Health Care Appropriations Subcommittee

Tuesday, January 28, 2020
12:00 pm – 3:00 pm
Sumner Hall (404 HOB)

MEETING PACKET

Jose R. Oliva
Speaker

MaryLynn Magar
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time: Tuesday, January 28, 2020 12:00 pm

End Date and Time: Tuesday, January 28, 2020 03:00 pm

Location: Sumner Hall (404 HOB)

Duration: 3.00 hrs

Consideration of the following proposed committee bill(s):

PCB HCA 20-01 -- Health Care

Consideration of the following bill(s):

CS/HB 577 Coordinated Specialty Care Programs by Children, Families & Seniors Subcommittee, Stevenson
CS/HB 713 Department of Health by Health Quality Subcommittee, Rodriguez, A. M.
HB 743 Nonopioid Alternatives by Plakon
HB 827 Recovery Care Services by Stevenson
HB 959 Medical Billing by Duggan
HB 1147 Patient Access to Records by Payne
HB 6059 Specialty Hospitals by Fitzenhagen
HB 7021 Recovery Care Center Fees by Health Market Reform Subcommittee, McClure

Chair's Budget Proposal for FY 2020-2021

NOTICE FINALIZED on 01/24/2020 4:10PM by SPB

The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Jose Oliva
Speaker

MaryLynn Magar
Chair

AGENDA
Tuesday, January 28, 2020
12:00 PM – 3:00 PM
Sumner Hall (404 HOB)

I. **Call to Order/Roll Call**

II. **Opening Remarks by Chair Magar**

III. **Consideration of the following proposed committee bill(s):**

PCB HCA 20-01 -- Health Care

Consideration of the following bill(s):

CS/HB 577 Coordinated Specialty Care Programs by Children, Families & Seniors Subcommittee, Stevenson
CS/HB 713 Department of Health by Health Quality Subcommittee, Rodriguez, A. M.
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HB 6059 Specialty Hospitals by Fitzenhagen
HB 7021 Recovery Care Center Fees by Health Market Reform Subcommittee, McClure

IV. **Chair's Budget Proposal for FY 2020-2021**

V. **Closing Remarks/Adjournment**

221 The Capitol, 402 South Monroe Street, Tallahassee, FL 32399-1300
(850) 717-4810

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 20-01 Health Care
SPONSOR(S): Health Care Appropriations Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Care Appropriations Subcommittee		Nobles JRN	Clark

SUMMARY ANALYSIS

The bill conforms statutes to the funding decisions related to Health Care included in the House proposed General Appropriations Act (GAA) for Fiscal Year 2020-2021. The bill:

- Terminates the Welfare Transition Trust Fund and provides for the disposition of balances in and revenues of the trust fund and payment of debts and obligations of the terminated trust fund;
- Continues the personal needs allowance of residents of Veterans Nursing Homes at $130 per month;
- Reduces the Medicaid nursing home lease bond alternative collection threshold from $25 million to $10 million;
- Requires nursing homes and home offices to report audited financial information to the Agency for Health Care's uniform reporting system;
- Defines Florida Nursing Home Uniform Reporting System (FNHURS) and home office;
- Continues the policy of retroactive Medicaid eligibility for non-pregnant adults to the first day of the month in which an application for Medicaid is submitted;
- Amends statute to continue to hold the County Health Departments' reimbursement to the level established on July 1, 2011;
- Amends statute to include the Low Income Pool (LIP) program to conform to the other program's due dates that rely on Intergovernmental Transfers (IGTs) for funding. Requires that Letters of Agreement for LIP be received by the Agency for Health Care Administration (AHCA) by October 1 and the funds outlined in the Letters of Agreement be received by October 31;
- Amends the years of audited data to be used to determine disproportionate share payments to hospitals, teaching hospitals, and specialty hospitals for children;
- Requires the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI providers who achieve a Medical Loss Ratio below 85 percent. These refunds shall be deposited into the General Revenue Fund, unallocated;
- Administratively assigns the Correctional Medical Authority (CMA) to the Department of Health;
- Transfers powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the CMA in the Executive Office of the Governor to the Department of Health;
- Provides for technical corrections to statutory cross references in Managed Care Plan Accountability and Appropriations to First Accredited Medical Schools due to the change in the number of definitions listed in s. 408.07, F.S.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Welfare Transition Trust Fund

The Welfare Transition Trust Fund was created within the Department of Health (DOH) for the purpose of receiving federal block grant funds under the Temporary Assistance for Needy Families Program.[1]

Trust fund dollars are to be used exclusively for the purpose of providing services to individuals eligible for Temporary Assistance for Needy Families pursuant to the requirements and limitations of part A of Title IV of the Social Security Act, as amended, or any other applicable federal requirement or limitation.[2]

Funds credited to the trust fund consist of those funds collected from the Temporary Assistance for Needy Families Block Grant.[3]

The Department of Health no longer provides services related to the Temporary Assistance for Needy Families Block Grant.

Veterans Nursing Homes

Once an individual requiring an institutional level of care has established Medicaid eligibility, some of his or her income is used to pay for Medicaid services. For individuals residing in an institution, most of their incomes are applied to the cost of that care, with the exception of a small personal needs allowance used to pay for personal needs that are not covered by Medicaid. A personal needs allowance is the amount of income a resident may retain for personal expenditures not covered by the nursing home such as toiletries and haircuts.

Section 296.37, F.S., requires every resident of a state veteran domiciliary or nursing home who receives a pension, compensation, or gratuity from the United States Government or income from any other source of more than $130 per month to contribute to his or her maintenance and support while residing in a home, pursuant to a schedule of payment determined by the home administrator and department director that shall not exceed the actual cost of operating and maintaining the home. Chapter 2017-157, Laws of Florida, amended s. 296.37, F.S., to increase the personal needs allowance to $105 per month from $35 per month. For the past two fiscal years the General Appropriations Act implementing legislation increased the personal needs allowance to $130 per month.[4] This prior legislation expires July 1, 2020.

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a federal and state partnership established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children

[1] s. 20.435(8)(a), F.S.
[2] *Id.*
[3] *Id.*
[4] Ch. 2018-10 and Ch. 2016-116, Laws of Florida.

and Families, the Department of Health (DOH), the Agency for Persons with Disabilities (APD), and the Department of Elderly Affairs (DOEA).

The Florida Medicaid program covers approximately 3.8 million low-income individuals, including approximately 2.2 million, or 57.1%, of the children in Florida.[5] Medicaid is the second largest single program in the state, behind public education, representing 31.3 percent of the total FY 2019-20 budget.

Nursing Home Lease Bond Alternative

All nursing home facilities currently leasing the property where nursing facility services are provided are required to submit a Surety Bond annually. As an alternative, a nonrefundable fee may be presented to the AHCA in the amount equal to 1 percent of 3 months of Medicaid payments to the facility based on the preceding 12-month average Medicaid payments to the facility as calculated by the AHCA. These funds are held in a trust fund as a Medicaid nursing home overpayment account. These fees are used at the sole discretion of the AHCA to repay nursing home Medicaid overpayments should a facility be unable to pay the liability but does not release the licensee from any liability for any Medicaid overpayments. Each year, the AHCA will assess the fund after all overpayments have been repaid and, if the balance after all other amounts have been subtracted is greater than $25 million, collections of the fee will be suspended for the subsequent fiscal year.

Nursing Home Uniform Reporting System

Currently, nursing homes, continuing care facilities, and state run hospitals are exempt from the requirement to submit their actual financial experience for the fiscal year to the AHCA. All other health care facilities are mandated to do so. In addition, hospitals must submit their actual audited financial experience and submit the information in the Florida Hospital Uniform Reporting System (FHURS). The FHURS is a database designed by the AHCA expressly for the reporting of the hospitals' audited actual financial experience. The hospitals have had this requirement since 1992 and it has been an aid to the AHCA to make management decisions and the Legislature to make policy and budgetary decisions. The hospital financial information has been used to determine revenues for the Public Medical Assistance Trust Fund, hospital assessments, review certificates of need, licensure condition compliance, for research, to prepare hospital financial data reports, and to respond to media and legislative requests.

