for a Recovery Care Center (RCC), defined as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to a RCC. A patient may receive recovery care services in a RCC upon:

- Discharge from an Ambulatory Surgical Center (ASC) after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving out-patient medical treatment such as chemotherapy.

The new RCC license is modeled after the current licensing procedures for hospitals and ASCs, subjecting RCCs to similar regulatory standards, inspections, and rules. RCCs must have emergency care and transfer protocols, including transportation arrangements, and a referral or admission agreement with at least one hospital.

The bill has an indeterminate, negative fiscal impact on the Agency for Health Care Administration, which will be offset by fees authorized by linked HB 7021.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Recovery Care Centers

Recovery care centers (RCCs) are entities that provide short-term nursing care, support, and pain control for patients that do not require acute hospitalization.[1] RCC patients are typically healthy persons that have had elective surgery. RCCs are not eligible for Medicare reimbursement.[2] However, RCCs may receive payments from Medicaid programs and commercial payers.

RCCs can be either freestanding or attached to an ambulatory surgical center (ASC) or hospital. In practice, RCCs typically provide care to patients transferred from an ASC following surgery, which allows the ASC to perform more complex procedures.[3]

There has been a steady increase in the complexity of cases performed in ASCs. Total joint arthroplasty is representative of procedures that have experienced transition from the inpatient to the ASC setting. From 2012 to 2015, elective total joint replacements in the outpatient setting increased by nearly 50 percent, and in the next decade outpatient total joint replacement is expected to increase 457 percent for total knee replacements and 633 percent for total hip replacements.[4]

In 2014, the Office of the Inspector General for the U.S. Department of Health and Human Services studied the cost efficiency associated with Medicare beneficiaries obtaining surgical services in an outpatient setting.[5] The OIG found that Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 due primarily to the lower rates for surgical procedures done in ASCs.[6] The OIG also found that Medicare beneficiaries realized savings of $2 billion in the form of reduced co-payment obligations in the ASC setting.[7] In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduced hospital outpatient department payment rates for ASC-approved procedures to ASC payment levels.[8] Beneficiaries, in turn, would save $3 billion.[9]

A review of commercial medical claims data found that U.S. healthcare costs are reduced by more than $38 billion per year due to the availability of ASCs for outpatient procedures.[10] More than $5 billion of the cost reduction accrued to the patient through lower deductible and coinsurance payments.[11] This cost reduction is driven by the fact that, in general, ASC prices are significantly lower than hospital outpatient department prices for the same procedure in all markets, regardless of payer. The study also looks at the potential savings that could be achieved if additional procedures were redirected to

[1] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment for Post-Surgical Recovery Care Centers*, (2000), available at https://permanent.access.gpo.gov/lps20907/nov2000medpay.pdf (last viewed January 1, 2020).
[2] Id.
[3] Id. at pg. 4.
[4] Dyrda, L.(2017, February 10). 16 things to know about outpatient total joint replacement and ASCs. *Becker's ASC Review.*
[5] U.S. Department of Health and Human Services, Office of Inspector General, *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates*, Audit A-05-12-00020 (April 16, 2014).
[6] Id. at pg. i.
[7] Id. at pg. ii.
[8] Id.
[9] Id.
[10] Healthcare Bluebook and HealthSmart, *Commercial Insurance Cost Savings in Ambulatory Surgery Centers*, page 7 (June 2016), available at http://www.ascassociation.org/asca/communities/community-home/librarydocuments/viewdocument?DocumentKey=61197e80-d852-4004-860a-2424968b005b (last viewed January 1, 2020).
[11] Id.

ASCs. As much as $55 billion could be saved annually depending on the percentage of procedures that migrate to ASCs and the mix of ASCs selected instead of HOPDs.[12] As a result, patients, employers, and insurers are interested in ways to safely migrate procedures to ASCs. Conversely, hospitals remain in solitary opposition of the idea.

Three states have specific licenses for RCCs.[13] Other states license RCCs as nursing facilities or hospitals.[14] One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a maximum stay of 72 hours.[15]

Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

Regulation	Arizona[16]	Connecticut[17]	Illinois[18]
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient's Bill of Rights	X	X	X
Freestanding and Attached	Not Addressed.	X	X
Length of Stay	Not Addressed.	Expected 3 days; maximum 21 days	Expected 48 hours; maximum 72 hrs
Emergency Care Transfer	For care not provided by the RCC.	With a hospital and an ambulance service.	With a hospital within 15 minutes travel time.
Prohibited Patients	• Intensive care • Coronary care • Critical care	• Intensive care • Coronary care • Critical care	• Patients with chronic infectious conditions • Children under age 3
Prohibited Services	• Surgical • Radiological • Pediatric • Obstetrical	• Surgical • Hospice • Pre-adolescent pediatric • OB (over 24 weeks) • IV-therapy (non-hospital RCC) • Radiological	Blood administration (only blood products allowed)
Required Services	• Laboratory • Pharmaceutical • Food	• Pharmacy • Dietary • Personal care • Rehabilitation • Therapeutic • Social work	• Laboratory • Pharmaceutical • Food • Radiological
Bed Limit	Not Addressed.	Not Addressed.	20
Required Staff	• Governing authority • Administrator	• Governing body • Administrator	Consulting committee
Required Medical Personnel	• At least two physicians • Director of nursing	• Medical advisory board • Medical director • Director of nursing	• Medical director • Nursing supervisor
Required Personnel When Patients Present	• Director of nursing 40 hrs/wk • One RN • One other nurse	• Two persons for patient care	• One RN • One other nurse

[12] Id.
[13] Ariz. Rev. Stat. Ann.§§ 36-448.51-36-448.55; Conn. Conn. Agencies Regs § 19A-495-571; 210 Ill. Comp. Stat. Ann. 3/35. In 2009, Illinois limited the total number of RCCs to those centers holding a certificate of need for beds as of January 1, 2008. The five existing RCCs were grandfathered in and continue to be regulated under 77 Ill. Admin. Code 210.
[14] Sandra Lee Breisch, *Profits in Short Stays*, Am. Acad. of Orthopedic Surgeons Bulletin (June, 1999), available at http://www2.aaos.org/bulletin/jun99/asc.htm (last viewed January 1, 2020).
[15] Supra FN 1, at pg. 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).
[16] Ariz. Rev. Stat. Ann. §§ 36-448.51-36-448.55; Ariz. Admin. Code §§ R9-10-501-R9-10-518 (updated in 2013, formerly R9-10-1401-R9-10-1412).
[17] Conn. Agencies Regs. § 19A-495-571.
[18] 210 Ill. Comp. Stat. Ann. 3/35; Ill. Admin. Code tit. 77, §§ 210.2500 & 210.2800.

Effect of Proposed Changes

The bill creates a new license for a Recovery Care Center (RCC). The new RCC license is modeled after the current licensure program for hospitals and ASCs in Chapters 395 and 408, F.S. An applicant for RCC licensure must follow the general licensing procedures in Chapter 408, Part II. Additionally, the applicant will be subject to the license, inspection, safety, facility, and other requirements of Chapter 395, Part I.

The bill defines a RCC as a facility whose primary purpose is to provide recovery care services, to which the patient is admitted and discharged within 72 hours, and is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to a RCC. A patient may receive recovery care services in a RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving an out-patient medical treatment, such as chemotherapy.

A RCC must have emergency care and transfer protocols, including transportation arrangements, and a referral or admission agreement with at least one hospital. Further, AHCA is authorized to adopt rules regarding RCC admission and discharge procedures.

The bill authorizes AHCA to adopt, by rule, appropriate standards for RCCs pursuant to s. 395.1055, F.S. in the same categories for hospitals and ASCs:

- Staffing;
- Infection control;
- Housekeeping;
- Medical records;
- Emergency management;
- Inspections;
- Accreditation;
- Organization, including a governing body and organized medical staff;
- Departments and services;
- Quality assessment and improvement;
- Minimum space; and
- Equipment and furnishings.

In addition, the bill requires AHCA to adopt rules to set standards for dietetic departments, proper use of medications, and pharmacies in RCCs.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.001, F.S., related to legislative intent.
Section 2: Amends s. 395.002, F.S., related to definitions.
Section 3: Amends s. 395.003, F.S., related to licensure; denial, suspension, and revocation.
Section 4: Creates s. 395.0171, F.S., related to recovery care center admissions; emergency and transfer protocols; discharge planning and protocols.
Section 5: Amends s. 395.1055, F.S., related to rules and enforcement.
Section 6: Amends s. 395.10973, F.S., related to powers and duties of the agency.
Section 7: Amends s. 408.802, F.S., related to applicability.
Section 8: Amends s. 408.820, F.S., related to exemptions.
Section 9: Amends 385.211, F.S., related to refractory and intractable epilepsy treatment and research at recognized medical centers.
Section 10: Amends s. 394.4787, F.S., related to definitions.
Section 11: Amends s. 409.975, F.S., related to managed care plan accountability.
Section 12: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Section 408.805, F.S., requires AHCA to set license fees that are reasonably calculated to cover the cost of regulation. HB 7021, which is linked to this bill, authorizes AHCA to set license fees for RCCs. Applicants for licensure as a RCC will be subject to the current Plans and Construction project review fee of $2,000 plus $100 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.[19]

2. Expenditures:

   The bill requires AHCA to regulate RCCs in accordance with Chapters 395 and 408, F.S., and any rules adopted by the agency. HB 7021, which is linked to this bill, authorizes AHCA to set license fees for RCCs. The fees associated with the license are anticipated to cover the expense incurred by AHCA in enforcing and regulating the new license.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals needing surgery may save money by being able to stay in a RCC rather than having the original procedure in a hospital and remaining in the hospital to recover.

Hospitals may experience a negative fiscal impact if patients receive care in an ASC followed by RCC care.

[19]Agency for Health Care Administration, 2019 Agency Legislative Bill Analysis-HB 25, March 11, 2019 (on file with Health Market Reform Subcommittee staff).

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:

There is sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to recovery care services; amending s.
3 395.001, F.S.; revising legislative intent; amending
4 s. 395.002, F.S.; revising and providing definitions;
5 amending s. 395.003, F.S.; providing for licensure of
6 recovery care centers by the Agency for Health Care
7 Administration; creating s. 395.0171, F.S.; providing
8 criteria for the admission of patients to recovery
9 care centers; requiring recovery care centers to have
10 emergency care, transfer, and discharge protocols;
11 authorizing the agency to adopt rules; amending s.
12 395.1055, F.S.; conforming provisions to changes made
13 by the act; requiring the agency to adopt rules
14 establishing separate, minimum standards for the care
15 and treatment of patients in recovery care centers;
16 amending s. 395.10973, F.S.; directing the agency to
17 enforce special-occupancy provisions of the Florida
18 Building Code applicable to recovery care centers;
19 amending s. 408.802, F.S.; providing applicability of
20 the Health Care Licensing Procedures Act to recovery
21 care centers; amending s. 408.820, F.S.; exempting
22 recovery care centers from specified minimum licensure
23 requirements; amending ss. 385.211, 394.4787, and
24 409.975, F.S.; conforming cross-references; providing
25 an effective date.

26
27 Be It Enacted by the Legislature of the State of Florida:
28
29 Section 1. Section 395.001, Florida Statutes, is amended
30 to read:
31 395.001 Legislative intent.—It is the intent of the
32 Legislature to provide for the protection of public health and
33 safety in the establishment, construction, maintenance, and
34 operation of hospitals, recovery care centers, and ambulatory
35 surgical centers by providing for licensure of same and for the
36 development, establishment, and enforcement of minimum standards
37 with respect thereto.
38 Section 2. Subsections (24) through (32) of section
39 395.002, Florida Statutes, are renumbered as subsections (26)
40 through (34), respectively, subsections (16) and (22) are
41 amended, and new subsections (24) and (25) are added to that
42 section, to read:
43 395.002 Definitions.—As used in this chapter:
44 (16) "Licensed facility" means a hospital, recovery care
45 center, or ambulatory surgical center licensed in accordance
46 with this chapter.
47 (22) "Premises" means those buildings, beds, and equipment
48 located at the address of the licensed facility and all other
49 buildings, beds, and equipment for the provision of hospital
50 care, recovery care, or ambulatory surgical care located in such

51 reasonable proximity to the address of the licensed facility as
52 to appear to the public to be under the dominion and control of
53 the licensee. For any licensee that is a teaching hospital as
54 defined in s. 408.07, reasonable proximity includes any
55 buildings, beds, services, programs, and equipment under the
56 dominion and control of the licensee that are located at a site
57 with a main address that is within 1 mile of the main address of
58 the licensed facility; and all such buildings, beds, and
59 equipment may, at the request of a licensee or applicant, be
60 included on the facility license as a single premises.
61 (24) "Recovery care center" means a facility the primary
62 purpose of which is to provide recovery care services, in which
63 a patient is admitted and discharged within 72 hours, and which
64 is not part of a hospital.
65 (25) "Recovery care services" means postsurgical and
66 postdiagnostic medical and general nursing care provided to a
67 patient for whom acute care hospitalization is not required and
68 uncomplicated recovery is reasonably expected. The term includes
69 postsurgical rehabilitation services. The term does not include
70 intensive care services, coronary care services, or critical
71 care services.
72 Section 3. Paragraphs (a) and (b) of subsection (1) of
73 section 395.003, Florida Statutes, are amended to read:
74 395.003 Licensure; denial, suspension, and revocation.—
75 (1)(a) The requirements of part II of chapter 408 apply to

76 the provision of services that require licensure pursuant to ss.
77 395.001-395.1065 and part II of chapter 408 and to entities
78 licensed by or applying for such licensure from the Agency for
79 Health Care Administration pursuant to ss. 395.001-395.1065. A
80 license issued by the agency is required in order to operate a
81 hospital, recovery care center, or ambulatory surgical center in
82 this state.
83 (b)1. It is unlawful for a person to use or advertise to
84 the public, in any way or by any medium whatsoever, any facility
85 as a "hospital," "recovery care center," or "ambulatory surgical
86 center" unless such facility has first secured a license under
87 this part.
88 2. This part does not apply to veterinary hospitals or to
89 commercial business establishments using the word "hospital,"
90 "recovery care center," or "ambulatory surgical center" as a
91 part of a trade name if no treatment of human beings is
92 performed on the premises of such establishments.
93 Section 4. Section 395.0171, Florida Statutes, is created
94 to read:
95 395.0171 Recovery care center admissions; emergency care
96 and transfer protocols; discharge planning and protocols.—
97 (1) Admission to a recovery care center is restricted to a
98 patient who is in need of recovery care services and who has
99 been certified by his or her attending or referring physician,
100 or by a physician on staff at the facility, as medically stable

101 and not in need of acute care hospitalization before admission
102 to the recovery care center.
103 (2) A patient may be admitted for recovery care services
104 postdiagnosis and posttreatment or upon discharge from a
105 hospital or an ambulatory surgical center.
106 (3) A recovery care center must have emergency care and
107 transfer protocols, including transportation arrangements, and
108 referral or admission agreements with at least one hospital.
109 (4) A recovery care center must have procedures for
110 discharge planning and discharge protocols.
111 (5) The agency may adopt rules to implement this section.
112 Section 5. Subsections (12) through (19) of section
113 395.1055, Florida Statutes, are renumbered as subsections (13)
114 through (20), respectively, subsections (2) and (9) are amended,
115 and a new subsection (12) is added to that section, to read:
116 395.1055 Rules and enforcement.—
117 (2) Separate standards may be provided for general and
118 specialty hospitals, ambulatory surgical centers, recovery care
119 centers, and statutory rural hospitals as defined in s. 395.602.
120 (9) The agency may not adopt any rule governing the
121 design, construction, erection, alteration, modification,
122 repair, or demolition of any public or private hospital,
123 intermediate residential treatment facility, recovery care
124 center, or ambulatory surgical center. It is the intent of the
125 Legislature to preempt that function to the Florida Building

126 Commission and the State Fire Marshal through adoption and
127 maintenance of the Florida Building Code and the Florida Fire
128 Prevention Code. However, the agency shall provide technical
129 assistance to the commission and the State Fire Marshal in
130 updating the construction standards of the Florida Building Code
131 and the Florida Fire Prevention Code which govern hospitals,
132 intermediate residential treatment facilities, recovery care
133 centers, and ambulatory surgical centers.
134 (12) The agency shall adopt rules for recovery care
135 centers which include fair and reasonable minimum standards for
136 ensuring that recovery care centers have:
137 (a) A dietetic department, service, or other similarly
138 titled unit, either on the premises or under contract, which
139 shall be organized, directed, and staffed to ensure the
140 provision of appropriate nutritional care and quality food
141 service.
142 (b) Procedures to ensure the proper administration of
143 medications. Such procedures shall address the prescribing,
144 ordering, preparing, and dispensing of medications and
145 appropriate monitoring of the effects of such medications on
146 patients.
147 (c) A pharmacy, pharmaceutical department, or
148 pharmaceutical service, or other similarly titled unit, on the
149 premises or under contract.
150 Section 6. Subsection (3) of section 395.10973, Florida

151 Statutes, is amended to read:
152 395.10973 Powers and duties of the agency.—It is the
153 function of the agency to:
154 (3) Enforce the special-occupancy provisions of the
155 Florida Building Code which apply to hospitals, intermediate
156 residential treatment facilities, recovery care centers, and
157 ambulatory surgical centers in conducting any inspection
158 authorized by this chapter and part II of chapter 408.
159 Section 7. Subsection (27) is added to section 408.802,
160 Florida Statutes, to read:
161 408.802 Applicability.—The provisions of this part apply
162 to the provision of services that require licensure as defined
163 in this part and to the following entities licensed, registered,
164 or certified by the agency, as described in chapters 112, 383,
165 390, 394, 395, 400, 429, 440, 483, and 765:
166 (27) Recovery care centers, as provided under part I of
167 chapter 395.
168 Section 8. Subsection (26) is added to section 408.820,
169 Florida Statutes, to read:
170 408.820 Exemptions.—Except as prescribed in authorizing
171 statutes, the following exemptions shall apply to specified
172 requirements of this part:
173 (26) Recovery care centers, as provided under part I of
174 chapter 395, are exempt from s. 408.810(7)-(10).
175 Section 9. Subsection (2) of section 385.211, Florida

176 Statutes, is amended to read:
177 385.211 Refractory and intractable epilepsy treatment and
178 research at recognized medical centers.—
179 (2) Notwithstanding chapter 893, medical centers
180 recognized pursuant to s. 381.925, or an academic medical
181 research institution legally affiliated with a licensed
182 children's specialty hospital as defined in s. 395.002(29) ~~s.~~
183 ~~395.002(27)~~ that contracts with the Department of Health, may
184 conduct research on cannabidiol and low-THC cannabis. This
185 research may include, but is not limited to, the agricultural
186 development, production, clinical research, and use of liquid
187 medical derivatives of cannabidiol and low-THC cannabis for the
188 treatment for refractory or intractable epilepsy. The authority
189 for recognized medical centers to conduct this research is
190 derived from 21 C.F.R. parts 312 and 316. Current state or
191 privately obtained research funds may be used to support the
192 activities described in this section.
193 Section 10. Subsection (7) of section 394.4787, Florida
194 Statutes, is amended to read:
195 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788,
196 and 394.4789.—As used in this section and ss. 394.4786,
197 394.4788, and 394.4789:
198 (7) "Specialty psychiatric hospital" means a hospital
199 licensed by the agency pursuant to s. 395.002(29) ~~s. 395.002(27)~~
200 and part II of chapter 408 as a specialty psychiatric hospital.

201 Section 11. Paragraph (b) of subsection (1) of section
202 409.975, Florida Statutes, is amended to read:
203 409.975 Managed care plan accountability.—In addition to
204 the requirements of s. 409.967, plans and providers
205 participating in the managed medical assistance program shall
206 comply with the requirements of this section.
207 (1) PROVIDER NETWORKS.—Managed care plans must develop and
208 maintain provider networks that meet the medical needs of their
209 enrollees in accordance with standards established pursuant to
210 s. 409.967(2)(c). Except as provided in this section, managed
211 care plans may limit the providers in their networks based on
212 credentials, quality indicators, and price.
213 (b) Certain providers are statewide resources and
214 essential providers for all managed care plans in all regions.
215 All managed care plans must include these essential providers in
216 their networks. Statewide essential providers include:
217 1. Faculty plans of Florida medical schools.
218 2. Regional perinatal intensive care centers as defined in
219 s. 383.16(2).
220 3. Hospitals licensed as specialty children's hospitals as
221 defined in s. 395.002(29) ~~s. 395.002(27)~~.
222 4. Accredited and integrated systems serving medically
223 complex children which comprise separately licensed, but
224 commonly owned, health care providers delivering at least the
225 following services: medical group home, in-home and outpatient

226 nursing care and therapies, pharmacy services, durable medical
227 equipment, and Prescribed Pediatric Extended Care.
228
229 Managed care plans that have not contracted with all statewide
230 essential providers in all regions as of the first date of
231 recipient enrollment must continue to negotiate in good faith.
232 Payments to physicians on the faculty of nonparticipating
233 Florida medical schools shall be made at the applicable Medicaid
234 rate. Payments for services rendered by regional perinatal
235 intensive care centers shall be made at the applicable Medicaid
236 rate as of the first day of the contract between the agency and
237 the plan. Except for payments for emergency services, payments
238 to nonparticipating specialty children's hospitals shall equal
239 the highest rate established by contract between that provider
240 and any other Medicaid managed care plan.
241 Section 12. 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	______	

---

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Stevenson offered the following:
4
5 **Amendment (with directory amendment)**
6 Between lines 119 and 120, insert:
7 (3) The agency shall adopt rules that establish minimum
8 standards for pediatric patient care in ambulatory surgical
9 centers and recovery care centers to ensure the safe and
10 effective delivery of ~~surgical~~ care to children in these
11 facilities ~~ambulatory surgical centers~~. Such standards must
12 include quality of care, nurse staffing, physician staffing, and
13 equipment standards. Ambulatory surgical centers may not provide
14 operative procedures to children under 18 years of age which
15 require a length of stay past midnight until such standards are
16 established by rule. Recovery care centers may not provide

17 recovery care services to children under 18 years of age until
18 such standards are established by rule.
19
20 ---
21 **D I R E C T O R Y A M E N D M E N T**
22 Remove lines 112-115 and insert:
23 Section 5. Subsections (12) through (19) of section
24 395.1055, Florida Statutes, are renumbered as subsections (13)
25 through (20), respectively, subsections (2), (3) and (9) are
26 amended, and a new subsection (12) is added to that section, to
27 read:

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 959 Medical Billing
SPONSOR(S): Duggan
TIED BILLS: **IDEN./SIM. BILLS:** SB 1664

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	14 Y, 0 N	Grabowski	Calamas
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Nobles	Clark
3) Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to select value-based health care. Costs associated with health care services and procedures have the potential to result in significant medical debt for patients, and even the possibility of bankruptcy. Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families.

Current law requires hospitals and ambulatory surgical centers to provide patients with personalized pre-treatment estimates on the costs of care, *upon patient request*. HB 959 makes the estimate mandatory, regardless of whether a patient requests it. For inpatient services, an estimate must be provided either upon scheduling a service or upon admission. For outpatient services, an estimate must be provided prior to the provision of those services. A facility that levies charges exceeding the provided estimate by more than 10% must clearly document a rationale for those increased charges in a written communication to the patient.

The bill requires hospitals and ambulatory surgical centers to establish an internal grievance process for patients to dispute charges that appear on an itemized statement or bill. Additionally, the bill prohibits these facilities from taking collection actions to collect medical debt before determining whether a patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence.

Current law provides a court process for the collection of lawful debts, and makes some limited exemptions for personal property. The bill creates s. 222.26, F.S., to add additional exemptions from attachment, garnishment, or other legal process to include a single motor vehicle and personal property of a debtor of a value up to $10,000 when debt is incurred as a result of medical services provided in a licensed hospital facility, provided that the debtor does not receive a homestead exemption.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

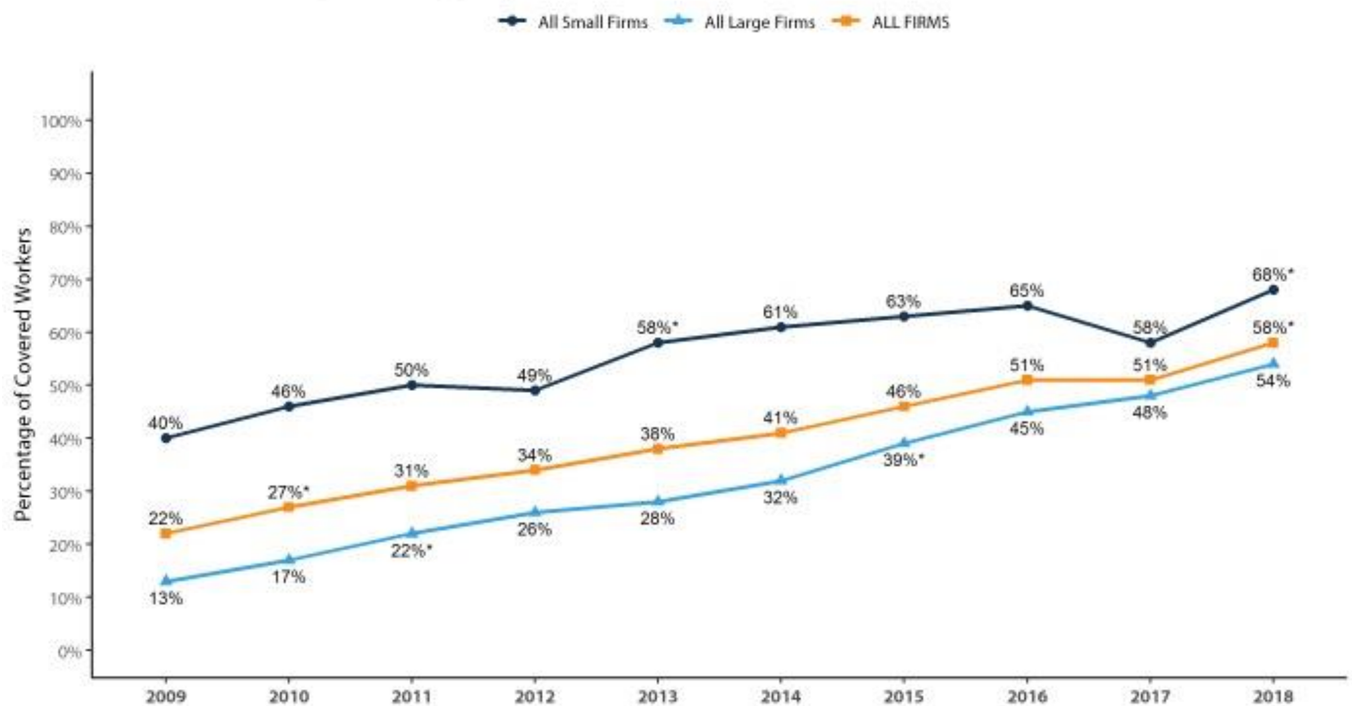
Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[1] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.[2] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[3] Indeed, the definition or the price or cost of health care has different meanings depending on who is incurring the cost.[4]

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan (HDHP). Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.[5]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,573.[6] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,132 in small firms, compared to $1,355 for workers in large firms.[7] Sixty-eight percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 54% in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (42% for small firms vs. 20% for large firms). The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2009 through 2018.[8]

---

[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791 (last accessed December 16, 2019).
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at https://www.hfma.org/Content.aspx?id=22305 (last accessed December 16, 2019).
[4] Id.
[5] The Henry J. Kaiser Family Foundation, *2018 Employer Health Benefits Survey*, October 3, 2018, available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018 (last accessed December 16, 2019).
[6] Id.
[7] Id.
[8] Id, figure 7.13.



Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 59% in 2008 to 78% in 2013 to 85% in 2018. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2018 is $1,350, up 53% from $883 in 2013 and 212% from $433 in 2008.

From 2013 to 2018, the average premium for covered workers with family coverage increased 20%, while wages have only increased 12%.[9] The dramatic increases in the costs of healthcare in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, “Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending.” This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

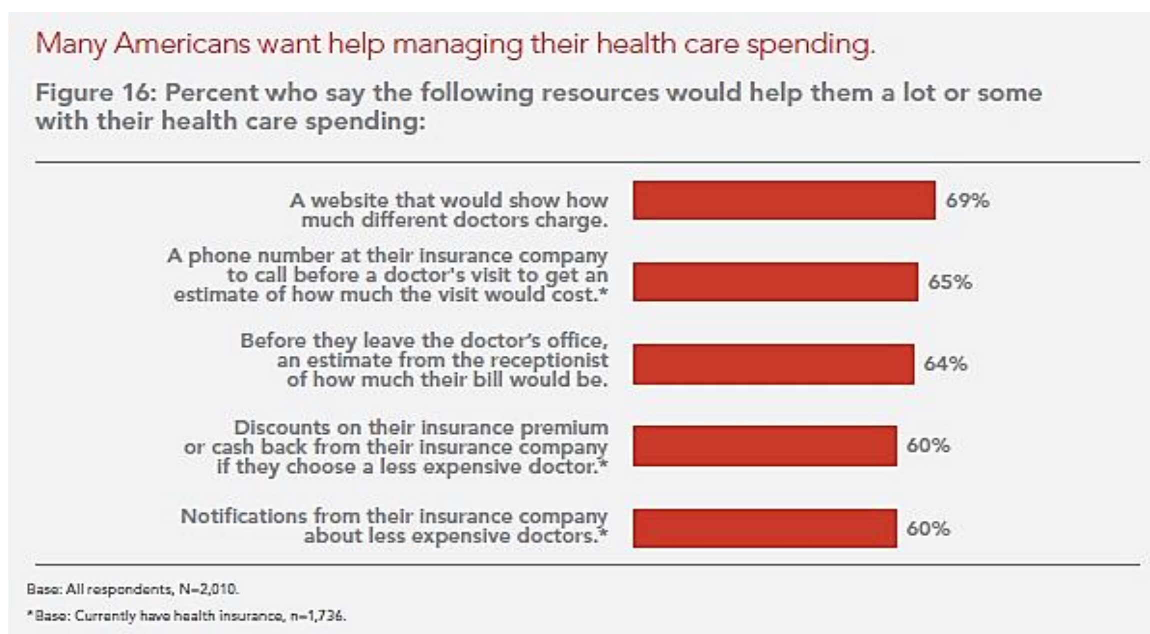
- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.

[9] Id.

- Expand state-based all-payer health claims databases (APCDs), which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[10]

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[11]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[12]

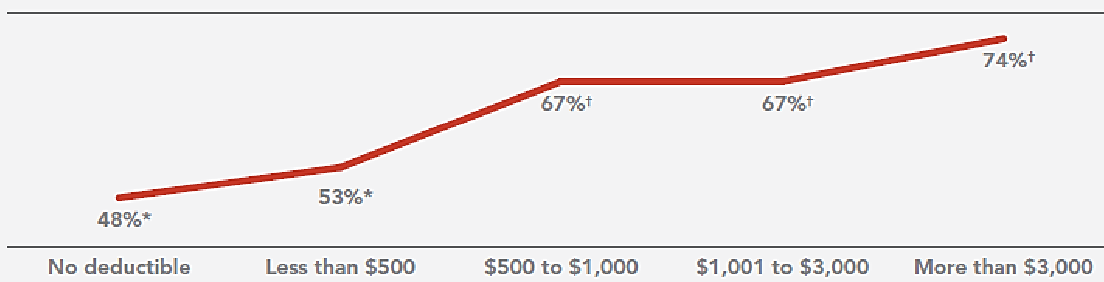


One study in 2014, which conducted a nationally representative survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[13] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[14]

[10] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (last accessed December 16, 2019).
[11] Id., pg. 1.
[12] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last accessed December 16, 2019).
[13] Id., pg. 3.
[14] Id., pg. 13.

People with deductibles over $500 are more likely to seek price information.

Figure 2: Percent who say they have tried to find price information before getting care, by deductible amount:



Base: Currently have health insurance, n=1,736.

Estimates for groups indicated by * are not statistically different from each other, and groups indicated by † are not statistically different from each other; groups indicated by * are statistically different from groups indicated by † at the p<.05 level.

The individuals who compared prices stated that such research affected their health care choices and saved them money.[15] In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher price impart a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[16] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[17] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[18]

Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient’s Bill of Rights and Responsibilities (Patient’s Bill of Rights).[19] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[20] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient’s knowledge of rights and responsibilities.

---

[15] Id., pg. 4.
[16] Supra note 13.
[17] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126 (last accessed December 16, 2019).
[18] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568.
[19] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient’s Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient’s knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient’s health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility’s rules and regulations affecting patient care and conduct.
[20] S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.[21] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[22] Estimates must be written in language "comprehensible to an ordinary layperson."[23] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[24] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[25]

Currently, under the Patient's Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[26]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[27] to publish a schedule of charges for the medical services offered to patients.[28] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[29] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[30] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[31]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[32] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in

---

[21] S. 381.026(4)(c), F.S.
[22] S. 381.026(4)(c)3., F.S.
[23] Id.
[24] Id.
[25] S. 381.026(4)(c)5., F.S.
[26] S. 381.0261, F.S.
[27] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[28] S. 381.026(4)(c)3., F.S.
[29] Id.
[30] Id.
[31] S. 381.026(4)(c)4., F.S.
[32] S. 395.107(1), F.S.

three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[33] The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[34]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[35] must provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[36] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[37] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[38]

---

[33] S. 395.107(2), F.S.
[34] In 2012, the Legislature considered, but did not pass, HB 1329. The bill required ambulatory surgical centers and diagnostic-imaging centers to comply with the provisions of s. 395.107, F.S., established by HB 935 in 2011, and required physicians to publish, in writing, a schedule of medical charges. The bill would have imposed a fine of $1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges subjected the practitioner to discipline under the applicable practice act and s. 456.072, F.S. Lastly, the bill addressed balance billing by requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. Failure to provide disclosure to the insured as required by this provision of the bill resulted in a $500 fine, per occurrence, to be imposed by the AHCA.
[35] The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under part I of Chapter 395, F.S.
[36] S. 395.301, F.S.
[37] S. 408.05(3)(c), F.S.
[38] Id.