Medicaid Retroactive Eligibility

The Social Security Act provides the requirements under which state Medicaid programs must operate. Federal law directs state Medicaid programs to cover, and provides federal matching funds for, medical bills up to three months prior to a recipient's application date.[6] The federal Medicaid statute requires that Medicaid coverage for most eligibility groups include retroactive coverage for a period of 90 days prior to the date of the application for medical assistance, however, this requirement can be waived pursuant to federal regulations.

An initial analysis by the AHCA indicated that approximately 39,000 non-pregnant adults were made retroactively eligible under the 90-day requirement of federal regulations in State Fiscal Year 2015-2016.[7] A more recent AHCA analysis indicates that 11,466 distinct individuals were granted such retroactive eligibility and utilized services during their retroactive period during State Fiscal Year 2017-

[5] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, November 2019, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed January 9, 2020).

[6] 42 U.S.C. s. 1396a.

[7] See Agency for Health Care Administration, Florida's 1115 Managed Medical Assistance (MMA) Prepaid Dental Health Program (PDHP), Low Income Pool (LIP), and Retroactive Eligibility Amendment Request (March 28, 2018), Power Point presentation, available at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/MMA_PDHP_LIP-Retro_Elig_amendment_presentation_032818.pdf (last visited January 9, 2020).

2018.[8] In compliance with the federal requirement for 90 days of retroactive eligibility, the Florida Medicaid State Plan previously provided that "[c]overage is available beginning the first day of the third month before the date of application if individuals who are aged, blind or disabled, or who are AFDC-related,[9] would have been eligible at any time during that month, had they applied." These provisions had been applicable to the Florida Medicaid State Plan since at least October 1, 1991.[10]

In 2018, the Florida Legislature, via the General Appropriations Act (GAA)[11] and the Implementing Bill accompanying the GAA[12], approved a measure to direct the AHCA to seek a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to eliminate the 90-day retroactive eligibility period for non-pregnant adults aged 21 and older. For these adults, eligibility would become retroactively effective on the first day of the month in which their Medicaid application was filed, instead of the first day of the third month prior to the date of application.

The waiver request that included the retroactive eligibility item was submitted to federal CMS by AHCA on April 27, 2018, and was approved by federal CMS on November 30, 2018 to be effective February 1, 2019. The waiver included the stipulation that waiver authority ends on June 30, 2019 and that AHCA must timely submit a letter to CMS by May 17, 2019 if legislative approval is granted to continue the waiver past June 30, 2019.[13] Legislative approval was granted in section 30 of the 2019 General Appropriations Act Implementing Bill[14] and the letter was sent timely to CMS on May 17, 2019.

County Health Departments

Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, L.O.F., amended s. 409.908(23), F.S., to provide that Nursing Home Medicaid reimbursement would no longer be held to a rate freeze, but rather be based upon a prospective payment system. This change left only the county health departments subject to the rate freeze.

Low Income Pool

The terms and conditions of Florida's Medicaid reform 1115 waiver created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured. The current LIP pool is authorized for $1.5 billion and has federal approval to operate through the 2021-2022 fiscal year.

The LIP is funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. The local taxing authorities commit to sending these funds to the state in the form of an executed Letter of Agreement with the AHCA. In order for AHCA to make timely payments to hospitals, AHCA must know which local governments will be submitting IGTs and the

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[8] Agency for Health Care Administration, Senate Bill 192 Analysis (February 27, 2019) (on file with Senate Committee on Health Policy).

[9] Aid to Families with Dependent Children (AFDC) was a federal assistance program in effect from 1935 to 1996 created by the Social Security Act and administered by the United States Department of Health and Human Services that provided financial assistance to children whose families had low or no income.

[10] See Florida Medicaid State Plan, page 373 of 431, available at https://ahca.myflorida.com/medicaid/stateplanpdf/Florida_Medicaid_State_Plan_Part_I.pdf (last visited January 9, 2020).

[11] See Specific Appropriation 199 of the General Appropriations Act for Fiscal Year 2018-2019, Chapter 2018-9, Laws of Florida, available at http://laws.flrules.org/2018/9 (last visited January 10, 2020).

[12] See section 20 of the Implementing bill for Fiscal Year 2018-2019, Chapter 2018-10, Laws of Florida, available at http://laws.flrules.org/2018/10 (last visited January 10, 2020).

[13] See the November 30, 2018, CMS letter and waiver approval document, including waiver Special Terms and Conditions, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-ca.pdf (last visited January 9, 2020).

[14] See section 30 of the Implementing bill for Fiscal Year 2019-2020, Chapter 2019-116, Laws of Florida, available at http://laws.flrules.org/2019/116 (last visited January 10, 2020).

amount of the funds prior to using the funds to draw the federal match. Current law requires local governments who participate in IGT-funded programs, to submit to AHCA the final executed letter of agreement containing the total amount of the IGTs authorized by the entity, no later than October 1 of each year. Additionally, the local governments are required to transfer the actual IGT funds to AHCA by October 31. There is currently no requirement for local governments to comply with these date requirements for the participation in the LIP program.

Disproportionate Share Hospital Program

The Medicaid Disproportionate Share Hospital (DSH) Program funding distributions are provided to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. Each year, the Legislature delineates how the funds will be distributed to each eligible facility either through statutory formulas or other direction in the implementing bill or proviso.

Florida Healthy Kids Corporation

The Florida Healthy Kids Corporation was created in 1990 by the Florida Legislature as a public-private effort to improve access to health insurance for the state's uninsured children. The program came about as a result of an article published in the March 31, 1988, New England Journal of Medicine by Steve A. Freedman, Ph.D., F.A.A.P., then-Director of the Institute for Child Health Policy at the University of Florida.

Since its beginning, Healthy Kids has covered millions of children in Florida. Identified as one of three state programs that was grandfathered into the original Children's Health Insurance Program (CHIP) legislation in 1997. Healthy Kids was joined with two other existing state health care programs for children (Medicaid and Children's Medical Services) and a new program (Medikids) to create Florida's KidCare program in 1998.[15]

In s. 624.91, F.S., Florida Healthy Kids Corporation is mandated to purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care to uninsured and underinsured children through contracts with health care providers. These contracted health care providers are mandated to maintain a minimum medical loss ratio (MLR) of 85 percent and maximum administrative costs of 15 percent.

Correctional Medical Authority

The State of Florida Correctional Medical Authority (CMA) was created in 1986.[16] The CMA is housed within the Executive Office of the Governor (EOG) for administrative purposes but is not subject to the control or supervision by the EOG or the Department of Corrections.[17]

According to section 945.603, F.S.:

> The purpose of the CMA is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions.[18]

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[15] Florida Healthy Kids Corporation History, 2019, retrieved from https://www.healthykids.org/healthykids/history/ (last visited January 9, 2020).
[16] Ch. 86-183, Laws of Florida.
[17] s. 945.602, F.S.
[18] s. 945.603, F.S.

Pursuant to this section the CMA has the authority to:

1. Review and advise the Secretary of Corrections on cost containment measures the Department of Corrections could implement.
2. Review and make recommendations regarding health care for the delivery of health care services including, but not limited to, acute hospital-based services and facilities, primary and tertiary care services, ancillary and clinical services, dental services, mental health services, intake and screening services, medical transportation services, and the use of nurse practitioner and physician assistant personnel to act as physician extenders as these relate to inmates in the Department of Corrections.
3. Develop and recommend to the Governor and the Legislature an annual budget for all or part of the operation of the State of Florida prison health care system.
4. Review and advise the Secretary of Corrections on contracts between the Department of Corrections and third parties for quality management programs.
5. Review and advise the Secretary of Corrections on minimum standards needed to ensure that an adequate physical and mental health care delivery system is maintained by the Department of Corrections.
6. Review and advise the Secretary of Corrections on the sufficiency, adequacy, and effectiveness of the Department of Corrections' Office of Health Services' quality management program.
7. Review and advise the Secretary of Corrections on the projected medical needs of the inmate population and the types of programs and resources required to meet such needs.
8. Review and advise the Secretary of Corrections on the adequacy of preservice, inservice, and continuing medical education programs for all health care personnel and, if necessary, recommend changes to such programs within the Department of Corrections.
9. Identify and recommend to the Secretary of Corrections the professional incentives required to attract and retain qualified professional health care staff within the prison health care system.
10. Coordinate the development of prospective payment arrangements as described in s. 408.50 when appropriate for the acquisition of inmate health care services.
11. Review the Department of Corrections' health services plan and advise the Secretary of Corrections on its implementation.
12. Sue and be sued in its own name and plead and be impleaded.
13. Make and execute agreements of lease, contracts, deeds, mortgages, notes, and other instruments necessary or convenient in the exercise of its powers and functions under this act.
14. Employ or contract with health care providers, medical personnel, management consultants, consulting engineers, architects, surveyors, attorneys, accountants, financial experts, and such other employees, entities, or agents as may be necessary in its judgment to carry out the mandates of the Correctional Medical Authority and fix their compensation.
15. Recommend to the Legislature such performance and financial audits of the Office of Health Services in the Department of Corrections as the authority considers advisable.

The governing board of the CMA is composed of seven persons appointed by the Governor subject to confirmation by the Senate. Members of the CMA are not compensated for the performance of their duties but are paid expenses incurred while engaged in the performance of such duties pursuant to s. 112.061, F.S.[19]

Prior to July 1, 2012, the CMA was administratively housed within the Department of Health (DOH). During the 2012 Regular Legislative Session, Senate Bill 1958 was passed and subsequently signed into law by the Governor. The bill transferred the CMA from the DOH to the EOG.[20]

[19] *Supra* note 2.
[20] Ch. 2012-122, Laws of Florida.

Effect of Proposed Changes

Welfare Transition Trust Fund

The bill repeals Subsection (8) of Section 20.435, F.S., related to the creation of the Welfare Transition Trust Fund.

The bill terminates the Welfare Transition Trust Fund within the Department of Health and provides for the balance, and all revenues, to be transferred to the Federal Grants Trust Fund.

The bill directs the Department of Health to pay any outstanding debts and obligations of the Welfare Transition Trust Fund as soon as practicable, and the Chief Financial Officer to close out and remove the Welfare Transition Trust Fund from the various state accounting systems.

Veterans Nursing Homes

The bill permanently sets the personal needs allowance at $130 per month to reflect Medicaid funding in the General Appropriations Act for the 2020-2021 Fiscal Year.

Nursing Home Lease Bond Alternative

The bill amends s. 400.179(d), F.S., to decrease the collection threshold for the nursing home lease bond alternative from $25 million to $10 million.

Nursing Home Uniform Reporting System

The bill requires nursing homes and their respective home offices to submit annually audited financial information to the agency in a uniform reporting system. Nursing homes will now have the same requirements as all other health care facilities, with the exception of continuing care facilities and state run hospitals.

Medicaid Retroactive Eligibility

The bill amends s. 409.904, F.S., to continue the policy begun in the 2018-2019 fiscal year by providing payments for Medicaid eligible services for eligible non-pregnant adults retroactive to the first day of the month in which an application for Medicaid is submitted. Eligible children and pregnant women will continue to have retroactive Medicaid eligibility for a period of no more than 90 days before the month in which an application for Medicaid is submitted.

County Health Departments

The bill amends s. 409.908(23), F.S., to reenact the language in Section 19 of the 2019 General Appropriations Act Implementing Bill, Ch. 2019-116, L.O.F., that is applicable to the reimbursement of county health departments, thereby keeping the county health departments subject to the rate freeze.

Low Income Pool

The bill amends s. 409.908(26), F.S., to include the Low Income Pool program among the other programs that rely on IGTs to be provided to AHCA. Local governments, on behalf of providers participating in the LIP program, will be required to submit a final, executed Letter of Agreement to AHCA no later than October 1, which will delineate the amount of funds the local government will submit. Additionally, the funds pledged in the Letter of Agreement on behalf of a provider participating

in the LIP program, must be transferred to AHCA no later than October 31, unless an alternative plan is approved by AHCA.

Disproportionate Share Hospital Program

The bill amends ss. 409.911, 409.9113, and 409.9119, F.S., to update existing law to provide payments for the 2020-2021 fiscal year related to hospitals in the Medicaid Disproportionate Share Hospital (DSH) Program based upon the average of the 2012, 2013, and 2014 audited disproportionate share data to determine each hospital's Medicaid days and charity care.

Florida Healthy Kids Corporation

The bill amends s. 624.91, F.S., to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI authorized insurers and providers of health care services who achieve a MLR below 85 percent. These refunds shall be deposited into the General Revenue Fund, unallocated.

Correctional Medical Authority

The bill reassigns, for administrative purposes, the State of Florida Correctional Medical Authority from the Executive Office of the Governor to the Department of Health. All powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the CMA in the Executive Office of the Governor are transferred to the Department of Health.

This bill provides for an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Terminates the Welfare Transition Trust Fund within the Department of Health and provides for the disposition of balances in and revenues of the trust fund and payment of debts and obligations of the terminated fund.
Section 2: Repeals s. 20.435(8), F.S., relating to the Welfare Transition Trust Fund.
Section 3: Amends s. 296.37(1), F.S., relating to personal needs allowances for residents of Veterans Nursing Homes.
Section 4: Amends s. 400.179, F.S., relating to nursing home lease bonds.
Section 5: Amends s. 408.061, F.S., relating to reporting audited financial information.
Section 6: Amends s. 408.07, F.S., relating to definitions for Health Care Administration.
Section 7: Amends s. 409.904, F.S., relating to Medicaid Eligibility.
Section 8: Amends s. 409.908(23), F.S., relating to provider reimbursement.
Section 9: Amends s. 409.908(26), F.S., relating to Low Income Pool.
Section 10: Amends s. 409.911, F.S., relating to Disproportionate Share Program for hospitals.
Section 11: Amends s. 409.9113(3), F.S., relating to Disproportionate Share Program for teaching hospitals.
Section 12: Amends s. 409.9119(4), F.S., relating to Disproportionate Share Program for specialty hospitals for children.
Section 13: Amends s. 624.91, F.S., relating to Florida Healthy Kids Corporation.
Section 14: Amends s. 945.602, F.S., transferring the CMA from the EOG to the DOH for administrative purposes.
Section 15: Transfers all powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the CMA from the EOG to the DOH.
Section 16: Amends s. 409.975(a), F.S., relating to Managed Care Plan Accountability.
Section 17: Amends s 1011.52(2), F.S, relating to appropriations to first accredited medical schools.
Section 18: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

With the collection threshold for the Lease Bond Alternative decreasing from $25 million to $10 million, revenues would decrease due to the new, lower threshold for halting collections. The fund would also keep a lower balance, leading to a decrease in interest earned. The current balance of the fund is $14.67 million.

In order for providers to earn matching federal dollars for LIP, local governments and other local political subdivisions will be required to provide to AHCA an executed letter of agreement by October 1 of each fiscal year and the transfer of all funds as pledged in the LIP IGT agreement letter, no later than October 31 of each fiscal year, unless an alternative plan is approved by AHCA.

2. Expenditures:

In Fiscal Year 2018-2019, $3.99 million in refunds were collected due to the Medicaid plans not achieving the 85% MLR. In future periods, the refunds will be transferred to the General Revenue Fund, unallocated. It is unknown if the refunds will continue at the same level as the prior year, or whether adjusted premiums, increased services, or other approaches will mitigate the refund amounts.