The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[39]

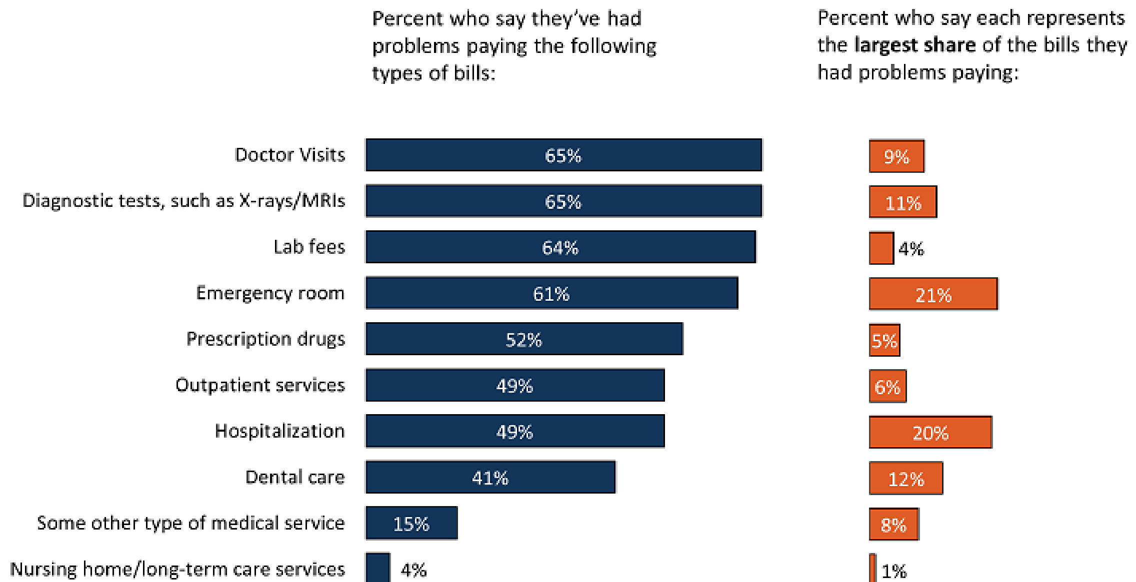
Medical Debt

Medical costs can result in untenable debts to patients, and in some cases, bankruptcy. A 2007 study suggested that illness and medical bills contributed to 62.1% of all personal bankruptcies filed in the U.S. during that year.[40] A more recent analysis, which considered only the impact of hospital charges, found that 4% of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[41]

Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying or an inability to pay medical bills in the past 12 months.[42] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[43]

Among those who reported problems paying medical bills, two-thirds (66 percent) said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that have accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like pneumonia and flu (9 percent).[44] The following illustration provides additional detail on the type of medical services that led to an accumulation of medical debt:

[39] S. 456.0575(2), F.S.
[40] David U. Himmelstein, et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *American Journal of Medicine* 2009; 122: 741-6. Available at https://www.amjmed.com/article/S0002-9343(09)00404-5/abstract (last accessed December 16, 2019).
[41] Carlos Dobkin, et al. "Myth and Measurement: The Case of Medical Bankruptcies." *New England Journal of Medicine* 2018; 378:1076-1078. Available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604 (last accessed December 16, 2019).
[42] The Henry J. Kaiser Family Foundation, "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." January 5, 2016. Available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/ (last accessed December 16, 2019).
[43] Id.
[44] Id.



Legal Debt Collection Process

Current law provides a court process for the collection of lawful debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding money damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means for forcibly collecting on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being forcibly taken by a creditor. The state constitution provides that the debtor's homestead and $1,000 of personal property is exempt. Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[45]

In addition to the protection from creditors contained in the State Constitution, chapter 222, F.S., protects other personal property, from certain claims of creditors and legal process: garnishment of wages for a head of family;[46] proceeds from life insurance policies;[47] wages or unemployment compensation payments due certain deceased employees;[48] disability income benefits;[49] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[50] $1,000 interest in a motor vehicle; professionally prescribed health aids; and

[45] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[46] S. 222.11, F.S.
[47] S. 222.13, F.S.
[48] S. 222.15, F.S.
[49] S. 222.18, F.S.
[50] S. 222.22, F.S.

certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the state constitution.[51]

Bankruptcy is a means by which a person's assets are liquidated in order to pay the person's debts under court supervision. Art. 1, s. 8, cl. 4 of the United States Constitution gives Congress the right to uniformly govern bankruptcy law. Bankruptcy courts are operated by the federal government. A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Certain property is deemed "exempt" from the bankruptcy case, and may be kept by the debtor without being subject to creditor claims. The Bankruptcy Code at 11 U.S.C. s. 522 provides for exempt property in a bankruptcy case. In general, a debtor may choose to utilize the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law and thereby insist that debtors only utilize state law exemptions.[52] Florida, like most states, has made the opt-out election to prohibit the use of the federal exemptions and require that debtors may only use state law exemptions.[53]

Effect of Proposed Changes

Billing Estimates

HB 959 revises s. 395.301, F.S., to ensure that all patients are furnished with cost-of-care information prior to electing treatment provided by hospitals, ambulatory surgical centers, urgent care centers, and physicians providing services in those facilities.

At present, facilities licensed under chapter 395, F.S., are required to provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition, *upon request of the patient*. HB 959 deletes the reference to a patient request and requires a facility to provide each patient with a good-faith estimate of charges prior to providing any nonemergency medical services. For inpatient services, an estimate must be provided either upon scheduling a service or upon admission. For outpatient services, an estimate must be provided prior to the provision of those services.

The bill also requires that the estimate of charges provided by a facility be binding. The amount ultimately charged by the facility may not exceed the estimate by more than 10%, unless unforeseen circumstances dictate that the charges be higher. If a facility determines that charges must exceed this threshold, the facility must clearly document the rationale for the higher charges to the patient.

Medical Debt Collection

The bill requires each hospital, ambulatory surgical center, and mobile surgical center, to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within 7 business days.

The bill prohibits these facilities from engaging in any "extraordinary collection actions" against a patient prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence. For purposes of the provision, "extraordinary collection action" means any action that require a legal or judicial process, including:

---

[51] S. 222.25, F.S.
[52] 11 U.S.C. s. 522(b).
[53] S. 222.20, F.S.

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

The bill also establishes a new set of debt collection exemptions in chapter 222, F.S., that apply explicitly to debt incurred as a result of medical services provided in hospitals, ambulatory surgical centers, or mobile surgical centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill increases the ceiling on the debt collection exemptions, when the debt results from services provided in a ch. 395 facility, as follows:

- To $10,000 interest in a single motor vehicle;
- To $10,000 interest in personal property, provided that a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 222.26, F.S.; related to additional exemptions from legal processes concerning medical debt.
Section 2: Amends s. 395.301, F.S.; relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 3: Creates s. 395.3011, F.S.; related to billing and collection activities.
Section 4: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may increase workload for facilities licensed under chapter 395, F.S., to issue cost estimates for all non-emergency patients. Facilities may forego revenues due to the bill's binding patient cost estimates, and the bill's limits on the use of extraordinary collection activities.

Additionally, the increased dollar limit on personal property exemptions under chapter 222, F.S., may reduce revenues for medical service providers.

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 AHCA with sufficient rule-making authority to execute the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to medical billing; creating s.
3 222.26, F.S.; providing additional personal property
4 exemptions from legal process for medical debts
5 resulting from services provided in certain licensed
6 facilities; amending s. 395.301, F.S.; requiring a
7 licensed facility to provide a cost estimate to a
8 patient under certain conditions; prohibiting a
9 licensed facility from charging a patient an amount
10 that exceeds such cost estimate by a set threshold;
11 requiring a licensed facility to provide a patient
12 with a written explanation of excess charges under
13 certain circumstances; requiring a licensed facility
14 to establish an internal grievance process for
15 patients to dispute charges; requiring a facility to
16 make available information necessary for initiating a
17 grievance; requiring a facility to respond to a
18 patient grievance within a specified timeframe;
19 creating s. 395.3011, F.S.; prohibiting certain
20 collection activities by a licensed facility;
21 providing an effective date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Section 222.26, Florida Statutes, is created to

26 read:
27 222.26 Additional exemptions from legal process concerning
28 medical debt.—If a debt is owed for medical services provided by
29 a facility licensed under chapter 395, the following property is
30 exempt from attachment, garnishment, or other legal process:
31 (1) A debtor's interest, not to exceed $10,000 in value,
32 in a single motor vehicle as defined in s. 320.01(1).
33 (2) A debtor's interest in personal property, not to
34 exceed $10,000 in value, if the debtor does not claim or receive
35 the benefits of a homestead exemption under s. 4, Art. X of the
36 State Constitution.
37 Section 2. Subsection (6) of section 395.301, Florida
38 Statutes, is renumbered as subsection (7), paragraph (b) of
39 subsection (1) is amended, and a new subsection (6) is added to
40 that section, to read:
41 395.301 Price transparency; itemized patient statement or
42 bill; patient admission status notification.—
43 (1) A facility licensed under this chapter shall provide
44 timely and accurate financial information and quality of service
45 measures to patients and prospective patients of the facility,
46 or to patients' survivors or legal guardians, as appropriate.
47 Such information shall be provided in accordance with this
48 section and rules adopted by the agency pursuant to this chapter
49 and s. 408.05. Licensed facilities operating exclusively as
50 state facilities are exempt from this subsection.

51 (b)1. ~~Upon request, and before providing any nonemergency~~
52 ~~medical services,~~ Each licensed facility shall provide in
53 writing or by electronic means a good faith estimate of
54 reasonably anticipated charges by the facility for the treatment
55 of a ~~the~~ patient's or prospective patient's specific condition.
56 Such estimate must be provided to the patient or prospective
57 patient upon scheduling a medical service or upon admission to
58 the facility, or before the provision of nonemergency medical
59 services on an outpatient basis, as applicable. The facility
60 ~~must provide the estimate to the patient or prospective patient~~
61 ~~within 7 business days after the receipt of the request and~~ is
62 not required to adjust the estimate for any potential insurance
63 coverage. The estimate may be based on the descriptive service
64 bundles developed by the agency under s. 408.05(3)(c) unless the
65 patient or prospective patient requests a more personalized and
66 specific estimate that accounts for the specific condition and
67 characteristics of the patient or prospective patient. The
68 facility shall inform the patient or prospective patient that he
69 or she may contact his or her health insurer or health
70 maintenance organization for additional information concerning
71 cost-sharing responsibilities. The facility may not charge the
72 patient more than 110 percent of the estimate. However, if the
73 facility determines that such charges are warranted due to
74 unforeseen circumstances or the provision of additional
75 services, the facility must provide the patient with a written

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

76 explanation of the excess charges as part of the detailed,
77 itemized statement or bill to the patient.
78 2. In the estimate, the facility shall provide to the
79 patient or prospective patient information on the facility's
80 financial assistance policy, including the application process,
81 payment plans, and discounts and the facility's charity care
82 policy and collection procedures.
83 3. The estimate shall clearly identify any facility fees
84 and, if applicable, include a statement notifying the patient or
85 prospective patient that a facility fee is included in the
86 estimate, the purpose of the fee, and that the patient may pay
87 less for the procedure or service at another facility or in
88 another health care setting.
89 4. ~~Upon request,~~ The facility shall notify the patient or
90 prospective patient of any revision to the estimate.
91 5. In the estimate, the facility must notify the patient
92 or prospective patient that services may be provided in the
93 health care facility by the facility as well as by other health
94 care providers that may separately bill the patient, if
95 applicable.
96 ~~6. The facility shall take action to educate the public~~
97 ~~that such estimates are available upon request.~~
98 6.~~7.~~ Failure to ~~timely~~ provide the estimate within the
99 timeframe required in subparagraph 1. ~~pursuant to this paragraph~~
100 shall result in a daily fine of $1,000 until the estimate is

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

101 provided to the patient or prospective patient. The total fine
102 may not exceed $10,000.
103
104 ~~The provision of an estimate does not preclude the actual~~
105 ~~charges from exceeding the estimate.~~
106 (6) Each facility shall establish an internal process for
107 reviewing and responding to grievances from patients. Such
108 process must allow patients to dispute charges that appear on
109 the patient's itemized statement or bill. The facility shall
110 prominently post on its website and indicate in bold print on
111 each itemized statement or bill the instructions for initiating
112 a grievance and the direct contact information required to
113 initiate the grievance process. The facility must provide an
114 initial response to a patient grievance within 7 business days
115 after the patient formally files a grievance disputing all or a
116 portion of an itemized statement or bill.
117 Section 3. Section 395.3011, Florida Statutes, is created
118 to read:
119 395.3011 Billing and collection activities.—
120 (1) As used in this section, the term "extraordinary
121 collection action" means any of the following actions taken by a
122 licensed facility against an individual in relation to obtaining
123 payment of a bill for care covered under the facility's
124 financial assistance policy:
125 (a) Selling the individual's debt to another party.

126 (b) Reporting adverse information about the individual to
127 consumer credit reporting agencies or credit bureaus.
128 (c) Deferring, denying, or requiring a payment before
129 providing medically necessary care because of the individual's
130 nonpayment of one or more bills for previously provided care
131 covered under the facility's financial assistance policy.
132 (d) Actions that require a legal or judicial process,
133 including, but not limited to:
134 1. Placing a lien on the individual's property;
135 2. Foreclosing on the individual's real property;
136 3. Attaching or seizing the individual's bank account or
137 any other personal property;
138 4. Commencing a civil action against the individual;
139 5. Causing the individual's arrest; or
140 6. Garnishing the individual's wages.
141 (2) A facility shall not engage in an extraordinary
142 collection action against an individual to obtain payment for
143 services:
144 (a) Before the facility has made reasonable efforts to
145 determine whether the individual is eligible for assistance
146 under its financial assistance policy for the care provided.
147 (b) Before the facility has provided the individual with
148 an itemized statement or bill.
149 (c) During an ongoing grievance process as described in s.
150 395.301(6).

151 (d) Before billing any applicable insurer and allowing the
152 insurer to adjudicate a claim.
153 (e) For 30 days after notifying the patient in writing, by
154 certified mail or other traceable delivery method, that a
155 collection action will commence absent additional action by the
156 patient.
157 Section 4. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1059 Parental Rights
SPONSOR(S): Grall and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1634

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Education Committee	15 Y, 2 N	Satterly	Hassell
2) Health & Human Services Committee		McElroy	Calamas
3) Judiciary Committee			

SUMMARY ANALYSIS

The bill creates Chapter 1014, Florida Statutes, as the “Parents’ Bill of Rights”. Chapter 1014, F.S., enumerates rights of a parent with respect to his or her minor child for education, health care, and criminal justice procedures. The bill prohibits the state, its political subdivision, any other governmental entity or any other institution from infringing upon the fundamental right of a parent to direct the upbringing, education, health care, and mental health of his or her minor child. The bill requires state action that infringes upon this fundamental right to be reviewed according to strict scrutiny.

For education-related parental rights, the Florida K-20 Education Code currently includes Section 1002.20, F.S., relating to K-12 Student and Parents Rights. This section enumerates 24 rights of students and parents, most of which are duplicated in the bill. The bill requires school districts to adopt policies that govern the plans and procedures by which each school district shall promote parental involvement. School districts must also adopt notification procedures for specific parental rights.

The bill establishes parental consent requirements for, among other things, the collection of certain identifying information for a minor child. The bill requires parental notification when a state actor suspects a child is the victim of a criminal offense but provides exceptions including when a suspected offense has been reported to law enforcement or the Department of Children and Families.

The bill establishes parental consent requirements for health care services and subjects health care practitioners and health care facilities to disciplinary action for violation of these parental consent requirements in certain instances.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Constitutional Principles

It is well settled that the interest of parents in the care, custody, and control of their children is perhaps the oldest of the recognized fundamental liberty interests protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[1] This fundamental liberty interest is rooted in the fundamental right of privacy from interference in making important decisions relating to things such as marriage, family relationships, and child rearing and education.[2] The United States Supreme Court has explained the fundamental nature of this right is rooted in history and tradition:[3]

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

The Florida Supreme Court has likewise recognized that parents have a fundamental liberty interest in determining the care and upbringing of their children.[4] These rights may not be intruded upon absent a compelling state interest.[5] According to the Florida Supreme Court, when analyzing a statute that infringes on the fundamental right of privacy, the applicable standard of review requires that the statute survive the highest level of scrutiny:[6]

> The right of privacy is a fundamental right which we believe demands the compelling state interest standard. This test shifts the burden of proof to the state to justify an intrusion on privacy. The burden can be met by demonstrating that the challenged regulation serves a compelling state interest and accomplishes its goal through the use of the least intrusive means.

Present Situation - Education

Student and Parental Rights Protected under Current Florida Law

Dependent upon the area of law, Florida Statutes includes several definitions of the term "parent." For example, for purposes of the child welfare system, parent is defined as, "a woman who gives birth to a

---

[1] *Santosky v. Kramer*, 455 U.S. 745, 748 and 753 (1982)(holding the fundamental liberty interest of natural parents in the care custody, and management of their child is protected by the Fourteenth Amendment, and termination of any parental rights requires due process proceedings); *Troxel v. Granville,* 530 U.S. 57, 66 (2000)(holding there is a fundamental right under the Fourteenth Amendment for parents to oversee the care, custody, and control of their children).

[2] *Carey v. Population Svcs. Int'l*, 431 US 678, 684-685 (1977)(recognizing the right of privacy in personal decisions relating to marriage, family relationships, child rearing, and education); *See Wisconsin v. Yoder*, 406, U.S. 205, 232-33 (1972)(holding a state law requiring that children attend school past eight grade violates the parents' constitutional right to direct the religious upbringing of their children); See *Parham v. J.R.*, 442 U.S. 584, 602 (1979)(recognizing the presumption that parents act in their children's best interest); *Meyer v. Nebraska,* 262 U.S. 390, 400-01 (1923)(affirming that the Constitution protects the preferences of the parent in education over those of the state)*; Pierce v. Society of Sisters,* 268 U.S. 510, 534-35 (1925)(recognizing the right of parents to direct the upbringing of and education of their children).

[3] *Wisconsin v. Yoder*, 406, U.S. 205, 232 (1972).

[4] *Beagle v. Beagle*, 678 So.2d 1271, 1272 (Fla. 1996)(holding a state law violated a parent's constitutional right to privacy by imposing grandparent visitation rights over objection of the parent without evidence of harm to the child or other compelling state interest).

[5] Id. *See, e.g., Shevin v. Byron, Harless, Schaffer, Reid & Assocs., Inc*., 379 So.2d 633, 637 (Fla. 1980) and *Belair v. Drew*, 776 So.2d 1105, 1107 (Fla. 5th DCA 2001).

[6] *Winfield v. Division of Pari-Mutuel Wagering, Dept. of Bus. Regulation*, 477 So.2d 544, 547 (Fla. 1985).

child and a man whose consent to the adoption of the child would be required under s. 63.062(1), F.S. The term "parent" also means legal father as defined in this section."[7] In the Florida K-20 Education Code,[8] parent is defined as, "either or both parents of a student, any guardian of a student, any person in a parental relationship to a student, or any person exercising supervisory authority over a student in place of the parent."[9]

According to the K-12 Student and Parents Rights section of Florida law, "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."[10] In furtherance, the Florida Education Code includes numerous statutory rights of students and their parents. Among other rights, s. 1002.20, F.S. establishes that parents have the right to seek education school choice options including charter schools, private schools that accept students who participate in a state scholarship program listed in s. 1002, F.S., and home education programs.[11] Additionally, a school district must notify high school students and their parents, in writing, of the requirements for a standard high school diploma, available diploma designations,[12] and the eligibility requirements for state scholarship programs[13] and postsecondary admissions.[14]

Parents of public school students must be provided accurate and timely information regarding their child's academic progress and informed of ways they can help their child to succeed in school.[15] Parents must be provided the student's report card, progress reports, the school's report cards and financial reports.[16]

To inform parents and enable them to direct and control their child's education, current law specifies various parental notice requirements, requires parental consent before public schools may take certain actions, and allows parents to opt their child out of certain requirements for religious or other reasons.[17] Students and their parents must be notified regarding student promotion policies, including policies for whole grade and mid-year promotion, 3rd grade retention, and remediating academic deficiencies.[18]

Among other things, current law requires public schools to notify a student's parent regarding:

- Education records privacy rights.[19]
- The Academically Challenging Curriculum to Enhance Learning (ACCEL) options available at the school and student eligibility requirements for ACCEL options.[20]
- Accessing their child's instructional materials through the district's local instructional improvement system.[21]

---

[7] Section 39.01(56), F.S.
[8] Chapters 1000-1013, F.S., are referred to as the K-20 Education Code.
[9] Section 1000.21(5), F.S.
[10] Section 1002.20, F.S.
[11] Section 1002.20(6), F.S.
[12] Students who satisfy standard high school diploma requirements and complete specified credit and testing requirements may earn a Scholar designation. Students who satisfy standard high school diploma requirements and attain one or more industry certifications may earn a Merit designation. Section 1003.4285(1)b, F.S.
[13]State law establishes several scholarship programs, such as the Bright Futures Scholarship Program, that enable qualified students to earn money for postsecondary education. Subpart B., ch. 1009, F.S.
[14] Section 1003.4282(2), F.S.
[15] Section 1002.20, F.S.
[16] Section 1002.20(14)-(16), F.S.
[17] *See, e.g.,* s. 1002.20(3), F.S.
[18] Section 1008.25(2), (4), (5), and (7), F.S.
[19] Section 1002.22(2)(e), F.S.
[20] Section 1002.3105 (4)(a), F.S.
[21] Section 1006.283(2)(b)11., F.S.

- The process for a parent to request that his or her child be transferred to another classroom teacher.[22]
- The availability of a scholarship from the Opportunity Scholarship Program,[23] John M. McKay Scholarship Program,[24] or Florida Tax Credit Scholarship Program, if the student is eligible.[25]

Additionally, current law requires each district school board to share the following with parents:

- The district's code of student conduct.[26]
- A parent guide to successful student achievement, consistent with the guidelines of the Department of Education, which addresses what parents need to know about their child's educational progress and how parents can help their child to succeed in school.[27]
- A checklist of parental actions that can strengthen parental involvement in their child's educational progress. The checklist must be provided each school year to all parents of students in kindergarten through grade 12 and must focus on academics, especially reading; high expectations for students; citizenship; and communication.[28]

Current Florida law authorizes a parent to opt his or her child out of a school entry health examination or school immunization requirements if the parent submits a written request stating objections on religious grounds.[29] A parent of a public school student may also request that their child be excused from:

- Performing surgery or dissection in biological science classes.[30]
- The teaching of reproductive health or any disease, including HIV/AIDS.[31]
- Reciting the pledge of allegiance.[32]
- Reciting the Declaration of Independence during "Celebrate Freedom Week."[33]

Each district school board must establish a policy enabling a parent to object to the child's use of a specific instructional material and a process enabling parents to contest the district school board's adoption of a specific instructional material.[34] Florida law defines instructional material as, "items having intellectual content that by design serve as a major tool for assisting in the instruction of a subject or course. These items may be available in bound, unbound, kit, or package form and may consist of hardbacked or softbacked textbooks, electronic content, consumables, learning laboratories, manipulatives, electronic media, and computer courseware or software."[35]

State law prohibits public schools from collecting, obtaining, or retaining information on the political affiliation, voting history, religious affiliation, or biometric information of a student, a student's parent, or a student's sibling.[36]

---

[22] Sections 1003.3101 and 1012.42(2), F.S.
[23] Sections 1002.38(2) and (3)(a)1, F.S.
[24] Section 1002.39(5)(a)1., F.S.
[25] Section 1002.395, F.S.
[26] Section 1006.07(2), F.S.
[27] Section 1002.23(5), F.S.
[28] Section 1002.23(6), F.S.
[29] Sections 1002.20(3)(a)-(b) and 1003.22(5)(a), F.S.
[30] Sections 1002.20(3)(c) and 1003.47, F.S.
[31] Sections 1002.20(3)(d) and 1003.42(3), F.S.
[32] Sections 1002.20(12) and 1003.44(1) F.S.
[33] Section 1003.421(4), F.S.
[34] Section 1006.28(2)(a)2., F.S.
[35] Section 1006.29(2), F.S.
[36] Section 1002.222(1)(a), F.S. The law defines biometric information as information collected from the electronic measurement or evaluation of any physical or behavioral characteristics that may be personally identifiable, including characteristics of fingerprints, hands, eyes, and the voice. Thus, agencies or institutions may not use fingerprint scans, palm scans, retina or iris scans, face geometry scans, or voice prints. *Id.*

State law requires the Commissioner of Education and school districts to provide individual student assessment results and teacher, school and district-level student achievement levels and learning gains to parents annually.[37] Additionally, school districts are required to distribute an annual report to every student's parent that includes the student's individual results on statewide, standardized assessment and progress toward proficiency in English Language Arts, science, social studies and math. School districts are also required to annually publish the previous school year's aggregated results on specific assessments and revisions to district school policies with regard to retention and promotion.[38]

Effect of Proposed Changes – Education

Student and Parental Rights Protected under Current Florida Law

The bill creates Chapter 1014, Florida Statutes, as the "Parents' Bill of Rights". Chapter 1014, F.S., enumerates rights of parents with respect to their minor child for education, health care and criminal justice procedures. The bill provides legislative intent for the Parents' Bill of Rights. And, for the purposes of ch. 1014, F.S., defines "parent" as a person who has legal custody of a minor child as a natural or adoptive parent or a legal guardian.

The bill provides that a parent of a minor child has inalienable rights that exceed those delineated in newly-created ch. 1014, F.S. Further, the bill provides that the parental rights of a minor child in the state may not be limited or denied. The bill clarifies that newly-created ch. 1014, F.S., does not authorize a parent of a minor child to engage in conduct that is unlawful or to abuse or neglect his or her minor child and does not apply to a parental decision that would end life.

The bill requires the state, political subdivisions, governmental entities and other institutions to demonstrate as reasonable and necessary any action that would infringe on the fundamental rights of a parent to direct the upbringing, education, health care, and mental health of his or her minor child. The action must be narrowly tailored, achieve a compelling state interest and may not be achieved by a less restrictive means.

The bill enumerates the following rights of a parent:

- The right to direct the education and care of his or her minor child.
- The right to direct the upbringing and the moral or religious training of the minor child.
- The right, pursuant to s. 1002.20(2)(b) and (6), F.S., to enroll his or her child in a public school or, as an alternative to public education, a private school, religious school, a home education program, or other available options.
- The right, pursuant to s. 1002.20(13), F.S., to access and review all school records relating to the minor child.
- The right to make health care decisions for his or her minor child, unless otherwise prohibited by law.
- The right to access and review all medical records of the minor child, unless prohibited by law or if the parent is the subject of an investigation of a crime committed against the minor child and a law enforcement agency or official requests that the information not be released.
- The right to consent in writing before a biometric scan of the minor child is made, shared, or stored.
- The right to consent in writing before any record of his or her minor child's blood or deoxyribonucleic acid (DNA) is created, stored, or shared, except as required by general law or authorized pursuant to a court order.

[37] Section 1008.22, F.S.
[38] Section 1008.25(8), F.S.

- The right to consent in writing before the state or any of its political subdivisions makes a video or voice recording of his or her minor child. Exceptions to consent for recording include:
    - Made during or as part of a court proceeding.
    - Made as part of a forensic interview in a criminal or Department of Children and Families investigation.
    - Used solely for the following purposes:
        - a safety demonstration, including the maintenance of order and discipline in the common areas of a school or on student transportation vehicles;
        - a purpose related to a legitimate academic or extracurricular activity;
        - a purpose related to regular classroom instructions;
        - security or surveillance of buildings or grounds; or
        - a photo identification card.
- The right to be notified promptly if an employee of the state, any of its political subdivisions, any other governmental entity, or any other institution suspects that a criminal offense has been committed against his or her minor child. The bill provides an exception to this notification right for incidents that have first been reported to law enforcement or the Department of Children and Families and notifying the parent would impede the investigation.

The bill clarifies that parental rights enumerated in the bill do not prohibit or impede child welfare activities when performed by a court of competent jurisdiction, law enforcement officer, or employees of a government agency. The bill also provides that these parental rights do not prohibit a court of competent jurisdiction from issuing an order that is otherwise permitted by law.

Additionally, the bill authorizes disciplinary action against an employee of the state, any of its political subdivisions, or any other governmental entity for coercing or attempting to encourage or coerce a minor child to withhold information from his or her parent.

The bill requires a school district to adopt a policy that governs the plans and procedures by which the school district shall promote parental involvement and provide notification to parents of specific parental rights. Policy development and notification is required for:

- A plan, pursuant to s. 1002.23, F.S., for parental participation in schools to improve parent and teacher cooperation in such areas as homework, school attendance, and discipline.
- A procedure, pursuant to s. 1002.20(19)(b), F.S., for a parent to learn about his or her child's course of study, including the source of any supplemental education materials.
- Procedures for a parent to object to classroom materials and activities, pursuant to s. 1006.28(2)(a)2., F.S., and a process for withdrawing his or her student from the activity, class, or program in which such materials or activities are used. Such objections may be based on beliefs regarding morality, sex, and religion or the belief that such materials or activities are harmful.
- Procedures, pursuant to s. 1002.20(3)(d), F.S., for a parent to withdraw his or her student from any portion of the school district's comprehensive health education required under s. 1003.42(2)(n), F.S., that relates to sex education or instruction in acquired immune deficiency syndrome education or any instruction regarding sexuality if the parent provides a written objection to his or her child's participation. Such procedures must provide for a parent to be notified in advance of such course content so that he or she may withdraw his or her student from those portions of the course.
- Procedures, pursuant to s. 1006.195(1)(a), F.S., for a parent to learn about the nature and purpose of clubs and activities offered at his or her child's school, including those that are extracurricular or part of the school curriculum.

The bill requires school districts to develop procedures for parents to learn about specific parental rights and responsibilities. They are:

- Pursuant to s. 1002.20(3)(d), F.S., the right to opt his or her minor child out of any portion of the school district's comprehensive health education required under s. 1003.42(2)(n), F.S., that relates to sex education instruction in acquired immune deficiency syndrome education or any instruction regarding sexuality.
- A plan to disseminate information, pursuant to s. 1002.20(6), F.S., about school choice options, including open enrollment.
- In accordance with s. 1002.20(3)(b), F.S., the right of a parent to exempt his or her student from immunizations.
- In accordance with s. 1008.22, F.S., the right of a parent to review statewide, standardized assessment results
- In accordance with s. 1003.57, F.S., the right of a parent to enroll his or her student in gifted or special education programs.
- In accordance with s. 1006.28(2)(a)1., F.S., the right of a parent to inspect school district instructional materials.
- In accordance with s. 1008.25, F.S., the right of a parent to access to information relating to the school district's policies for promotion or retention, including high school graduation requirements.
- In accordance with s. 1002.20(14), F.S., the right of a parent to receive a school report card and be informed of his or her child's attendance requirements.
- In accordance with s. 1002.23, F.S., the right of a parent to access information relating to the state public education system, state standards, report card requirements, attendance requirements, and instructional materials requirements.
- In accordance with s. 1002.23(4), F.S., the right of a parent to participate in parent-teacher associations and organizations that are sanctioned by a district school board or the Department of Education.
- In accordance with s. 1002.222(1)(a), F.S., the right of a parent to opt out of any district-level data collection relating to his or her minor child not required by law.

The bill defines "instructional materials" as including "but not limited to, textbooks, workbooks and worksheets, handouts, software, applications, internet courses, and any and all digital medial available to student pursuant to their role as a student in public school."

The bill authorizes school districts to post parental rights information on their websites or to transmit the information electronically. If a parent requests any information governed in newly-created ch. 1014, F.S., the district must provide the requested information within 10 days. The bill creates a process by which a parent may appeal to the school board should a district deny a request for information.

Present Situation – Health Care

Parental Consent for Medical Treatment

Parents generally have the right to be informed about, and give consent for, proposed medical procedures on their children. However, the state also has an obligation to ensure that children receive reasonable medical treatment that is necessary for the preservation of life.[39] The state's interest diminishes as the severity of an affliction and the likelihood of death increase:[40]

> There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where . . . the issue is not whether, but when, for how long and at what cost to the individual . . . life may be briefly extended.

[39] *Von Eiff v. Azicri*, 720 So.2d 510, 515 (Fla. 1998).
[40] *M.N. v. S. Baptist Hosp*., 648 So.2d 769, 771 (Fla. 1st DCA 1994).

A parent may reject medical treatment for a child and the state may not interfere with such decision if the evidence is not sufficiently compelling to establish the primacy of the state's interest, or that the child's own welfare would be best served by such treatment.[41]

Medical Treatment without Parental Consent

Current Florida law does not expressly provide that medical care of a minor requires parental consent. Instead, it provides exceptions for circumstances in which someone other than a parent may consent for medical care of a minor or provide medical care without parental consent.

Section 743.064, F.S., allows physicians, paramedics, emergency medical technicians, or other emergency medical services personnel to provide emergency medical care or treatment to a minor without parental consent when a child has been injured in an accident or is suffering from an acute illness, disease, or condition and delaying treatment would endanger the health or physical well-being of the minor. Even in emergency situations, medical treatment can only be provided without parental consent if:[42]

- The child's condition has rendered him or her unable to reveal the identity of his or her parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the child to the hospital.
- The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.

The hospital must notify the parent or legal guardian as soon as possible after the emergency medical care or treatment is administered and document in the hospital records the reason parental consent was not initially obtained. This must include a statement from the attending physician that immediate emergency medical care or treatment was necessary for the child's health or physical well-being.[43]

Section 743.0645, F.S., establishes a list of people, by priority, who may consent to the medical care or treatment of a minor in instances where the treatment provider is unable to contact the parent or legal guardian and the provider has not been given contrary instructions. Specifically, the following people may consent, in this order:

- A health care surrogate or a person with power of attorney to provide medical consent for the minor;[44]
- The stepparent;
- The grandparent of the minor;
- An adult brother or sister of the minor; or
- An adult aunt or uncle of the minor.

If a parent or legal guardian cannot be reached while the child is committed to the Department of Children Families or the Department of Juvenile Justice,[45] then the following individuals may consent to the medical care or treatment of a minor, unless the parent or legal guardian has expressly stated otherwise:[46]

---

[41] *Id.*
[42] Section 743.064(2), F.S.
[43] Section 743.064(3), F.S.
[44] A health care surrogate designation under s. 765.2035, F.S., executed after September 30, 2015, or a power of attorney executed after July 1, 2001, to provide medical consent for a minor includes the power to consent to medically necessary surgical and general anesthesia services for the minor unless such services are excluded by the individual who executes the health care surrogate for a minor or power of attorney, s. 743.0645(2)(a), F.S.
[45] Specifically, under chs. 39, 984, or 985, F.S.
[46] Section 743.0645, F.S

- The caseworker, juvenile probation officer, or person primarily responsible for the case management of the child.
- The administrator of the state-licensed facility[47] or state-contracted or state-operated delinquency residential treatment facility where the child is committed.

In both of these instances, the treatment provider must document the reasonable attempts made to contact the parent or legal guardian in the minor's treatment records, and must notify the parent or legal guardian as soon as possible after the medical care or treatment is administered.[48]

Effect of Proposed Changes – Health Care

Parental Consent for Health Care Purposes

The bill establishes parental consent requirements for health care services. Specifically, unless otherwise permitted by law, without written, parental consent:

- A health care practitioner, as defined in s. 456.001, may not provide or solicit or arrange to provide health care services or prescribe medicinal drugs to a minor.
- A person, as defined in s. 1.01, F.S.,[49] or an individual employed by such person may not provide or solicit or arrange to provide health care services or prescribe medicinal drugs to a minor child.
- A provider, as defined in s. 408.803,[50] may not allow a medical procedure to be performed on a minor child in its facility.

The bill subjects health care practitioners and health care facilities to disciplinary action under ss. 456.072[51] and 408.813, F.S.,[52] respectively, and makes it a first-degree misdemeanor to violate these parental consent requirements, subject to a fine of up to $1,000 and imprisonment of up to one year.

The bill does not apply to abortions, which are governed by ch. 390, F.S.