Medicaid Retroactive Eligibility began in FY 2018-2019 under the 2018 GAA Implementing Bill. The 2018 GAA included a recurring savings due to the implementation of Medicaid Retroactive Eligibility. AHCA estimates that the Legislature will need to appropriate an additional $103.6 million if this policy is not continued.

The House proposed General Appropriations Act for Fiscal Year 2020-2021 transfers six FTE and $748,674 in recurring General Revenue from the Executive Office of the Governor to the Department of Health to cover operating costs for the Correctional Medical Authority.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

In order to earn matching federal dollars for LIP, local governments and other local political subdivisions would be required to provide all funds pledged in LIP IGT agreements, no later than October 31, 2020.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

With the decrease in the threshold from $25 million to $10 million to halt collection of the lease bond alternative, the private sector nursing homes may pay less in lease bond alternative fees.

Residents in a veterans nursing home will retain $130 per month as a personal needs allowance.

D. FISCAL COMMENTS:

The Welfare Transition Trust Fund cash balance at the beginning of Fiscal Year 2015-2016 was $0.00. There have been no receipts nor has the trust fund carried a balance since that time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

Correctional Medical Authority: Rule-making authority is transferred to the DOH from the EOG.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care; terminating the Welfare Transition Trust Fund created within the Department of Health; providing for the disposition of balances in and revenues of the trust fund; requiring the department to pay any outstanding debts and obligations and requiring the Chief Financial Officer to close out and remove the terminated fund from state accounting systems; amending s. 20.435, F.S.; removing provisions relating to the Welfare Transition Trust Fund to conform to changes made by the act; amending s. 296.37, F.S.; revising the threshold dollar amount relating to a requirement that a resident of a certain health care facility contribute to his or her maintenance and support; amending s. 400.179, F.S.; decreasing the net cumulative threshold amount of specified fees collected by the Agency for Health Care Administration from certain nursing homes to maintain lease bonds; amending s. 408.061, F.S.; requiring nursing homes and their home offices to annually submit to the agency audited financial data and certain other information within a specified timeframe using a certain uniform system of financial reporting; amending s. 408.07, F.S.; providing definitions; amending s. 409.904, F.S.; revising dates relating to

a requirement that the agency make payments for Medicaid-covered services retroactive for a specified period for certain eligible persons; abrogating the future expiration of certain provisions; reenacting s. 409.908(23), F.S., relating to a requirement that the agency establish Medicaid reimbursement rates for specified services; amending s. 409.908, F.S.; authorizing the agency to receive funds from certain entities to make Low Income Pool Program payments; amending s. 409.911, F.S.; revising dates relating to certain data used by the agency to calculate the disproportionate share payment for hospitals; amending s. 409.9113, F.S.; revising dates relating to certain data used by the agency to calculate the disproportionate share payment for teaching hospitals; abrogating the future expiration of certain provisions; amending s. 409.9119, F.S.; revising dates relating to certain data used by the agency to calculate the disproportionate share payment for specialty hospitals for children; abrogating the future expiration of certain provisions; amending s. 624.91, F.S.; requiring an insurer or any provider of health care services under a Florida Healthy Kids Corporation contract to refund an amount to be deposited into a specified fund under certain

conditions; amending s. 945.602, F.S.; conforming provisions to changes made by the act; providing for a type two transfer of the State of Florida Correctional Medical Authority to the Department of Health; amending ss. 409.975 and 1011.52, F.S.; conforming cross-references; providing an effective date.

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

Section 1. (1) The Welfare Transition Trust Fund within the Department of Health, FLAIR number 64-2-401, is terminated.

(2) All current balances remaining in, and all revenues of, the trust fund, shall be transferred to the Federal Grants Trust Fund, FLAIR number 64-2-261.

(3) The Department of Health shall pay any outstanding debts and obligations of the terminated fund as soon as practicable, and the Chief Financial Officer shall close out and remove the terminated fund from the various state accounting systems using generally accepted accounting principles concerning warrants outstanding, assets, and liabilities.

Section 2. Subsection (8) of section 20.435, Florida Statutes, is amended to read:

20.435 Department of Health; trust funds.—The following trust funds shall be administered by the Department of Health:

~~(8) Welfare Transition Trust Fund.~~

~~(a) The Welfare Transition Trust Fund is created within the Department of Health for the purposes of receiving federal funds under the Temporary Assistance for Needy Families Program. Trust fund moneys shall be used exclusively for the purpose of providing services to individuals eligible for Temporary Assistance for Needy Families pursuant to the requirements and limitations of part A of Title IV of the Social Security Act, as amended, or any other applicable federal requirement or limitation. Funds credited to the trust fund consist of those funds collected from the Temporary Assistance for Needy Families Block Grant.~~

~~(b) Notwithstanding the provisions of s. 216.301 and pursuant to s. 216.351, any balance in the trust fund at the end of any fiscal year shall remain in the trust fund at the end of the year and shall be available for carrying out the purposes of the trust fund.~~

Section 3. Subsection (1) of section 296.37, Florida Statutes, is amended to read:

296.37 Residents; contribution to support.—

(1) Every resident of the home who receives a pension, compensation, or gratuity from the United States Government, or income from any other source of more than $130 ~~$105~~ per month, shall contribute to his or her maintenance and support while a resident of the home in accordance with a schedule of payment determined by the administrator and approved by the director.

The total amount of such contributions shall be to the fullest extent possible but shall not exceed the actual cost of operating and maintaining the home.

Section 4. Upon the expiration and reversion of the amendment made to section 400.179, Florida Statutes, pursuant to section 29 of chapter 2019-116, Laws of Florida, paragraph (d) of subsection (2) of section 400.179, Florida Statutes, is amended to read:

400.179 Liability for Medicaid underpayments and overpayments.—

(2) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of

subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid annually thereafter, in the amount of 1 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Grants and Donations Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments or for enhanced payments to nursing facilities as specified in the General Appropriations Act or other law. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application. The financial

viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits. By March 31 of each year, the agency shall assess the cumulative fees collected under this subparagraph, minus any amounts used to repay nursing home Medicaid overpayments and amounts transferred to contribute to the General Revenue Fund pursuant to s. 215.20. If the net cumulative collections, minus amounts utilized to repay nursing home Medicaid overpayments, exceed $10 ~~$25~~ million, the provisions of this subparagraph shall not apply for the subsequent fiscal year.

3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency

annually.

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, revoke, and suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium pursuant to part II of chapter 408, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

Section 5. Subsections (5) through (13) of section 408.061, Florida Statutes, are renumbered as subsections (7) through (15), respectively, subsection (4) is amended, and new subsections (5) and (6) are added to that section, to read:

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

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, and hospitals operated by state agencies~~, and nursing homes~~ as those

terms are defined in s. 408.07, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

(5) Within 120 days after the end of its fiscal year, each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the chief financial officer of the nursing home. However, the nursing home's actual financial experience shall be its audited actual financial experience, as audited by an independent certified

professional accountant. This audited actual experience shall include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and shall be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The nursing home shall provide all necessary records for the independent certified professional accountant to form an opinion and complete an accurate audit report. The independent certified professional accountant's opinion and audit report shall accompany the financial statements submitted to the agency. The audited financial statements shall tie to the information submitted in the uniform system of financial reporting and a crosswalk shall be submitted along with the audited financial statements.

(6) Within 120 days after the end of its fiscal year, the home office of each nursing home as defined in s. 408.07 shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the chief financial officer of the nursing home. However, the home office's actual financial experience shall be its audited actual financial experience, as audited by an independent certified professional accountant.