B. SECTION DIRECTORY:

Section 1: Creates ch. 1014, F.S. relating to the "Parents' Bill of Rights."
Section 2: Creates s. 1014.01, F.S., providing a short title.
Section 3: Creates s. 1014.02, F.S., providing legislative findings and definition.
Section 4: Creates s. 1014.03, F.S., relating to infringement of parental rights.
Section 5: Creates s. 1014.04, F.S., relating to parental rights.
Section 6: Creates s. 1014.05, F.S., relating to school district notifications on parental rights.
Section 7: Creates s. 1014.06, F.S., relating to parental consent for health care services.
Section 8: Amends s. 408.813, F.S., relating to administrative fines; violations.
Section 9: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 10: Provides an effective date of July 1, 2020.

---

[47] Section 393.067, F.S., licensed facilities for individuals with developmental disabilities; s. 394.875, F.S., licensed mental health facilities for children and adolescents; s. 409.175, F.S., licensed family foster homes, residential child-caring agencies, and child-placing agencies.
[48] Sections 743.0645(2)-(4), F.S.
[49] "Person" includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations.
[50] "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.
[51] Section 456.072(1), F.S., provides grounds for disciplinary action against health care practitioners.
[52] Section 408.813, F.S., authorizes the Agency for Health Care Administration to impose administrative fines against providers for violations of its regulations.

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:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

Not applicable.

1 A bill to be entitled
2 An act relating to parental rights; creating chapter
3 1014, F.S.; creating s. 1014.01, F.S.; providing a
4 short title; creating s. 1014.02, F.S.; providing
5 legislative findings; defining the term "parent";
6 creating s. 1014.03, F.S.; providing that the state,
7 its political subdivisions, other governmental
8 entities, or other institutions may not infringe on
9 parental rights without demonstrating specified
10 information; creating s. 1014.04, F.S.; providing that
11 a parent of a minor child has specified rights
12 relating to his or her minor child; prohibiting the
13 state from infringing upon specified parental rights;
14 prohibiting specified parental rights from being
15 denied or abridged; providing that certain actions by
16 specified individuals are grounds for disciplinary
17 actions against such individuals; providing
18 constructions; creating s. 1014.05, F.S.; requiring
19 each district school board to develop and adopt a
20 policy to promote parental involvement in the public
21 school system; providing requirements for such policy;
22 defining the term "instructional materials";
23 authorizing a district school board to provide such
24 policy electronically or on its website; authorizing a
25 parent to request certain information in writing;

26 providing a procedure for the denial of such
27 information; creating s. 1014.06, F.S.; prohibiting
28 certain health care practitioners from taking
29 specified actions without a parent's written
30 permission; prohibiting certain entities from taking
31 specified actions relating to a minor's health care
32 without a parent's written permission; prohibiting a
33 health care facility from allowing certain actions
34 without a parent's written permission; providing
35 exceptions; providing for disciplinary actions and
36 criminal penalties; amending s. 408.813, F.S.;
37 providing that certain violations relating to parental
38 consent are grounds for administrative fines for
39 health care facilities; amending s. 456.072, F.S.;
40 providing that failure to comply with certain parental
41 consent requirements is grounds for disciplinary
42 action for health care practitioners; providing an
43 effective date.
44
45 Be It Enacted by the Legislature of the State of Florida:
46
47 Section 1. Chapter 1014, Florida Statutes, consisting of
48 ss. 1014.01-1014.06, is created and shall be entitled "Parents'
49 Bill of Rights."
50 Section 2. Section 1014.01, Florida Statutes, is created

51 to read:
52 1014.01 Short title.—This section and ss. 1014.02-1014.06
53 may be cited as the "Parents' Bill of Rights."
54 Section 3. Section 1014.02, Florida Statutes, is created
55 to read:
56 1014.02 Legislative findings and definition.—
57 (1) The Legislature finds that it is a fundamental right
58 of parents to direct the upbringing, education, and care of
59 their minor children. The Legislature further finds that
60 important information relating to a minor child should not be
61 withheld, either inadvertently or purposefully, from his or her
62 parent, including information relating to the minor child's
63 health, well-being, and education, while the minor child is in
64 the custody of the school district. The Legislature further
65 finds it is necessary to establish a consistent mechanism for
66 parents to be notified of information relating to the health and
67 well-being of their minor children.
68 (2) For purposes of this chapter, the term "parent" means
69 a person who has legal custody of a minor child as a natural or
70 adoptive parent or a legal guardian.
71 Section 4. Section 1014.03, Florida Statutes, is created
72 to read:
73 1014.03 Infringement of parental rights.—The state, any of
74 its political subdivisions, any other governmental entity, or
75 any other institution may not infringe on the fundamental rights

76 of a parent to direct the upbringing, education, health care,
77 and mental health of his or her minor child without
78 demonstrating that such action is reasonable and necessary to
79 achieve a compelling state interest and that such action is
80 narrowly tailored and is not otherwise served by a less
81 restrictive means.
82 Section 5. Section 1014.04, Florida Statutes, is created
83 to read:
84 1014.04 Parental rights.—
85 (1) All parental rights are reserved to the parent of a
86 minor child in this state without obstruction or interference
87 from the state, any of its political subdivisions, any other
88 governmental entity, or any other institution, including, but
89 not limited to, all of the following rights of a parent of a
90 minor child in this state:
91 (a) The right to direct the education and care of his or
92 her minor child.
93 (b) The right to direct the upbringing and the moral or
94 religious training of his or her minor child.
95 (c) The right, pursuant to s. 1002.20(2)(b) and (6), to
96 enroll his or her minor child in a public school or, as an
97 alternative to public education, a private school, religious
98 school, a home education program, or other available options.
99 (d) The right, pursuant to s. 1002.20(13), to access and
100 review all school records relating to his or her minor child.

101 (e) The right to make health care decisions for his or her
102 minor child, unless otherwise prohibited by law.
103 (f) The right to access and review all medical records of
104 his or her minor child, unless prohibited by law or if the
105 parent is the subject of an investigation of a crime committed
106 against the minor child and a law enforcement agency or official
107 requests that the information not be released.
108 (g) The right to consent in writing before a biometric
109 scan of his or her minor child is made, shared, or stored.
110 (h) The right to consent in writing before any record of
111 his or her minor child's blood or deoxyribonucleic acid (DNA) is
112 created, stored, or shared, except as required by general law or
113 authorized pursuant to a court order.
114 (i) The right to consent in writing before the state or
115 any of its political subdivisions makes a video or voice
116 recording of his or her minor child unless such recording is
117 made during or as part of a court proceeding or is made as part
118 of a forensic interview in a criminal or Department of Children
119 and Families investigation or is to be used solely for the
120 following purposes:
121 1. A safety demonstration, including the maintenance of
122 order and discipline in the common areas of a school or on
123 student transportation vehicles;
124 2. A purpose related to a legitimate academic or
125 extracurricular activity;

126 3. A purpose related to regular classroom instructions;
127 4. Security or surveillance of buildings or grounds; or
128 5. A photo identification card.
129 (j) The right to be notified promptly if an employee of
130 the state, any of its political subdivisions, any other
131 governmental entity, or any other institution suspects that a
132 criminal offense has been committed against his or her minor
133 child, unless the incident has first been reported to law
134 enforcement or the Department of Children and Families and
135 notifying the parent would impede the investigation.
136 (2) This section does not:
137 (a) Authorize a parent of a minor child in this state to
138 engage in conduct that is unlawful or to abuse or neglect his or
139 her minor child in violation of general law;
140 (b) Condone, authorize, approve, or apply to a parental
141 action or decision that would end life;
142 (c) Prohibit a court of competent jurisdiction, law
143 enforcement officer, or employees of a government agency that is
144 responsible for child welfare from acting in his or her official
145 capacity within the reasonable and prudent scope of his or her
146 authority; or
147 (d) Prohibit a court of competent jurisdiction from
148 issuing an order that is otherwise permitted by law.
149 (3) An employee of the state, any of its political
150 subdivisions, or any other governmental entity who encourages or

151 coerces, or attempts to encourage or coerce, a minor child to
152 withhold information from his or her parent may be subject to
153 disciplinary action.
154 (4) A parent of a minor child in this state has
155 inalienable rights that are more comprehensive than those listed
156 in this section, unless such rights have been legally waived or
157 terminated. This chapter does not prescribe all rights to a
158 parent of a minor child in this state. Unless required by law,
159 the rights of a parent of a minor child in this state may not be
160 limited or denied. This chapter may not be construed to apply to
161 a parental action or decision that would end life.
162 Section 6. Section 1014.05, Florida Statutes, is created
163 to read:
164 1014.05 School district notifications on parental rights.—
165 (1) Each district school board shall, in consultation with
166 parents, teachers, and administrators, develop and adopt a
167 policy to promote parental involvement in the public school
168 system. Such policy must include:
169 (a) A plan, pursuant to s. 1002.23, for parental
170 participation in schools to improve parent and teacher
171 cooperation in such areas as homework, school attendance, and
172 discipline.
173 (b) A procedure, pursuant to s. 1002.20(19)(b), for a
174 parent to learn about his or her minor child's course of study,
175 including the source of any supplemental education materials.

176 (c) Procedures for a parent to object to instructional
177 materials, including all classroom materials and school
178 activities, pursuant to s. 1006.28(2)(a)2., and a process for
179 withdrawing his or her minor child from the activity, class, or
180 program in which such materials or activities are used. Such
181 objections may be based on beliefs regarding morality, sex, and
182 religion or the belief that such materials or activities are
183 harmful. The term "instructional materials" includes, but is not
184 limited to, textbooks, workbooks and worksheets, handouts,
185 software, applications, internet courses, and any and all
186 digital media available to students pursuant to their role as a
187 student in public school.
188 (d) Procedures, pursuant to s. 1002.20(3)(d), for a parent
189 to withdraw his or her minor child from any portion of the
190 school district's comprehensive health education required under
191 s. 1003.42(2)(n) that relates to sex education or instruction in
192 acquired immune deficiency syndrome education or any instruction
193 regarding sexuality if the parent provides a written objection
194 to his or her minor child's participation. Such procedures must
195 provide for a parent to be notified in advance of such course
196 content so that he or she may withdraw his or her minor child
197 from those portions of the course.
198 (e) Procedures, pursuant to s. 1006.195(1)(a), for a
199 parent to learn about the nature and purpose of clubs and
200 activities offered at his or her minor child's school, including

201 those that are extracurricular or part of the school curriculum.
202 (f) Procedures for a parent to learn about parental rights
203 and responsibilities under general law, including all of the
204 following:
205 1. Pursuant to s. 1002.20(3)(d), the right to opt his or
206 her minor child out of any portion of the school district's
207 comprehensive health education required under s. 1003.42(2)(n)
208 that relates to sex education instruction in acquired immune
209 deficiency syndrome education or any instruction regarding
210 sexuality.
211 2. A plan to disseminate information, pursuant to s.
212 1002.20(6), about school choice options, including open
213 enrollment.
214 3. In accordance with s. 1002.20(3)(b), the right of a
215 parent to exempt his or her minor child from immunizations.
216 4. In accordance with s. 1008.22, the right of a parent to
217 review statewide, standardized assessment results.
218 5. In accordance with s. 1003.57, the right of a parent to
219 enroll his or her minor child in gifted or special education
220 programs.
221 6. In accordance with s. 1006.28(2)(a)1., the right of a
222 parent to inspect school district instructional materials.
223 7. In accordance with s. 1008.25, the right of a parent to
224 access information relating to the school district's policies
225 for promotion or retention, including high school graduation

226 requirements.
227 8. In accordance with s. 1002.20(14), the right of a
228 parent to receive a school report card and be informed of his or
229 her minor child's attendance requirements.
230 9. In accordance with s. 1002.23, the right of a parent to
231 access information relating to the state public education
232 system, state standards, report card requirements, attendance
233 requirements, and instructional materials requirements.
234 10. In accordance with s. 1002.23(4), the right of a
235 parent to participate in parent-teacher associations and
236 organizations that are sanctioned by a district school board or
237 the Department of Education.
238 11. In accordance with s. 1002.222(1)(a), the right of a
239 parent to opt out of any district-level data collection relating
240 to his or her minor child not required by law.
241 (2) A district school board may provide the information
242 required in this section electronically or post such information
243 on its website.
244 (3) A parent may request, in writing, from the district
245 school superintendent the information required under this
246 section. Within 10 days, the district school superintendent must
247 provide such information to the parent. If the district school
248 superintendent denies a parent's request for information or does
249 not respond to the parent's request within 10 days, the parent
250 may appeal the denial to the district school board. The district

251 school board must place a parent's appeal on the agenda for its
252 next public meeting. If it is too late for a parent's appeal to
253 appear on the next agenda, the appeal must be included on the
254 agenda for the subsequent meeting.
255 Section 7. Section 1014.06, Florida Statutes, is created
256 to read:
257 1014.06 Parental consent for health care services.—
258 (1)(a) Except as otherwise provided by law, a health care
259 practitioner, as defined in s. 456.001, may not provide or
260 solicit or arrange to provide health care services or prescribe
261 medicinal drugs to a minor child without first obtaining written
262 parental consent.
263 (b) Except as otherwise provided by law, a person, as
264 defined in s. 1.01, or an individual employed by such person may
265 not provide or solicit or arrange to provide health care
266 services or prescribe medicinal drugs to a minor child without
267 first obtaining written parental consent.
268 (2) Except as otherwise provided by law or a court order,
269 a provider, as defined in s. 408.803, may not allow a medical
270 procedure to be performed on a minor child in its facility
271 without first obtaining written parental consent.
272 (3) This section does not apply to an abortion, which is
273 governed by chapter 390.
274 (4) A health care practitioner or other person who
275 violates this section is subject to disciplinary action pursuant

276 to s. 408.813 or s. 456.072, as applicable, and commits a
277 misdemeanor of the first degree, punishable as provided in s.
278 775.082 or s. 775.083.
279 Section 8. Paragraph (f) is added to subsection (3) of
280 section 408.813, Florida Statutes, to read:
281 408.813 Administrative fines; violations.—As a penalty for
282 any violation of this part, authorizing statutes, or applicable
283 rules, the agency may impose an administrative fine.
284 (3) The agency may impose an administrative fine for a
285 violation that is not designated as a class I, class II, class
286 III, or class IV violation. Unless otherwise specified by law,
287 the amount of the fine may not exceed $500 for each violation.
288 Unclassified violations include:
289 (f) Violating the parental consent requirements of s.
290 1014.06.
291 Section 9. Paragraph (pp) is added to subsection (1) of
292 section 456.072, Florida Statutes, to read:
293 456.072 Grounds for discipline; penalties; enforcement.—
294 (1) The following acts shall constitute grounds for which
295 the disciplinary actions specified in subsection (2) may be
296 taken:
297 (pp) Failure to comply with the parental consent
298 requirements of s. 1014.06.
299 Section 10. This act shall take effect July 1, 2020.

CS/HB 1087

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1087 Domestic Violence Services
SPONSOR(S): Children, Families & Seniors Subcommittee, Fernandez-Barquin
TIED BILLS: **IDEN./SIM. BILLS:** SB 1482

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Woodruff	Brazzell
2) Public Integrity & Ethics Committee	14 Y, 0 N	Fakes	Rubottom
3) Health & Human Services Committee		Woodruff	Calamas

SUMMARY ANALYSIS

The Department of Children and Families (DCF) administers the statewide domestic violence program. The program protects adults and their children from domestic violence and helps victims develop ways to avoid further harm. DCF certifies, monitors, and oversees the funding of domestic violence centers. These centers are community-based organizations and serve victims of domestic violence. In 2012, the Legislature amended statute to require DCF to contract with the Florida Coalition Against Domestic Violence (FCADV) to manage the domestic violence programs. While DCF retains overall authority to certify domestic violence centers, the FCADV is responsible for monitoring, evaluating, and distributing the state and federal funds to the state's domestic violence centers.

The express statutory requirement to contract with a specific provider has presented challenges to DCF in overseeing the state's domestic violence services, including DCF's inability to obtain desired contract provisions or complete an audit regarding the organization's spending.

CS/HB 1087 removes the express requirement for DCF to contract with the FCADV. The bill does not prohibit DCF and FCADV from contracting for domestic violence services in the future.

Further, the bill amends various statutes to remove duties previously held by FCADV. All functions will now be under DCF, unless DCF chooses to contract for the provision of domestic violence services.

CS/HB 1087 has an indeterminate fiscal impact on DCF, and has no fiscal impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Domestic Violence Program

The Domestic Violence Program protects adults and their children from domestic violence and helps victims develop ways to avoid further harm. The Department of Children and Families (DCF) is statutorily responsible for the statewide domestic violence program, which certifies, monitors, and oversees funding of the state's domestic violence centers.[1] Domestic violence centers are community-based organizations that provide services to the victims of domestic violence. Florida has 42 certified domestic violence centers throughout the state, which are responsible for emergency shelter services and programs to survivors of domestic violence and their children.[2] Pursuant to Florida Statutes, the minimum services that a center must provide are:

- Information and referrals;
- Counseling and case management;
- Temporary emergency shelter for more than 24 hours;
- A 24-hour emergency hotline;
- Training for law enforcement and other professionals;
- Educational services for community awareness; and
- Assessment and appropriate referral of resident children.[3]

In addition to the services required by statute, the certified centers provide transportation, rent, utility assistance, transitional housing, legal and court advocacy, work skills and job-readiness training and placement, financial literacy and other training and educational programs.[4]

The program is funded by state general revenue and federal funding from the federal Administration of Children and Families at the United States Department of Health and Human Services. In FY 2019-20 the Legislature appropriated $46,679,559 in state and federal funds to the program. During the 2018-19 fiscal year, certified centers provided 646,971 nights of emergency shelter to 14,817 women, children, and men.[5]

Florida Coalition Against Domestic Violence

The Florida Coalition Against Domestic Violence (FCADV) is a nonprofit with the mission to work towards ending violence through public awareness, policy development and support for Florida's domestic violence centers.[6] DCF contracts with FCADV to monitor, evaluate, and distribute funds to the certified domestic violence centers.

The FCADV board of directors has eleven members:

- Tiffany Carr, CEO
- Melody Keeth, Chairman
- Angela Diaz-Vidaillet, Vice-President, 1st Vice-Chair
- Donna Fagan, Vice-President, 2nd Vice-Chair

---

[1] S. 39.903, F.S.
[2] Florida Coalition Against Domestic Violence, *Leading Florida Higher, Lifting Survivors Upward; Florida's Commitment to Ending Domestic Violence and Saving Lives*, https://www.fcadv.org/sites/default/files/2019AnnualReportFinal.pdf (last visited Jan. 15, 2020).
[3] S. 39.905(1)(c), F.S.
[4] *Supra* note 2.
[5] *Id.*
[6] Florida Coalition Against Domestic Violence, https://www.fcadv.org/ (last visited Jan. 15, 2020).

- Laurel Lynch, Director
- Sherrie Schwab, Director
- Lorna Taylor, Director
- Penny Morrill, Director
- Shandra Riffey, Treasurer
- Theresa Beachy, Secretary

Most the board members previously or currently serve in leadership roles for certified domestic violence centers in Florida.[7]

Certification of Domestic Violence Centers

Current law requires domestic violence centers to be certified by DCF in order to receive state funding.[8] DCF sets criteria for certification and sets minimum standards to ensure the health and safety of clients served.[9] To be eligible for certification as a domestic violence center, an applicant must apply to DCF and be a not-for-profit entity. A domestic violence center's primary mission must be to provide services to victims of domestic violence, as defined as any assault, aggravated assault, battery, aggravated battery, sexual assault, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.[10]

An applicant may seek certification to serve an area that has an existing certified domestic center; however, the applicant must show there is an unmet need in the area.[11] An applicant can only apply if their domestic violence center has been providing services to victims for 18 consecutive months, including 12 months as an emergency shelter.[12] In addition to other requirements for certification, DCF requires an applicant to become a member of the FCADV and maintain membership as a condition of certification.[13] Failure to join the FCADV and maintain membership is grounds for revocation of certification.[14]

After DCF certifies a domestic violence center, the certification is good for one year and automatically expiries on June 30.[15] DCF will annually renew a domestic violence center's certification provided there is a favorable report from the FCADV.[16]

Florida Coalition Against Domestic Violence Contract

In 2004, the Legislature directed DCF to contract with a statewide association for the domestic violence program to help with the delivery of domestic violence services. To implement this legislative directive, DCF contracted with FCADV. In 2012, the Legislature amended statute to require DCF to contract specifically with FCADV to monitor, evaluate, and fund the state's domestic violence centers.[17] This express directive means DCF cannot competitively procure the contract to find the best provider, but must contract with FCADV regardless of qualifications, so DCF has very little negotiating power.

Under current law, DCF and FCADV must work in collaboration to administer the state's domestic violence program. While DCF retains overall authority to certify domestic violence centers, FCADV is

---

[7] *See* Florida Coalition Against Domestic Violence, *2018 Directory of Florida Certified Domestic Violence Centers*, https://www.fcadv.org/sites/default/files/1.%20FCADV%20Hotline%20Info%20%28PAGE%206%20ONLY%29.pdf (last visited Feb. 5, 2020).
[8] S. 39.905(6)(a), F.S.
[9] S. 39.903(9), F.S.; R. 65H-1, F.A.C.
[10] S. 741.28(2), F.S.
[11] R. 65H-1.012(1)(e), F.A.C.
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] S. 39.903, F.S., Ch. 2012-147, F.S.

responsible for monitoring, evaluating, and funding the centers. Under the contract, FCADV responsibilities include, but are not limited to:

- the administration of contracts and grants;
- implementation of special projects;
- provision of training and technical assistance to certified domestic violence centers; and
- prevention, research, evaluation, and educational programs for professionals and the public.[18]

The FCADV is the sole recipient of the state's domestic violence money. It receives state and federal dollars and distributes the money to the community-based domestic violence centers. FCADV is also required to ensure the money is spent properly.[19]

FCADV receives funding from the federal and state government, as well from private donations. The 2019-20 General Appropriations Act appropriated $46,679,559 to FCADV for domestic violence services. This included funding from the following sources:

- General Revenue Fund: $11,164,596
- Domestic Violence Trust Fund: $7,951,132
- Federal Grants Trust Fund: $19,813,831
- Welfare Transition Trust Fund: $7,750,000[20]

FCADV's Form 990 filing with the IRS indicates that on their 2017 tax return they had total revenues of $52,010,131 with 99.75 percent being public funds.[21] FCADV's Form 990 filing for 2016 reflects that they had total revenues of $42,751,725.[22] According to DCF, it provided 89.13 percent ($38,102,717) of the 2016 funding and Florida's Office of Attorney General provided 7.9 percent ($3,403,910).[23] Combined, at least 97.09 percent of FCADV's funding was received through the state that fiscal year. The FCADV's 2018-19 annual report lists total funding of $43,942,812, though the report does not indicate the time period on which this is based.[24]

DCF operates as the main oversight body for FCADV. DCF's Inspector General reviews a third-party audit of FCADV's contract annually and conducts annual reviews to ensure funds are spent properly.[25]

According to DCF, the statutory requirement to contract with FCADV leaves DCF with little bargaining power in contractual negotiations. For example, DCF's Office of General Counsel has been unable to come to an agreement with FCADV to add provisions to the contract that require FCADV employees to be subject to DCF's background screening process; this is in addition to FCADV's refusal to provide records it deems private to DCF's Inspector General.[26] Despite these disputes, DCF is statutorily required to contract with FCADV. DCF simply does not have leverage to seek anything more than what is currently in its contract with FCADV because it is not legally authorized to negotiate with any other vendor.

Executive Compensation

The present contract between DCF and FCADV does not place any limitation on executive salaries. There has been a federal investigation and a state audit of FCADV's funding and expenditures after media reports criticized the exorbitant salary of the FCADV executive director.

[18] Contract No. LN967
[19] S. 39.9035, F.S.
[20] Ch. 2019-115, L.O.F.
[21] Form 990, Return of Organization Exempt from Income Tax, 2017, Florida Coalition Against Domestic Violence, https://pdf.guidestar.org/PDF_Images/2018/592/055/2018-592055476-1099952d-9.pdf (last viewed January 28, 2020).
[22] Form 990, Return of Organization Exempt from Income Tax, 2016, Florida Coalition Against Domestic Violence, https://pdf.guidestar.org/PDF_Images/2017/592/055/2017-592055476-0f80825c-9.pdf (last viewed January 20, 2020).
[23] Florida Department of Children and Families, Agency Analysis of 2020 House Bill 1087.
[24] *Id.*
[25]. *Id.*
[26] Email from John Paul Fiore, Department of Children and Families, HB 1087 Questions and Analysis, (Jan. 21, 2020).

Federal Investigation

In 2018, Florida media outlets published reports alleging FCADV's executive director was receiving a high salary while domestic violence centers went understaffed and under-resourced.[27] For example, a Tampa Bay area domestic violence shelter was reported to have roaches and moldy food.[28] In response to these reports, the Family Violence Prevention and Services Act Program in the Family & Youth Services Bureau of the federal Administration of Children and Families (ACF) contacted FCADV expressing concerns about the executive director's reported compensation and requested specific documentation of her compensation.[29] Federal law limits the salary amount an executive level employee may receive if the organization receives federal funds.[30]

According to letters from ACF, unless it was satisfied that the executive director's salary complied with federal limits of $189,600, ACF would take corrective action, including withholding payment and possible referral to the United States Department of Health and Human Services Inspector General.[31] The FCADV responded to the ACF requests stating that the executive director's base salary charged to the Family Violence Prevention and Services Act grants was $137,562.[32]

State Audit

The DCF Secretary requested the DCF Inspector General to do an audit to determine the proportion of DCF's funding expended on administrative costs and executive compensation and to determine whether funding expended on executive compensation agrees with information provided to DCF.[33]

Between August 27, 2018, and November 7, 2019, DCF provided at least four written requests to FCADV for documentation in relation to the audit.[34] Although FCADV provided some information to DCF, the Inspector General found the information incomplete.[35] FCADV refused to turn over documents relating to compensation and personnel files of the president and chief executive office, chief operating officer, and chief financial officer, minutes for specified FCADV meetings, as well as information relating to dues[36] collected from certified domestic violence centers.[37] Relying on its contract with DCF, FCADV believes it provided all information that was subject to the audit and did not need to provide information that it considers private in nature.[38]

As of January 30, 2020, DCF has not received the requested documentation it requires to complete the audit.[39]

Background Screenings

While DCF has requested FCADV to require coalition employees to be subject to DCF's background

---

[27] *See* Adiel Kaplan, 'That's… ridiculous.' Florida domestic violence chief is paid $761,000 a year, Miami Herald (Jul. 25, 2018), https://www.miamiherald.com/news/state/florida/article214972045.html (last visited Jan. 15, 2020).
[28] Kylie McGivern, *Former residents call for action after roaches, moldy food found in domestic violence shelters*, (Aug. 14, 2019), https://www.abcactionnews.com/news/local-news/i-team-investigates/former-residents-call-for-action-after-roaches-moldy-food-found-in-domestic-violence-shelters (Jan. 21, 2020).
[29] *Supra* note 23.
[30] 30 U.S.C. § 962 (2011).
[31] *Supra* note 23.
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] The Florida House Public Integrity & Ethics Committee has requested information on what these dues include as part of an investigation on the Florida Coalition Against Domestic Violence.
[37] Letter from Javier A. Enriquez, General Counsel, Department of Children and Families (Nov. 7, 2019)
[38] *Supra* note 26.
[39] On January 20, FCADV provided salary payment information to DCF without explaining the sources of those funds.

screening process, FCADV has refused to agree to require screenings.[40] Requiring background screenings would seem to promote a safer environment.[41] However, FCADV believes that background screenings could potentially harm potential employees, who may be victims of domestic violence themselves who had to commit crimes in order to satisfy or even escape their abuser.[42] FCADV believes that background screenings might disqualify these potential employees.[43]

Effect of Proposed Changes

CS/HB 1087 amends various statutes to remove the express requirement for DCF to contract with FCADV. The bill still allows DCF to contract for domestic violence services. It allows DCF more flexibility in determining with whom it contracts and what domestic violence services are covered by contract. It will potentially broaden the pool of providers with which DCF may contract, and increase DCF's negotiating power. This may increase transparency of the use of appropriated funds that pay for services that help victims of domestic violence.

The bill does not prohibit FCADV from contracting in the future with DCF if both parties choose to do so.

The bill also amends statutes to shift duties previously held by FCADV to DCF. The bill removes all duties previously held by FCADV, including:

- Implementing, administering, and evaluating all domestic violence services provided by the certified domestic violence centers.
- Receiving and approving or rejecting applications for funding of certified domestic violence centers.
- Evaluating certified domestic violence center in order to determine compliance with minimum certification standards.
- Having the right to enter and inspect the premises of certified domestic violence centers for monitoring purposes.
- Providing a report to the Legislature on the status of domestic violence in the state.
- Having the domestic violence centers provide the names of the domestic violence advocates employed at the centers who may claim privilege to refuse to disclose a confidential communication between a victim and the advocate.
- Requiring the contract between domestic violence centers and FCADV to contain provisions ensuring the available and geographic accessibility of services in the area and allowing the domestic violence centers to distribute funds through subcontractors with approval by FCADV.
- Requiring the FCADV to monitor food services for domestic violence centers.
- Being a representative on the Statewide Guardian ad Litem training curriculum committee.
- Being a member of the State Child Abuse Death Review Committee and being required to provide training to local child abuse death review committee members on the impact of domestic violence.
- Administering the domestic violence fatality review teams.
- Requiring the Criminal Justice Standards and Training Commission to work with the FCADV on law enforcement domestic violence training.
- Requiring the institute for Child Welfare to work with FCADV.

All functions will now be under DCF unless DCF chooses to contract for the provision of domestic violence services.

[40] Interview by Florida House Public Integrity & Ethics Committee staff with Florida Department of Children and Families Office of General Counsel's office staff (Jan. 24, 2020).
[41] *Id.*
[42] *Id.*
[43] *Id.*

B. SECTION DIRECTORY:

Section 1: amending s. 39.902, F.S., relating to definitions.
Section 2: amending s. 39.903, F.S., relating to duties and functions of the department with respect to domestic violence.
Section 3: repealing s. 39.9035, F.S., relating to duties and functions of the coalition with respect to domestic violence.
Section 4: amending s. 39.904, F.S., relating to report to the legislature on the status of domestic violence cases.
Section 5: amending s. 39.905, F.S., relating to domestic violence centers.
Section 6: amending s. 39.9055, F.S., relating to certified domestic violence centers; capital improvement grant program.
Section 7: amending s. 39.8296, F.S., relating to the statewide Guardian Ad Litem Office: legislative findings and intent; creation; appointment of executive director; duties of office.
Section 8: amending s. 381.006, F.S., relating to environmental health.
Section 9: amending s. 381.0072, F.S., relating to food service protection.
Section 10: amending s. 383.402, F.S., relating to child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committee.
Section 11: amending s. 402.40, F.S., relating to child welfare training and certification.
Section 12: amending s. 741.316, F.S., relating to domestic violence fatality review teams; definition; membership; duties.
Section 13: amending s. 753.03, F.S., relating to standards for supervised visitation and supervised exchange programs.
Section 14: amending s. 943.1701, F.S., relating to uniform statewide policies and procedures; duty of the commission.
Section 15: amending s. 1004.615, F.S., relating to Florida Institute of Child Welfare.
Section 16: providing an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Until decisions are finalized as to whether the domestic violence program's responsibilities will be fulfilled by DCF, through contract, or both, the expenditures to state government are indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If DCF and FCADV do not contract for the provision of domestic violence services in the future, the FCADV will lose the state funding it is provided through the contract for these services but will also no longer have the responsibilities that the contract funded.

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:

Rulemaking is not required to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 22, 2020, the Children, Families, and Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment removed section 14 of the bill that expanded the definition of "care" to include "victims of domestic violence" in s, 943.0542, F.S., regarding access to criminal history information provided by DCF to qualified entities who provide care to certain individuals.

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

1 A bill to be entitled
2 An act relating to domestic violence services;
3 amending s. 39.902, F.S.; deleting the definition of
4 the term "coalition"; amending s. 39.903, F.S.;
5 revising the duties of the Department of Children and
6 Families in relation to the domestic violence program;
7 repealing s. 39.9035, F.S., relating to the duties and
8 functions of the Florida Coalition Against Domestic
9 Violence with respect to domestic violence; amending
10 s. 39.904, F.S.; requiring the department to provide a
11 specified report; amending s. 39.905, F.S.; revising
12 the requirements of domestic violence centers;
13 amending s. 39.9055, F.S.; removing the coalition from
14 the capital improvement grant program process;
15 amending ss. 39.8296, 381.006, 381.0072, 383.402,
16 402.40, 741.316, 753.03, 943.1701, and 1004.615, F.S.;
17 conforming provisions to changes made by the act;
18 providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Subsection (1) of section 39.902, Florida
23 Statutes, is amended to read:
24 39.902 Definitions.—As used in this part, the term:
25 ~~(1) "Coalition" means the Florida Coalition Against~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26 ~~Domestic Violence.~~
27 Section 2. Subsections (1), (2), (7), and (8) of section
28 39.903, Florida Statutes, are amended to read:
29 39.903 Duties and functions of the department with respect
30 to domestic violence.—The department shall:
31 (1) Operate the domestic violence program and~~, in~~
32 ~~collaboration with the coalition, shall~~ coordinate and
33 administer statewide activities related to the prevention of
34 domestic violence.
35 (2) Receive and approve or reject applications for initial
36 certification of domestic violence centers<u>, and</u>~~. The department~~
37 ~~shall~~ annually renew the certification thereafter ~~upon receipt~~
38 ~~of a favorable monitoring report by the coalition~~.
39 (7) Contract with <u>an entity or entities</u> ~~the coalition~~ for
40 the delivery and management of services for the state's domestic
41 violence program <u>if the department determines that doing so is</u>
42 <u>in the best interest of the state</u>. ~~Services under this contract~~
43 ~~include, but are not limited to, the administration of contracts~~
44 ~~and grants.~~
45 (8) Consider applications from certified domestic violence
46 centers for capital improvement grants and award those grants <u>in</u>
47 <u>accordance with</u> ~~pursuant to~~ s. 39.9055.
48 Section 3. <u>Section 39.9035, Florida Statutes, is repealed.</u>
49 Section 4. Section 39.904, Florida Statutes, is amended to
50 read:

51 39.904 Report to the Legislature on the status of domestic
52 violence cases.—On or before January 1 of each year, the
53 department ~~coalition~~ shall furnish to the President of the
54 Senate and the Speaker of the House of Representatives a report
55 on the status of domestic violence in this state, which must
56 include, but need not be limited to, the following:
57 (1) The incidence of domestic violence in this state.
58 (2) An identification of the areas of the state where
59 domestic violence is of significant proportions, indicating the
60 number of cases of domestic violence officially reported, as
61 well as an assessment of the degree of unreported cases of
62 domestic violence.
63 (3) An identification and description of the types of
64 programs in the state which assist victims of domestic violence
65 or persons who commit domestic violence, including information
66 on funding for the programs.
67 (4) The number of persons who receive services from local
68 certified domestic violence programs that receive funding
69 through the department ~~coalition~~.
70 (5) The incidence of domestic violence homicides in the
71 state, including information and data collected from state and
72 local domestic violence fatality review teams.
73 Section 5. Paragraphs (f) and (g) of subsection (1),
74 subsections (2) and (4), paragraph (a) of subsection (6), and
75 subsections (7) and (8) of section 39.905, Florida Statutes, are