This audited actual experience shall include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and shall be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The home office shall provide all necessary records for the independent certified professional accountant to form an opinion and complete an accurate audit report. The independent certified professional accountant's opinion and audit report shall accompany the financial statements submitted to the agency. The audited financial statements shall tie to the information submitted in the uniform system of financial reporting and a crosswalk shall be submitted along with the audited financial statements.

Section 6. Subsections (19) through (27) of section 408.07, Florida Statutes, are renumbered as subsections (20) through (28), respectively, and subsections (28) through (44) are renumbered as subsections (30) through (46), and new subsections (19) and (29) are added to that section, to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(19) "FNHURS" means the Florida Nursing Home Uniform Reporting System developed by the agency.

(29) "Home office" has the same meaning as provided in the Provider Reimbursement Manual, Part 1 (Centers for Medicare and Medicaid Services, Pub. 15-1), as that definition exists on the

effective date of this act.

Section 7. Subsection (12) of section 409.904, Florida Statutes, is amended to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(12) Effective July 1, 2020 ~~July 1, 2019~~, the agency shall make payments for ~~to~~ Medicaid-covered services:

(a) For eligible children and pregnant women, retroactive for a period of no more than 90 days before the month in which an application for Medicaid is submitted.

(b) For eligible nonpregnant adults, retroactive to the first day of the month in which an application for Medicaid is submitted.

~~This subsection expires July 1, 2020.~~

Section 8. Notwithstanding the expiration date in section 19 of chapter 2019-116, Laws of Florida, subsection (23) of section 409.908, Florida Statutes, is reenacted to read:

409.908 Reimbursement of Medicaid providers.—Subject to

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

provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(23)(a) The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for county health departments effective July 1, 2011. Reimbursement rates shall be as provided in the General Appropriations Act.

(b)1. Base rate reimbursement for inpatient services under a diagnosis-related group payment methodology shall be provided in the General Appropriations Act.

2. Base rate reimbursement for outpatient services under an enhanced ambulatory payment group methodology shall be provided in the General Appropriations Act.

3. Prospective payment system reimbursement for nursing home services shall be as provided in subsection (2) and in the General Appropriations Act.

Section 9. Upon the expiration and reversion of the amendment made to section 409.908, Florida Statutes, pursuant to section 21 of chapter 2019-116, Laws of Florida, subsection (26) of section 409.908, Florida Statutes, is amended to read:

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

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

(26) The agency may receive funds from state entities, including, but not limited to, the Department of Health, local

governments, and other local political subdivisions, for the purpose of making special exception payments and Low Income Pool Program payments, including federal matching funds. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency.

Section 10. Paragraph (a) of subsection (2) of section

409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the 2012, 2013, and 2014 ~~2011, 2012, and 2013~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2020-2021 ~~2019-2020~~ state fiscal year.

Section 11. Subsection (3) of section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under s. 409.911, the agency shall make disproportionate share payments to teaching hospitals, as defined in s. 408.07, for their increased

costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments must conform to federal requirements and distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. The agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals, as defined in s. 395.805, pursuant to this section. The funds provided for statutorily defined teaching hospitals shall be distributed as provided in the General Appropriations Act. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

(3) Notwithstanding any provision of this section to the contrary, for the 2020-2021 ~~2019-2020~~ state fiscal year, the agency shall make disproportionate share payments to teaching hospitals, as defined in s. 408.07, as provided in the 2020-2021 ~~2019-2020~~ General Appropriations Act. ~~This subsection expires July 1, 2020.~~

Section 12. Subsection (4) of section 409.9119, Florida Statutes, is amended to read:

409.9119 Disproportionate share program for specialty

hospitals for children.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall develop and implement a system under which disproportionate share payments are made to those hospitals that are separately licensed by the state as specialty hospitals for children, have a federal Centers for Medicare and Medicaid Services certification number in the 3300-3399 range, have Medicaid days that exceed 55 percent of their total days and Medicare days that are less than 5 percent of their total days, and were licensed on January 1, 2013, as specialty hospitals for children. This system of payments must conform to federal requirements and must distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals that serve a disproportionate share of low-income patients. The agency may make disproportionate share payments to specialty hospitals for children as provided for in the General Appropriations Act.

(4) Notwithstanding any provision of this section to the contrary, for the 2020-2021 ~~2019-2020~~ state fiscal year, for hospitals achieving full compliance under subsection (3), the agency shall make disproportionate share payments to specialty hospitals for children as provided in the 2020-2021 ~~2019-2020~~ General Appropriations Act. ~~This subsection expires July 1,~~

~~2020.~~

Section 13. Upon the expiration and reversion of the amendment made to section 624.91, Florida Statutes, pursuant to section 31 of chapter 2019-116, Laws of Florida, paragraph (b) of subsection (5) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of Florida Kidcare program premiums for children who are not eligible for medical assistance under Title XIX or Title XXI of the Social Security Act.

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional Florida Kidcare coverage in contributing counties under Title XXI.

4. Establish the administrative and accounting procedures

for the operation of the corporation.

5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as provided in subsection (3).

7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

9. Establish enrollment criteria that include penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the

corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. <u>For an insurer or any provider of health care services that achieves an annual medical loss ratio below 85 percent, the Florida Healthy Kids Corporation shall validate the medical loss ratio and calculate an amount to be refunded by the insurer or any provider of health care services to the state which shall be deposited into the General Revenue Fund unallocated.</u> The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

12. Develop and implement a plan to publicize the Florida Kidcare program, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

13. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

14. In consultation with the partner agencies, provide a report on the Florida Kidcare program annually to the Governor, the Chief Financial Officer, the Commissioner of Education, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives.

15. Provide information on a quarterly basis to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the Florida Kidcare program. The information, at a minimum, must include:

a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and

b. The costs and utilization by service of the full-pay enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

16. Establish benefit packages that conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.821.

Section 14. Subsection (1) of section 945.602, Florida Statutes, is amended to read:

945.602 State of Florida Correctional Medical Authority; creation; members.—

(1) There is created the State of Florida Correctional Medical Authority, which for administrative purposes shall be assigned to the Department of Health ~~Executive Office of the Governor~~. The governing board of the authority shall be composed of seven persons appointed by the Governor subject to confirmation by the Senate. One member must be a member of the Florida Hospital Association, and one member must be a member of the Florida Medical Association. The authority shall contract with the Department of Health ~~Executive Office of the Governor~~ for the provision of administrative support services, including purchasing, personnel, general services, and budgetary matters. The authority is not subject to control, supervision, or direction by the Department of Health ~~Executive Office of the Governor~~ or the Department of Corrections. The authority shall annually elect one member to serve as chair. Members shall be

appointed for terms of 4 years each. Each member may continue to serve upon the expiration of his or her term until a successor is duly appointed as provided in this section. Before entering upon his or her duties, each member of the authority shall take and subscribe to the oath or affirmation required by the State Constitution.

Section 15. All powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, existing contracts, administrative authority, and administrative rules relating to the State of Florida Correctional Medical Authority in the Executive Office of the Governor are transferred by a type two transfer, as defined in s. 20.06(2), Florida Statutes, to the Department of Health.

Section 16. Paragraph (a) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on

credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(46) ~~s. 408.07(44)~~.

3. Hospitals that are trauma centers as defined in s. 395.4001(15).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

Section 17. Paragraph (e) of subsection (2) of section

1011.52, Florida Statutes, is amended to read:

1011.52 Appropriation to first accredited medical school.—

(2) In order for a medical school to qualify under this section and to be entitled to the benefits herein, such medical school:

(e) Must have in place an operating agreement with a government-owned hospital that is located in the same county as the medical school and that is a statutory teaching hospital as defined in s. 408.07(46) ~~s. 408.07(44)~~. The operating agreement must provide for the medical school to maintain the same level of affiliation with the hospital, including the level of services to indigent and charity care patients served by the hospital, which was in place in the prior fiscal year. Each year, documentation demonstrating that an operating agreement is in effect shall be submitted jointly to the Department of Education by the hospital and the medical school prior to the payment of moneys from the annual appropriation.