76 amended to read:
77 39.905 Domestic violence centers.—
78 (1) Domestic violence centers certified under this part
79 must:
80 (f) Comply with rules adopted under ~~pursuant to~~ this part.
81 (g) File with the department ~~coalition~~ a list of the names
82 of the domestic violence advocates who are employed or who
83 volunteer at the domestic violence center who may claim a
84 privilege under s. 90.5036 to refuse to disclose a confidential
85 communication between a victim of domestic violence and the
86 advocate regarding the domestic violence inflicted upon the
87 victim. The list must include the title of the position held by
88 the advocate whose name is listed and a description of the
89 duties of that position. A domestic violence center must file
90 amendments to this list as necessary.
91 (2) If the department finds that there is failure by a
92 center to comply with the requirements established, or rules
93 adopted, under this part ~~or with the rules adopted pursuant~~
94 ~~thereto~~, the department may deny, suspend, or revoke the
95 certification of the center.
96 (4) The domestic violence centers shall establish
97 procedures to facilitate ~~pursuant to which~~ persons subject to
98 domestic violence to ~~may~~ seek services from these centers
99 voluntarily.
100 (6) In order to receive state funds, a center must:

101 (a) Obtain certification under ~~pursuant to~~ this part.
102 However, the issuance of a certificate does not obligate the
103 department ~~coalition~~ to provide funding.
104 (7)(a) All funds collected and appropriated to the
105 domestic violence program for certified domestic violence
106 centers shall be distributed annually according to an allocation
107 formula approved by the department. In developing the formula,
108 the factors of population, rural characteristics, geographical
109 area, and the incidence of domestic violence must ~~shall~~ be
110 considered.
111 (b) A contract between the department ~~coalition~~ and a
112 certified domestic violence center shall contain provisions
113 ensuring the availability and geographic accessibility of
114 services throughout the service area. For this purpose, a center
115 may distribute funds through subcontracts or to center
116 satellites, if such arrangements and any subcontracts are
117 approved by the department ~~coalition~~.
118 ~~(8) If any of the required services are exempted from~~
119 ~~certification by the department under this section, the center~~
120 ~~may not receive funding from the coalition for those services.~~
121 Section 6. Section 39.9055, Florida Statutes, is amended
122 to read:
123 39.9055 Certified domestic violence centers; capital
124 improvement grant program.—There is established a certified
125 domestic violence center capital improvement grant program.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

126 (1) A certified domestic violence center as defined in s.
127 39.905 may apply to the department ~~of Children and Families~~ for
128 a capital improvement grant. The grant application must provide
129 information that includes:
130 (a) A statement specifying the capital improvement that
131 the certified domestic violence center proposes to make with the
132 grant funds.
133 (b) The proposed strategy for making the capital
134 improvement.
135 (c) The organizational structure that will carry out the
136 capital improvement.
137 (d) Evidence that the certified domestic violence center
138 has difficulty in obtaining funding or that funds available for
139 the proposed improvement are inadequate.
140 (e) Evidence that the funds will assist in meeting the
141 needs of victims of domestic violence and their children in the
142 certified domestic violence center service area.
143 (f) Evidence of a satisfactory recordkeeping system to
144 account for fund expenditures.
145 (g) Evidence of ability to generate local match.
146 (2) Certified domestic violence centers as defined in s.
147 39.905 may receive funding subject to legislative appropriation,
148 upon application to the department ~~of Children and Families~~, for
149 projects to construct, acquire, repair, improve, or upgrade
150 systems, facilities, or equipment, subject to availability of

151 funds. An award of funds under this section must be made in
152 accordance with a needs assessment developed by the ~~Florida~~
153 ~~Coalition Against Domestic Violence and the~~ department ~~of~~
154 ~~Children and Families~~. The department annually shall perform
155 this needs assessment and shall rank in order of need those
156 centers that are requesting funds for capital improvement.
157 (3) The department ~~of Children and Families~~ shall~~, in~~
158 ~~collaboration with the Florida Coalition Against Domestic~~
159 ~~Violence,~~ establish criteria for awarding the capital
160 improvement funds that must be used exclusively for support and
161 assistance with the capital improvement needs of the certified
162 domestic violence centers, as defined in s. 39.905.
163 (4) The department ~~of Children and Families~~ shall ensure
164 that the funds awarded under this section are used solely for
165 the purposes specified in this section. The department will also
166 ensure that the grant process maintains the confidentiality of
167 the location of the certified domestic violence centers, as
168 required under ~~pursuant to~~ s. 39.908. The total amount of grant
169 moneys awarded under this section may not exceed the amount
170 appropriated for this program.
171 Section 7. Paragraph (b) of subsection (2) of section
172 39.8296, Florida Statutes, is amended to read:
173 39.8296 Statewide Guardian Ad Litem Office; legislative
174 findings and intent; creation; appointment of executive
175 director; duties of office.—

176 (2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a
177 Statewide Guardian Ad Litem Office within the Justice
178 Administrative Commission. The Justice Administrative Commission
179 shall provide administrative support and service to the office
180 to the extent requested by the executive director within the
181 available resources of the commission. The Statewide Guardian Ad
182 Litem Office shall not be subject to control, supervision, or
183 direction by the Justice Administrative Commission in the
184 performance of its duties, but the employees of the office shall
185 be governed by the classification plan and salary and benefits
186 plan approved by the Justice Administrative Commission.
187 (b) The Statewide Guardian Ad Litem Office shall, within
188 available resources, have oversight responsibilities for and
189 provide technical assistance to all guardian ad litem and
190 attorney ad litem programs located within the judicial circuits.
191 1. The office shall identify the resources required to
192 implement methods of collecting, reporting, and tracking
193 reliable and consistent case data.
194 2. The office shall review the current guardian ad litem
195 programs in Florida and other states.
196 3. The office, in consultation with local guardian ad
197 litem offices, shall develop statewide performance measures and
198 standards.
199 4. The office shall develop a guardian ad litem training
200 program. The office shall establish a curriculum committee to

201 develop the training program specified in this subparagraph. The
202 curriculum committee shall include, but not be limited to,
203 dependency judges, directors of circuit guardian ad litem
204 programs, active certified guardians ad litem, a mental health
205 professional who specializes in the treatment of children, a
206 member of a child advocacy group, a representative of a domestic
207 violence advocacy group ~~the Florida Coalition Against Domestic~~
208 ~~Violence~~, and a social worker experienced in working with
209 victims and perpetrators of child abuse.
210 5. The office shall review the various methods of funding
211 guardian ad litem programs, shall maximize the use of those
212 funding sources to the extent possible, and shall review the
213 kinds of services being provided by circuit guardian ad litem
214 programs.
215 6. The office shall determine the feasibility or
216 desirability of new concepts of organization, administration,
217 financing, or service delivery designed to preserve the civil
218 and constitutional rights and fulfill other needs of dependent
219 children.
220 7. In an effort to promote normalcy and establish trust
221 between a court-appointed volunteer guardian ad litem and a
222 child alleged to be abused, abandoned, or neglected under this
223 chapter, a guardian ad litem may transport a child. However, a
224 guardian ad litem volunteer may not be required or directed by
225 the program or a court to transport a child.

226 8. The office shall submit to the Governor, the President
227 of the Senate, the Speaker of the House of Representatives, and
228 the Chief Justice of the Supreme Court an interim report
229 describing the progress of the office in meeting the goals as
230 described in this section. The office shall submit to the
231 Governor, the President of the Senate, the Speaker of the House
232 of Representatives, and the Chief Justice of the Supreme Court a
233 proposed plan including alternatives for meeting the state's
234 guardian ad litem and attorney ad litem needs. This plan may
235 include recommendations for less than the entire state, may
236 include a phase-in system, and shall include estimates of the
237 cost of each of the alternatives. Each year the office shall
238 provide a status report and provide further recommendations to
239 address the need for guardian ad litem services and related
240 issues.
241 Section 8. Subsection (18) of section 381.006, Florida
242 Statutes, is amended to read:
243 381.006 Environmental health.—The department shall conduct
244 an environmental health program as part of fulfilling the
245 state's public health mission. The purpose of this program is to
246 detect and prevent disease caused by natural and manmade factors
247 in the environment. The environmental health program shall
248 include, but not be limited to:
249 (18) A food service inspection function for domestic
250 violence centers that are certified and monitored by the

251 Department of Children and Families ~~and monitored by the Florida~~
252 ~~Coalition Against Domestic Violence~~ under part XII of chapter 39
253 and group care homes as described in subsection (16), which
254 shall be conducted annually and be limited to the requirements
255 in department rule applicable to community-based residential
256 facilities with five or fewer residents.
257
258 The department may adopt rules to carry out the provisions of
259 this section.
260 Section 9. Paragraph (c) of subsection (2) of section
261 381.0072, Florida Statutes, is amended to read:
262 381.0072 Food service protection.—
263 (2) DEFINITIONS.—As used in this section, the term:
264 (c) "Food service establishment" means detention
265 facilities, public or private schools, migrant labor camps,
266 assisted living facilities, facilities participating in the
267 United States Department of Agriculture Afterschool Meal Program
268 that are located at a facility or site that is not inspected by
269 another state agency for compliance with sanitation standards,
270 adult family-care homes, adult day care centers, short-term
271 residential treatment centers, residential treatment facilities,
272 homes for special services, transitional living facilities,
273 crisis stabilization units, hospices, prescribed pediatric
274 extended care centers, intermediate care facilities for persons
275 with developmental disabilities, boarding schools, civic or

276 fraternal organizations, bars and lounges, vending machines that
277 dispense potentially hazardous foods at facilities expressly
278 named in this paragraph, and facilities used as temporary food
279 events or mobile food units at any facility expressly named in
280 this paragraph, where food is prepared and intended for
281 individual portion service, including the site at which
282 individual portions are provided, regardless of whether
283 consumption is on or off the premises and regardless of whether
284 there is a charge for the food. The term includes a culinary
285 education program where food is prepared and intended for
286 individual portion service, regardless of whether there is a
287 charge for the food or whether the program is inspected by
288 another state agency for compliance with sanitation standards.
289 The term does not include any entity not expressly named in this
290 paragraph; nor does the term include a domestic violence center
291 certified <u>and monitored</u> by the Department of Children and
292 Families ~~and monitored by the Florida Coalition Against Domestic~~
293 ~~Violence~~ under part XII of chapter 39 if the center does not
294 prepare and serve food to its residents and does not advertise
295 food or drink for public consumption.
296 Section 10. Subsection (2) of section 383.402, Florida
297 Statutes, is amended to read:
298 383.402 Child abuse death review; State Child Abuse Death
299 Review Committee; local child abuse death review committees.—
300 (2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

301 (a) Membership.—
302 1. The State Child Abuse Death Review Committee is
303 established within the Department of Health and shall consist of
304 a representative of the Department of Health, appointed by the
305 State Surgeon General, who shall serve as the state committee
306 coordinator. The head of each of the following agencies or
307 organizations shall also appoint a representative to the state
308 committee:
309 a. The Department of Legal Affairs.
310 b. The Department of Children and Families.
311 c. The Department of Law Enforcement.
312 d. The Department of Education.
313 e. The Florida Prosecuting Attorneys Association, Inc.
314 f. The Florida Medical Examiners Commission, whose
315 representative must be a forensic pathologist.
316 2. In addition, the State Surgeon General shall appoint
317 the following members to the state committee, based on
318 recommendations from the Department of Health and the agencies
319 listed in subparagraph 1., and ensuring that the committee
320 represents the regional, gender, and ethnic diversity of the
321 state to the greatest extent possible:
322 a. The Department of Health Statewide Child Protection
323 Team Medical Director.
324 b. A public health nurse.
325 c. A mental health professional who treats children or

326 adolescents.
327 d. An employee of the Department of Children and Families
328 who supervises family services counselors and who has at least 5
329 years of experience in child protective investigations.
330 e. The medical director of a Child Protection Team.
331 f. A member of a child advocacy organization.
332 g. A social worker who has experience in working with
333 victims and perpetrators of child abuse.
334 h. A person trained as a paraprofessional in patient
335 resources who is employed in a child abuse prevention program.
336 i. A law enforcement officer who has at least 5 years of
337 experience in children's issues.
338 j. A representative of a domestic violence advocacy group
339 ~~the Florida Coalition Against Domestic Violence~~.
340 k. A representative from a private provider of programs on
341 preventing child abuse and neglect.
342 l. A substance abuse treatment professional.
343 3. The members of the state committee shall be appointed
344 to staggered terms not to exceed 2 years each, as determined by
345 the State Surgeon General. Members may be appointed to no more
346 than three consecutive terms. The state committee shall elect a
347 chairperson from among its members to serve for a 2-year term,
348 and the chairperson may appoint ad hoc committees as necessary
349 to carry out the duties of the committee.
350 4. Members of the state committee shall serve without

351 compensation but may receive reimbursement for per diem and
352 travel expenses incurred in the performance of their duties as
353 provided in s. 112.061 and to the extent that funds are
354 available.
355 (b) Duties.—The State Child Abuse Death Review Committee
356 shall:
357 1. Develop a system for collecting data from local
358 committees on deaths that are reported to the central abuse
359 hotline. The system must include a protocol for the uniform
360 collection of data statewide, which must, at a minimum, use the
361 National Child Death Review Case Reporting System administered
362 by the National Center for the Review and Prevention of Child
363 Deaths.
364 2. Provide training to cooperating agencies, individuals,
365 and local child abuse death review committees on the use of the
366 child abuse death data system.
367 3. Provide training to local child abuse death review
368 committee members on the dynamics and impact of domestic
369 violence, substance abuse, or mental health disorders when there
370 is a co-occurrence of child abuse. Training must be provided by
371 the Department of Children and Families ~~Florida Coalition~~
372 ~~Against Domestic Violence~~, the Florida Alcohol and Drug Abuse
373 Association, and the Florida Council for Community Mental Health
374 in each entity's respective area of expertise.
375 4. Develop statewide uniform guidelines, standards, and

376 protocols, including a protocol for standardized data collection
377 and reporting, for local child abuse death review committees and
378 provide training and technical assistance to local committees.
379 5. Develop statewide uniform guidelines for reviewing
380 deaths that are the result of child abuse, including guidelines
381 to be used by law enforcement agencies, prosecutors, medical
382 examiners, health care practitioners, health care facilities,
383 and social service agencies.
384 6. Study the adequacy of laws, rules, training, and
385 services to determine what changes are needed to decrease the
386 incidence of child abuse deaths and develop strategies and
387 recruit partners to implement these changes.
388 7. Provide consultation on individual cases to local
389 committees upon request.
390 8. Educate the public regarding the provisions of chapter
391 99-168, Laws of Florida, the incidence and causes of child abuse
392 death, and ways by which such deaths may be prevented.
393 9. Promote continuing education for professionals who
394 investigate, treat, and prevent child abuse or neglect.
395 10. Recommend, when appropriate, the review of the death
396 certificate of a child who died as a result of abuse or neglect.
397 Section 11. Paragraph (b) of subsection (5) of section
398 402.40, Florida Statutes, is amended to read:
399 402.40 Child welfare training and certification.—
400 (5) CORE COMPETENCIES AND SPECIALIZATIONS.—

401 (b) The identification of these core competencies and
402 development of preservice curricula shall be a collaborative
403 effort that includes professionals who have expertise in child
404 welfare services, department-approved third-party credentialing
405 entities, and providers that will be affected by the curriculum,
406 including, but not limited to, representatives from the
407 community-based care lead agencies, ~~the Florida Coalition~~
408 ~~Against Domestic Violence,~~ the Florida Alcohol and Drug Abuse
409 Association, the Florida Council for Community Mental Health,
410 sheriffs' offices conducting child protection investigations,
411 and child welfare legal services providers.
412 Section 12. Subsection (5) of section 741.316, Florida
413 Statutes, is amended to read:
414 741.316 Domestic violence fatality review teams;
415 definition; membership; duties.—
416 (5) The domestic violence fatality review teams are
417 assigned to the Department of Children and Families ~~Florida~~
418 ~~Coalition Against Domestic Violence~~ for administrative purposes.
419 Section 13. Paragraph (d) of subsection (2) of section
420 753.03, Florida Statutes, is amended to read:
421 753.03 Standards for supervised visitation and supervised
422 exchange programs.—
423 (2) The clearinghouse shall use an advisory board to
424 assist in developing the standards. The advisory board must
425 include:

426 ~~(d) A representative of the Florida Coalition Against~~
427 ~~Domestic Violence, appointed by the executive director of the~~
428 ~~Florida Coalition Against Domestic Violence.~~
429 Section 14. Section 943.1701, Florida Statutes, is amended
430 to read:
431 943.1701 Uniform statewide policies and procedures; duty
432 of the commission.—The commission, with the advice and
433 cooperation of the Department of Children and Families ~~Florida~~
434 ~~Coalition Against Domestic Violence~~, the Florida Sheriffs
435 Association, the Florida Police Chiefs Association, and other
436 agencies that verify, serve, and enforce injunctions for
437 protection against domestic violence, shall develop by rule
438 uniform statewide policies and procedures to be incorporated
439 into required courses of basic law enforcement training and
440 continuing education. These statewide policies and procedures
441 shall include:
442 (1) The duties and responsibilities of law enforcement in
443 response to domestic violence calls, enforcement of injunctions,
444 and data collection.
445 (2) The legal duties imposed on law enforcement officers
446 to make arrests and offer protection and assistance, including
447 guidelines for making felony and misdemeanor arrests.
448 (3) Techniques for handling incidents of domestic violence
449 that minimize the likelihood of injury to the officer and that
450 promote safety of the victim.