Section 18. This act shall take effect July 1, 2020.

Amendment No. 1

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

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Magar offered the following:

Amendment (with title amendment)

Remove line 399 and insert:

an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, providers determined by the agency to be essential providers pursuant to section 409.975(1)(a), and essential providers under section 409.975(1)(b)2. and 4. must contract with each managed care plan in its region. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers pursuant to section

409.975(1)(b)1. and 3. must contract with each managed care plan in the state.

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

Remove line 34 and insert:
entities to make Low Income Pool Program payments; requiring certain providers to contract with Medicaid managed care plans as a condition of receiving certain funding;

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Magar offered the following:

Amendment (with title amendment)

Between lines 476 and 477, insert:

Section 1. Subsection (5) is added to section 409.966, Florida Statutes, to read:

409.966 Eligible plans; selection.—

(5) Before executing a contract for a plan to operate in a specific region, the Secretary shall certify to the Governor, the President of the Senate, and the Speaker of the House of Representatives, that the plan has sufficiently documented its capability of providing quality services to Medicaid enrollees consistent with agency's requirements. The Secretary shall further certify that the agency's plan selection decisions and

automatic assignment procedures will not systematically prevent the plan from achieving the minimum enrollment level identified in the plan's pro forma financial statement as necessary for sustainable operations. This certification does not guarantee assignment of enrollees to any plan that fails to meet quality standards.

Section 2. Subsection (1) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another

except when temporarily necessary to enable a new plan in a region to attain a sustainable enrollment level and accommodate the certification by the agency under subsection 409.966(5).

Section 3. Subsection (1) of section 409.984, Florida Statutes, is amended to read:

409.984 Enrollment in a long-term care managed care plan.—

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another except when temporarily necessary to enable a new plan in a region to attain a sustainable

enrollment level and accommodate the certification by the agency under subsection 409.966(5).

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

Remove line 47 and insert:

s. 409.966, F.S.; requiring the secretary of the Agency for Health Care Administration to make certain certifications regarding prospective Medicaid managed care plans; amending s. 409.977, F.S.; authorizing certain temporary enrollment assignment actions in the managed medical assistance program; amending s. 409.984, F.S.; authorizing certain temporary enrollment assignment actions in the managed long term care program; amending s. 624.91, F.S.; requiring an insurer or any provider of

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

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

SUMMARY ANALYSIS

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

The bill:

- Defines CSC programs in this state;
- Allows the three-year implementation or expansion grant under the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program to support CSC programs;
- Establishes CSC programs as an essential element of a coordinated system of care;
- Requires the Department of Children and Families (DCF) to conduct an assessment of the availability of and access to CSC programs in the state, which must be included in DCF's annual assessment of behavioral health services in the state; and
- Requires CSC programs to submit de-identified data to the Department of Children and Families (DCF) on marijuana usage by individuals served by these programs.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

First-Episode Psychosis

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

Psychosis affects people from all walks of life. Approximately three out of 100 people will experience psychosis at some time in their lives, often beginning when a person is in their late teens to mid-twenties.[3] Researchers are still learning about how and why psychosis develops, but it is generally thought to be triggered by a combination of genetic predisposition and life stressors during critical stages of brain development.[4] As such, adolescents are at a greater risk of developing psychosis when facing life stressors such as physical illness, substance use, or psychological or physical trauma.[5]

Early psychosis, known as "first-episode psychosis," is the most important time to connect an individual with treatment.[6] Studies have shown that it is common for a person to experience psychotic symptoms for more than a year before ever receiving treatment.[7] Reducing the duration of untreated psychosis is critical to improving a person's chance of recovery. The most effective treatment for early psychosis is coordinated specialty care, which uses a team-based approach with shared decision-making that focuses on working with individuals to reach their recovery goals.[8] Programs that provide coordinated specialty care are often called first-episode psychosis programs. Key components of CSC programs include:[9]

- **Case Management** – Working with the individual to develop problem-solving skills, manage medication and coordinate services.
- **Family Support and Education** – Giving families information and skills to support their loved one's treatment and recovery.
- **Psychotherapy** – Using cognitive behavioral therapy to learn to focus on resiliency, managing the condition, promoting wellness, and developing coping skills.
- **Medication Management** – Finding the best medication at the lowest possible dose.
- **Supported Education and Employment** – Providing support to continue or return to school or work.
- **Peer Support** – Connecting the person with others who have been through similar experiences.

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[1] National Institute of Mental Health, *Fact Sheet: First Episode Psychosis*, https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml (last visited Dec. 23, 2019).
[2] Id.
[3] Id.
[4] National Alliance on Mental Illness, *What is Early and First-Episode Psychosis?*, July 2016, https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/What-is-Early-and-First-Episode-Psychosis.pdf (last visited Dec. 23, 2019).
[5] Id.
[6] Id.
[7] *Supra* note 1.
[8] Id.; *Supra* note 4.
[9] Id.

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

Several studies have linked marijuana use to increased risk for psychiatric disorders, including psychosis, depression, anxiety, and substance use disorders, but whether and to what extent it causes these conditions is not easy to determine.[13] Marijuana use has been shown to be a predictor of schizophrenia.[14]

Currently, there are seven Coordinated Specialty Care programs in Florida, located in Bay, Broward, Clay, Hillsborough, Miami Dade, Orange, and Palm Beach Counties.[15]

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

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[16]

A county, non-profit community provider or managing entity designated by a county planning council or committee may apply for a one-year planning grant or a three-year implementation expansion grant under the Program.[17] The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance abuse disorders, or co-occurring mental health and substance abuse disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.[18] Currently, there are 24 grant agreements for county programs.[19] Total funding for the 24 grant agreements over their lifetimes is $28,174,388.[20]

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[10] National Institute of Mental Health, *Recovery After an Initial Schizophrenia Episode (RAISE),* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml (last visited Dec. 27, 2019).
[11] National Institute of Mental Health, *RAISE Questions and Answers,* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml (last visited Dec. 27, 2019).
[12] Id.
[13] National Institutes on Drug Abuse, *Is there a link between marijuana use and psychiatric disorders?,* https://www.drugabuse.gov/publications/research-reports/marijuana/there-link-between-marijuana-use-psychiatric-disorders (last visited Jan. 16, 2020).
[14] Presentation to the Health and Human Services Committee by Bertha K. Madras, PhD, Professor of Psychobiology, Harvard Medical School, https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2997&Session=2020&DocumentType=Meeting%20Packets&FileName=hhs%2010-15-19.pdf (Oct. 15, 2019).
[15] Email from John Paul Fiore, Legislative Specialist, Florida Department of Children and Families, RE: Info. Request, (Dec. 27, 2019).
[16] S. 394.656(1), F.S.
[17] S. 394.656(5), F.S.
[18] Id.
[19] *Florida Substance Abuse and Mental Health Plan – Triennial State and Regional Master Plan Fiscal Years 2019-2022,* Florida Department of Children and Families, p. 28, (May 2019), https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202019-2022.pdf (last visited Dec. 27, 2019).
[20] Id. at 71-72.

Behavioral Health Services Annual Assessment

DCF is required to submit an assessment of the behavioral health services in Florida to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1 of each year. The report must include a compilation of all plans submitted by managing entities and DCF's evaluation of each plan.[21] At a minimum, the assessment must consider the functionality of no-wrong-door models within designated receiving systems, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, the use of evidence-informed practices, and the needs assessments conducted by managing entities.[22]

Coordinated System of Care

Managing Entities[23] are required to promote the development and implementation of a coordinated system of care.[24] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[25] A community or region provides a coordinated system of care for those suffering from mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[26] Managing entities must submit detailed plans to enhance services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[27] DCF must use performance-based contracts to award grants.[28]

There are several essential elements which make up a coordinated system of care, including:[29]

- Community interventions, such as prevention, primary care for behavioral health needs, therapeutic and supportive services, crisis response services, and diversion programs;
- A designated receiving system that consists of one or more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and involuntary, and treatment or triage of patients who have a mental health or substance use disorder, or co-occurring disorders;
- A transportation plan developed and implemented by each county in collaboration with the managing entity and in accordance with s. 394.462, F.S.;
- Crisis services, including mobile response teams, crisis stabilization units, addiction receiving facilities, and detoxification facilities;
- Case management, defined as direct services to clients for assessing needs; planning; arranging services; coordinating service providers; linking the service system to a client; monitoring service delivery; and evaluating patient outcomes to ensure the client is receiving the appropriate services;
- Care coordination, defined as the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage;
- Outpatient services;
- Residential services;
- Hospital inpatient care;

[21] S. 394.4573, F.S.
[22] Id.
[23] S. 394.9082(2)(e), F.S., defines a "managing entity" as a corporation selected by and under contract with DCF to manage the daily operational delivery of behavioral health services through a coordinated system of care.
[24] S. 394.9082(5)(d), F.S.
[25] S. 394.4573(1)(c), F.S.
[26] S. 394.4573(3), F.S. As of Jan. 2, 2020, the Legislature has not funded system improvement grants.
[27] Id.
[28] Id.
[29] S. 394.4573(2), F.S.

- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support, such as supportive housing, supported employment, family support and education, independent living skill development, wellness management, and self-care.

Managing entities are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub region.[30] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[31]

Effect of the Bill

The bill defines CSC programs as evidence-based programs that use intensive case management, individual or group therapy, supported employment, family education and supports, and appropriate psychotropic medication to treat individuals 15 to 30 years of age who are experiencing early indications of serious mental illness, especially symptoms of a first psychotic episode.

The bill establishes CSC programs as an essential element of a coordinated system of care and requires DCF to conduct an assessment of the availability of and access to CSC programs in the state, including any gaps in availability or access that may exist. This assessment must be included in DCF's annual report to the Governor and Legislature on the assessment of behavioral health services in the state.

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

The bill requires CSC programs to submit de-identified data to DCF regarding current and historical marijuana use by individuals served by these programs for inclusion in the behavioral health services assessment.

The bill makes technical and conforming changes.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.67, F.S., relating to definitions.
Section 3: Amends s. 394.658, F.S., relating to Criminal Justice, Mental health, and Substance Abuse Reinvestment Grant Program requirements.
Section 4: Amends s. 394.4573, F.S., relating to coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.
Section 5: Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of a child; physical, mental, or substance abuse examination of person with or requesting child custody.
Section 6: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 7: Amends s. 394.496, F.S., relating to service planning.
Section 8: Amends s. 394.674, F.S., relating to eligibility for publicly funded substance abuse and mental health services; fee collection requirements.
Section 9: Amends s. 394.74, F.S., relating to contracts for provision of local substance abuse and mental health programs.
Section 10: Amends s. 394.9085, F.S., relating to behavioral provider liability.

[30] S. 394.9082(5)(b), F.S.
[31] S. 394.75(3), F.S.

Section 11: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 12: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 13: Amends s. 744.2007, F.S., relating to powers and duties.
Section 14: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

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

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

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

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

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

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

The bill was reported favorably as a committee substitute.

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

A bill to be entitled

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

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

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

to that section to read:

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

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

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

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

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

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

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

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

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

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

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

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

1. Mental health courts;

2. Diversion programs;

3. Alternative prosecution and sentencing programs;

4. Crisis intervention teams;

5. Treatment accountability services;

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

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

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

9. Coordinated specialty care programs.

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

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

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

(1) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

a. A central receiving system that consists of a

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

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

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

An accurate inventory of the participating service providers

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

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

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

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

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

(g) Outpatient services.

(h) Residential services.

(i) Hospital inpatient care.

(j) Aftercare and other postdischarge services.

(k) Medication-assisted treatment and medication management.

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

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

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

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

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

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

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

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

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

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

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

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

(3) Assessments must be performed by:

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

(b) A professional licensed under chapter 491; or

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

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

394.496 Service planning.—

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

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

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

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

(a) For adult mental health services:

1. Adults who have severe and persistent mental illness,

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

a. Older adults in crisis.

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

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

d. Other persons involved in the criminal justice system.

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

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

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

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

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

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

health condition, or any other factor;

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

394.9085 Behavioral provider liability.—

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

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

409.972 Mandatory and voluntary enrollment.—

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

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

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

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

(4) In addition to the general functions specified in

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

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

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

744.2007 Powers and duties.—

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

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 713 Department of Health
SPONSOR(S): Health Quality Subcommittee, Rodriguez, A. M.
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 230

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

SUMMARY ANALYSIS

CS/HB 713 makes numerous changes to programs under the Department of Health (DOH) and health care professions regulated by Medical Quality Assurance within DOH. The bill:

- Authorizes DOH to establish patient care networks to plan for the care of individuals with the human immunodeficiency virus (HIV), rather than only those diagnosed with acquired immune deficiency syndrome (AIDS);
- Authorizes DOH to adopt rules to implement the Conrad 30 Waiver program;
- Revises DOH's rulemaking authority relating to the minimum standards for ground ambulances;
- Revises DOH's authority to regulate radiation machines;
- Authorizes DOH to request a date of birth on a licensure application;
- Authorizes DOH to issue a temporary license that expires 60 days after issuance, rather than 30 days, to certain applicants who have not yet been issued a social security number;
- Repeals a requirement that DOH discipline a healthcare practitioner's license for failing to repay a student loan;
- Authorizes DOH to issue medical faculty certificates to certain full-time faculty members of Nova Southeastern University and Lake Erie College of Osteopathic Medicine;
- Repeals a requirement that the Board of Medicine triennially review board certification organizations for dermatology;
- Revises the requirements for osteopathic internships and residencies to include those accredited by the Accreditation Council for Graduate Medical Education ;
- Repeals a requirement that a Florida-licensed dentist grade the dental licensure examination and that a Florida-licensed dentist or dental hygienist grade the dental hygienist licensure examination;
- Requires dentists and dental hygienists to report adverse incidents to the Board of Dentistry;
- Requires DOH to biennially inspect dental laboratories;
- Repeals the voluntary registration of registered chiropractic assistants;
- Authorizes DOH to issue a single registration to a prosthetist-orthotist;
- Requires an athletic trainer to work within his or her scope of practice and revises licensure requirements;
- Limits massage therapy apprenticeships to those in colonic irrigations, and requires licensure applicants to pass a national licensure examination designated by the Board of Massage Therapy;
- Revises psychology licensure requirements;
- Authorizes the Board of Clinical Social Work, Marriage and Family Therapists, and Mental Health Counseling to approve a one-time exception to the 60-month limit on an internship registration;
- Revises the licensure requirements for Marriage and Family Therapists and Licensed Mental Health Counselors;
- Extends the sunset date for Florida Center for Nursing annual reports on nursing education to January 30, 2025;
- Revives and reenacts health access dental licenses; and
- Deletes obsolete language and makes technical and conforming changes.

The bill has an insignificant, positive fiscal impact and an insignificant, negative fiscal impact on the DOH, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

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

The bill appears to implicate Article VII, s. 19 of the Florida Constitution. See Section III.A.2. of the analysis.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

HIV/AIDS

Human Immunodeficiency Virus (HIV) is an immune system debilitating virus that can lead to fatal acquired immunodeficiency syndrome (AIDS). HIV affects specific cells of the immune system and over time the virus can destroy enough of these cells that the body can no longer fight off infection and disease.[1] HIV is transmitted by sexual contact, sharing needles to inject drugs, and by a mother to her baby during pregnancy, birth, or breastfeeding.[2] There is no cure for HIV but it can be controlled with proper medical care, including antiretroviral therapy (ART). If taken properly, ART can dramatically prolong the lives of people infected with HIV, keep them healthy, and greatly lower the chance of infecting others.[3] However, untreated HIV is almost always fatal.[4]

There are three stages of HIV through which an infected person may typically progress:[5]

- Stage 1: Acute HIV infection. Within two to four weeks after infection with HIV, an individual may experience a flu-like illness.
- Stage 2: Clinical latency. HIV is still active but reproduces at a very low level. Those who are taking ART may remain at this stage for several decades.
- Stage 3: AIDS. This is the most severe phase of HIV infection. Opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS. Without treatment, a person with AIDS typically survives about three years.