451 (4) The dynamics of domestic violence and the magnitude of
452 the problem.
453 (5) The legal rights of, and remedies available to,
454 victims of domestic violence.
455 (6) Documentation, report writing, and evidence
456 collection.
457 (7) Tenancy issues and domestic violence.
458 (8) The impact of law enforcement intervention in
459 preventing future violence.
460 (9) Special needs of children at the scene of domestic
461 violence and the subsequent impact on their lives.
462 (10) The services and facilities available to victims and
463 batterers.
464 (11) The use and application of sections of the Florida
465 Statutes as they relate to domestic violence situations.
466 (12) Verification, enforcement, and service of injunctions
467 for protection when the suspect is present and when the suspect
468 has fled.
469 (13) Emergency assistance to victims and how to assist
470 victims in pursuing criminal justice options.
471 (14) Working with uncooperative victims, when the officer
472 becomes the complainant.
473 Section 15. Subsection (3) of section 1004.615, Florida
474 Statutes, is amended to read:
475 1004.615 Florida Institute for Child Welfare.—

476 (3) The institute shall work with the department, sheriffs
477 providing child protective investigative services, community-
478 based care lead agencies, community-based care provider
479 organizations, the court system, the Department of Juvenile
480 Justice, ~~the Florida Coalition Against Domestic Violence,~~ and
481 other partners who contribute to and participate in providing
482 child protection and child welfare services.
483 Section 16. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1461 Health Access Dental Licenses
SPONSOR(S): Health Quality Subcommittee, Brown
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1296

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N, As CS	Siples	Calamas
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

The health access dental license was established in 2008 to attract out-of-state dentists to practice in underserved health access settings in this state. Under this statutory authority, the Board of Dentistry, within the Department of Health, could issue a health access dental license to a licensed out-of-state dentist to provide dental care in certain underserved areas and programs. The Board of Dentistry was also authorized to set application, examination, licensure, and licensure renewal fees for health access dental licenses.

The health access dental license statute contained a sunset provision, by which the act would be automatically repealed on January 1, 2020, unless reenacted by the Legislature. The Legislature did not reenact the law prior to the sunset date, so the statutory authority for health access dental licenses was automatically repealed on January 1, 2020.

CS/HB 1461 revives and reenacts the authority for health access dental licenses, and repeals the scheduled sunset date of January 1, 2020. The bill also revives and reenacts the Board of Dentistry's authority to establish fees retroactively to January 1, 2020.

The bill will have an insignificant, negative fiscal impact on the Department of Health. The bill has no impact on local governments.

The bill provides an effective date of upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Dentistry

The Board of Dentistry (Board), within the Department of Health regulates the practice of dentistry.[1] Any person wishing to practice dentistry in this state must apply to DOH and meet specified requirements. Section 466.006, F.S., requires dentistry licensure applicants to sit for and pass the following licensure examinations:

- The National Board of Dental Examiners dental examination (NBDE);
- A written examination on Florida laws and rules regulating the practice of dentistry; and
- A practical examination, which is the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., and graded by a Florida-licensed dentist employed by DOH for such purpose.[2]

To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association Commission on Dental Accreditation (CODA) or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.[3] If the applicant is not a graduate of a CODA-accredited program, the applicant must demonstrate that he or she holds a degree from an accredited American dental school or has completed two years at a full-time supplemental general dentistry program accredited by CODA.[4]

Health Access Dental Licenses

The health access dental license was established in 2008 to attract out-of-state dentists to practice in underserved health access settings[5] in this state, without supervision.[6] A health access setting is a program or institution operated by the Department of Children and Families, Department of Health, Department of Juvenile Justice, a nonprofit health care center, a Head Start center, a federally-qualified health center or a lookalike, a school-based prevention program, a clinic operated by an accredited college of dentistry, or certain accredited dental hygiene program. In Fiscal Year 2018-2019, the Board of Dentistry issued 50 health access dental licenses.[7]

---

[1] Section 466.004, F.S.
[2] A passing score is valid for 365 days after the date the official examination results are published. A passing score on an examination obtained in another jurisdiction must be completed on or after October 1, 2011.
[3] Section 466.006(2), F.S.
[4] Section 466.006(3), F.S.
[5] Section 466.003(14), F.S.
[6] Chapter 2008-64, L.O.F., codified at s. 466.0067, F.S.
[7] 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 January 21, 2020).

With a health access dental license, a dentist who holds a valid, active license in good standing issued by another state, the District of Columbia, or a U.S. territory may practice in a health access setting in Florida if the dentist:[8]

- Submits proof of graduation from an accredited dental school;
- Submits documentation that the dentist has completed, or will obtain prior to licensure, continuing education equivalent to Florida's requirement for dentists for the last full reporting biennium;
- Submits proof of successful passage of parts I and II of the National Board of Dental Examiners and a state or regional clinical dental examination approved by the Board;
- Has never had a license revoked in another state, the District of Columbia, or a U.S. territory;
- Has never failed the Florida dental licensing examination, unless the dentist was reexamined and received a license to practice in Florida;
- Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the databank; and
- Submits proof that he or she has been actively engaged in the clinical practice of dentistry providing direct patient care for the five years immediately preceding application, or proof of continuous clinical practice providing direct patient care since graduation if the applicant graduated less than 5 years from his or her application.

Health access dental licenses must be renewed biennially[9]. A licensee must meet the same continuing education requirements as a Florida-licensed dentist.[10] Additionally, a licensee must continue to meet all the requirements for initial licensure.[11] DOH is authorized to establish application, examination, initial licensure, and licensure renewal fees for health access dental licenses.[12]

The Board may revoke a health access dental license if the licensee is terminated from employment at the health access setting, practices outside of the health access setting, fails the Florida dental examination, or is found to have violated the Dental Practice Act, other than a minor violation or a citation offense.[13]

Sections 466.067 through 466.00673, F.S., established the authority for Board to issue health access dental licenses. Section 466.00673, F.S., repeals the statutory authority for the health access dental license on January 1, 2020, if not reenacted by the Legislature. The authority the Board to issue such licenses was automatically repealed as the Legislature failed to reenact that authority by January 1, 2020.[14] Section 466.00673, F.S., also provides that any health access dental license that was issued before January 1, 2020, remains valid;[15] however, this provision authorizing the continued validity of the license was also repealed on that date.

The Board no longer has legal authority to issue or renew initial health access dental licenses. However, the Board is processing license renewals through February 28, 2020, without legal authority.[16]

---

[8] Section 466.0067, F.S.
[9] Section 466.00671, F.S.
[10] Id.
[11] Id.
[12] Sections 466.0067(2) and 466.0067(1)(c), F.S.
[13] Section 466.00672, F.S.
[14] Section 466.00673, F.S.
[15] Id.
[16] Department of Health, Florida Board of Dentistry, *Health Access Dentist*, available at https://floridasdentistry.gov/renewals/health-access-dentist/ (last visited January 21, 2020).

Effect of Proposed Changes

HB 1461 revives and reenacts the statutory authority for health access dental licenses and repeals the obsolete language setting the January 1, 2020, sunset of health access dental licenses. This gives DOH and the Board of Dentistry the statutory authority to resume issuing and renewing such licenses. The bill also revives and reenacts the Board of Dentistry's authority to establish application, examination, initial license, and license renewal fees retroactively to January 1, 2020, allowing the program to continue as if it had not expired on January 1, 2020.

The bill makes other technical, non-substantive changes.

The bill provides an effective date of upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 466.0067, F.S., relating to application for health access dental license.
Section 2: Amends s. 466.00671, F.S., relating to renewal of the health access dental license.
Section 3: Amends s. 466.00672, F.S., relating to revocation of health access dental licenses.
Section 4: Provides an effective date of upon becoming law.

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:

Individuals who have limited access to dental services may be able to receive dental care from those holding a health access dental license.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board of Dentistry has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Health Quality Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment made the reenactment of the health access dental licenses retroactive to January 1, 2020, and changed the effective date of the bill to upon becoming law.

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

1 A bill to be entitled
2 An act relating to health access dental licenses;
3 reviving, reenacting, and amending s. 466.0067, F.S.,
4 relating to the application for a health access dental
5 license; reviving, reenacting, and amending s.
6 466.00671, F.S., relating to the renewal of such a
7 license; reviving and reenacting s. 466.00672, F.S.,
8 relating to the revocation of such a license;
9 providing for retroactive application; providing an
10 effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Notwithstanding the January 1, 2020, repeal of
15 section 466.0067, Florida Statutes, that section is revived,
16 reenacted, and amended, to read:
17 466.0067 Application for health access dental license.—The
18 Legislature finds that there is an important state interest in
19 attracting dentists to practice in underserved health access
20 settings in this state and further, that allowing out-of-state
21 dentists who meet certain criteria to practice in health access
22 settings without the supervision of a dentist licensed in this
23 state is substantially related to achieving this important state
24 interest. Therefore, notwithstanding the requirements of s.
25 466.006, the board shall grant a health access dental license to

26 practice dentistry in this state in health access settings as
27 defined in s. 466.003 to an applicant who ~~that~~:
28 (1) Files an appropriate application approved by the
29 board;
30 (2) Pays an application license fee for a health access
31 dental license, laws-and-rule exam fee, and an initial licensure
32 fee. The fees specified in this subsection may not differ from
33 an applicant seeking licensure pursuant to s. 466.006;
34 (3) Has not been convicted of or pled nolo contendere to,
35 regardless of adjudication, any felony or misdemeanor related to
36 the practice of a health care profession;
37 (4) Submits proof of graduation from a dental school
38 accredited by the Commission on Dental Accreditation of the
39 American Dental Association or its successor agency;
40 (5) Submits documentation that she or he has completed, or
41 will obtain before ~~prior to~~ licensure, continuing education
42 equivalent to this state's requirement for dentists licensed
43 under s. 466.006 for the last full reporting biennium before
44 applying for a health access dental license;
45 (6) Submits proof of her or his successful completion of
46 parts I and II of the dental examination by the National Board
47 of Dental Examiners and a state or regional clinical dental
48 licensing examination that the board has determined effectively
49 measures the applicant's ability to practice safely;
50 (7) Currently holds a valid, active~~,~~ dental license in

51 good standing which has not been revoked, suspended, restricted,
52 or otherwise disciplined from another of the United States, the
53 District of Columbia, or a United States territory;
54 (8) Has never had a license revoked from another of the
55 United States, the District of Columbia, or a United States
56 territory;
57 (9) Has never failed the examination specified in s.
58 466.006, unless the applicant was reexamined pursuant to s.
59 466.006 and received a license to practice dentistry in this
60 state;
61 (10) Has not been reported to the National Practitioner
62 Data Bank, unless the applicant successfully appealed to have
63 his or her name removed from the data bank;
64 (11) Submits proof that he or she has been engaged in the
65 active, clinical practice of dentistry providing direct patient
66 care for 5 years immediately preceding the date of application,
67 or in instances when the applicant has graduated from an
68 accredited dental school within the preceding 5 years, submits
69 proof of continuous clinical practice providing direct patient
70 care since graduation; and
71 (12) Has passed an examination covering the laws and rules
72 of the practice of dentistry in this state as described in s.
73 466.006(4)(a).
74 Section 2. Notwithstanding the January 1, 2020, repeal of
75 section 466.00671, Florida Statutes, that section is revived,

76 reenacted, and amended to read:
77 466.00671 Renewal of the health access dental license.—
78 (1) A health access dental licensee shall apply for
79 renewal each biennium. At the time of renewal, the licensee
80 shall sign a statement that she or he has complied with all
81 continuing education requirements of an active dentist licensee.
82 The board shall renew a health access dental license for an
83 applicant who ~~that~~:
84 (a) Submits documentation, as approved by the board, from
85 the employer in the health access setting that the licensee has
86 at all times pertinent remained an employee;
87 (b) Has not been convicted of or pled nolo contendere to,
88 regardless of adjudication, any felony or misdemeanor related to
89 the practice of a health care profession;
90 (c) Has paid a renewal fee set by the board. The fee
91 specified herein may not differ from the renewal fee adopted by
92 the board pursuant to s. 466.013. The department may provide
93 payment for these fees through the dentist's salary, benefits,
94 or other department funds;
95 (d) Has not failed the examination specified in s. 466.006
96 since initially receiving a health access dental license or
97 since the last renewal; and
98 (e) Has not been reported to the National Practitioner
99 Data Bank, unless the applicant successfully appealed to have
100 his or her name removed from the data bank.

101 (2) The board may undertake measures to independently
102 verify the health access dental licensee's ongoing employment
103 status in the health access setting.
104 Section 3. Notwithstanding the January 1, 2020, repeal of
105 section 466.00672, Florida Statutes, that section is revived and
106 reenacted to read:
107 466.00672 Revocation of health access dental license.—
108 (1) The board shall revoke a health access dental license
109 upon:
110 (a) The licensee's termination from employment from a
111 qualifying health access setting;
112 (b) Final agency action determining that the licensee has
113 violated any provision of s. 466.027 or s. 466.028, other than
114 infractions constituting citation offenses or minor violations;
115 or
116 (c) Failure of the Florida dental licensure examination.
117 (2) Failure of an individual licensed pursuant to s.
118 466.0067 to limit the practice of dentistry to health access
119 settings as defined in s. 466.003 constitutes the unlicensed
120 practice of dentistry.
121 Section 4. The amendments and reenactments made by this
122 act to ss. 466.0067, 466.00671, and 466.00672, Florida Statutes,
123 are remedial in nature and apply retroactively to January 1,
124 2020.
125 Section 5. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7021 PCB HMR 20-01 Recovery Care Center Fees
SPONSOR(S): Health Market Reform Subcommittee, McClure
TIED BILLS: HB 827 **IDEN./SIM. BILLS:**

REFERENCE	**ACTION**	**ANALYST**	**STAFF DIRECTOR** or **BUDGET/POLICY CHIEF**
Orig. Comm.: Health Market Reform Subcommittee	14 Y, 0 N	Guzzo	Calamas
1) Health Care Appropriations Subcommittee	10 Y, 0 N	Nobles	Clark
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

HB 827 creates a new licensure category for a Recovery Care Center (RCC) to be regulated by the Agency for Health Care Administration (AHCA). HB 827 defines a RCC as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

HB 7021, which is linked to HB 827, authorizes AHCA to set license fees for RCCs. Applicants for licensure as a RCC will be subject to a Plans and Construction project review fee of $2,000 plus $100 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.

The bill becomes effective on the same date as HB 827 or similar legislation.

This bill appears to authorize 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 "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 Care Facility Licensure Fees

The Division of Health Quality Assurance, housed within the Agency for Health Care Administration (AHCA), licenses, certifies, and regulates 40 different types of health care facilities.[5] Section 408.805, F.S., requires AHCA to set license fees that are reasonably calculated to cover the cost of regulation.

HB 827 – Recovery Care Services

HB 827 creates a new licensure category for a Recovery Care Center (RCC), defined as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

---

[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] Agency for Health Care Administration, *Health Quality Assurance,* 2020, available at http://ahca.myflorida.com/MCHQ/ (last visited January 2, 2020).

Effect of the Bill

HB 7021, which is linked to HB 827, authorizes AHCA to set license fees for RCCs. Applicants for licensure as a RCC will be subject to the current Plans and Construction project review fee of $2,000 plus $100 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.

The bill becomes effective on the same date as HB 827 or similar legislation.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.003, F.S., relating to licensure; denial, suspension and revocation.
Section 2: Amends s. 408.802, F.S., relating to applicability.
Section 3: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Applicants for licensure as a RCC will be subject to the current Plans and Construction project review fee of $2,000 plus $100 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.

2. Expenditures:

   HB 827 requires AHCA to regulate RCCs in accordance with Chapters 395 and 408, F.S., and any rules adopted by the agency. The fees associated with the license are anticipated to cover the expense incurred by AHCA in enforcing and regulating the new license.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Entities licensed as RCCs will be subject to license fees set by AHCA.

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to recovery care center fees; amending
3 s. 395.003, F.S.; providing for licensure of recovery
4 care centers by the Agency for Health Care
5 Administration; amending s. 408.802, F.S.; adding
6 recovery care centers to the entities licensed,
7 registered, or certified by the agency; providing a
8 contingent effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Paragraphs (a) and (b) of subsection (1) of
13 section 395.003, Florida Statutes, are amended to read:
14 395.003 Licensure; denial, suspension, and revocation.—
15 (1)(a) The requirements of part II of chapter 408 apply to
16 the provision of services that require licensure pursuant to ss.
17 395.001-395.1065 and part II of chapter 408 and to entities
18 licensed by or applying for such licensure from the Agency for
19 Health Care Administration pursuant to ss. 395.001-395.1065. A
20 license issued by the agency is required in order to operate a
21 hospital, recovery care center, or ambulatory surgical center in
22 this state.
23 (b)1. It is unlawful for a person to use or advertise to
24 the public, in any way or by any medium whatsoever, any facility
25 as a "hospital," "recovery care center," or "ambulatory surgical

26 center" unless such facility has first secured a license under
27 this part.
28 2. This part does not apply to veterinary hospitals or to
29 commercial business establishments using the word "hospital<u>,</u>"
30 <u>"recovery care center,"</u> or "ambulatory surgical center" as a
31 part of a trade name if no treatment of human beings is
32 performed on the premises of such establishments.
33 Section 2. Subsection (27) is added to section 408.802,
34 Florida Statutes, to read:
35 408.802 Applicability.—The provisions of this part apply
36 to the provision of services that require licensure as defined
37 in this part and to the following entities licensed, registered,
38 or certified by the agency, as described in chapters 112, 383,
39 390, 394, 395, 400, 429, 440, 483, and 765:
40 <u>(27) Recovery care centers, as provided under part I of</u>
41 <u>chapter 395.</u>
42 Section 3. This act shall take effect on the same date
43 that HB 827 or similar legislation takes effect, if such
44 legislation is adopted in the same legislative session or an
45 extension thereof and becomes a law.