AIDS and HIV in Florida

The Department of Health (DOH) has identified the reduction in the transmission of HIV as one of its priority goals. It has adopted a comprehensive plan to prevent HIV transmission and strengthen patient care activities to reduce the risk of further transmission of HIV from those diagnosed and living with HIV. The plan includes:[6]

- Implementing routine HIV and sexually transmitted infections (STIs) screening in health care settings and priority testing in non-health care settings;
- Providing rapid access to treatment and ensuring retention in care;
- Improving and promoting access to antiretroviral pre-exposure prophylaxis and non-occupational post-exposure prophylaxis; and
- Increasing HIV awareness and community response through outreach, engagement, and messaging.

There has been an overall decrease in the number of newly diagnosed cases of HIV infection in the last 10 years. However, in the last five years, the number of newly diagnosed cases has increased.

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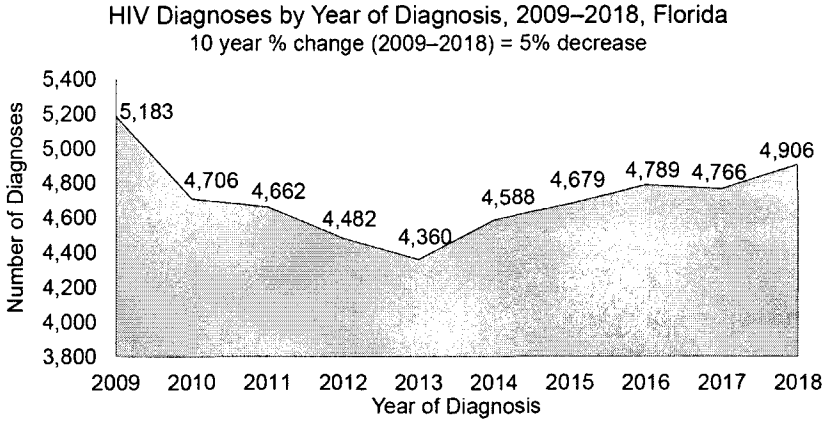
[1] Centers for Disease Control and Prevention, *About HIV/AIDS*, (last rev. Aug. 14, 2019), available at: https://www.cdc.gov/hiv/basics/whatishiv.html (last visited November 22, 2019).
[2] Id.
[3] Id.
[4] Id.
[5] Id.
[6] Department of Health, *HIV/AIDS*, available at http://www.floridahealth.gov/diseases-and-conditions/aids/ (last visited December 6, 2019).



Approximately, 1,918 individuals in Florida have AIDS.[7] This number has steadily declined in the last 20 years, with 4,646 AIDS cases in the state in 1999.[8] With advances in the treatment of HIV with ART, the number of individuals living with HIV has increased. In 2018, there were 119,661 individuals living with HIV in this state.[9] In the U.S., approximately 15 percent of individuals who have HIV are unaware that they are infected.[10] DOH estimated in 2017, that more than 18,000 Floridians were unaware of their HIV infection.[11]

Patient Care Networks

Current law authorizes DOH to establish patient care networks for individuals with AIDS in those areas of the state where the number of cases of AIDS and other HIV infections justifies the establishment of such networks.[12] The patient care networks must plan for the care and treatment of individuals with AIDS and AIDS-related conditions in a cost-effective and dignified manner, which emphasizes outpatient and home care.[13] In establishing the networks, DOH must take into account the natural trade areas and centers of medical excellence in treating AIDS, as well as federal, state, and other funds. The patient care networks have been established in the following geographic areas:[14]

- South Florida, consisting of Dade and Monroe counties;
- Palm Beach County;
- East central Florida, consisting of Orange, Osceola, Seminole, and Brevard counties;
- West central Florida, consisting of Hillsborough, Polk, Pinellas, and Pasco counties; and
- Northeast Florida, consisting of Duval, St. Johns, Nassau, Baker, Clay, and Flagler counties.

Each network must annually make recommendations regarding patient care needs to DOH.[15]

Conrad 30 Waiver Program

Federal law requires a foreign physician pursuing graduate medical education or training in the United States to obtain a J-1 visa. A holder of a J-1 visa is ineligible to apply for an immigrant visa, permanent

[7] Department of Health, Florida Health Charts, *AIDS Cases*, available at http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0141 (last visited November 22, 2019).
[8] Id.
[9] Department of Health, Florida Health Charts, *Persons Living with HIV*, available at http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=9866 (last visited November 22, 2019).
[10] HIV.gov, *Ending the HIV Epidemic: HIV in America*, (last rev. June 27, 2019), available at https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/hiv-in-america (last visited November 22, 2019).
[11] Department of Health, *2017 Florida HIV Surveillance Summary*, (Nov. 2018), available at http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/HIV_Surveillance_Trifold.pdf (last visited November 22, 2019).
[12] Section 381.0042, F.S.
[13] Id.
[14] Rule 64D-2.001, F.A.C.
[15] *Supra* note 12.

residence, or certain nonimmigrant statuses unless he or she has resided and been physically present in his or her country of nationality for at least two years after completion of the J-1 visa program.[16] However, the Conrad 30 Waiver program allows such foreign physicians to apply for a waiver of the two-year residency requirement upon the completion of the J-1 visa program. To be eligible for a Conrad 30 Waiver, the foreign physician must:[17]

- Obtain a contract for full-time employment at a health care facility in an area dedicated as a Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population;
- Obtain a "no objection" letter from his or her home country if the home government funded his or her exchange program; and
- Agree to begin employment at the health care facility within 90 days of receipt of the waiver, no later than the date his or her J-1 visa expires.

A state may only sponsor 30 physicians for waivers per year and each state may develop its own application rules and guidelines. DOH does not currently have statutory authority to develop rules and guidelines for its Conrad 30 program.

Florida has sponsored 30 physicians each year for each of the last 10 years under the program.[18] More than 70 percent, or nearly 450 physicians, have remained in practice in Florida since the inception of the Conrad 30 Waiver Program.[19] Currently, Florida approves these waivers on a first-come basis.

Emergency Medical Transportation Services

The Legislature recognized the need for the uniform and systematic provision of emergency medical services to save lives and reduce disability associated with illness and injury.[20] In 1973, the Florida Legislature passed and enacted what is known today as the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act (Act).[21] The Act establishes the licensing and operational requirements for emergency medical services.

The Act creates the Emergency Medical Services Advisory Council (Council)[22] to act as an advisory body to the emergency medical services within DOH.[23] The Council's duties include, among other things:[24]

- Identifying and making recommendations to the DOH regarding the appropriateness of suggested changes to statutes and administrative rules;
- Acting as a clearinghouse for information specific to changes in the provision of medical services and trauma care;
- Providing technical support to the DOH in the areas of emergency medical services and trauma systems design, required medical and rescue equipment, required drugs and dosages, medical

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[16] Department of Homeland Security, U.S. Citizenship and Immigration Services, *Conrad 30 Waiver Program*, (last rev. May 5, 2014), available at https://www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program#Background (last visited November 22, 2019).

[17] Id.

[18] Presentation by Jennifer Johnson, Division Director, Division of Public Health Statistics and Performance Management, Department of Health, before the Health Quality Subcommittee on January 23, 2019, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting%20Packets&FileName=hqs%201-23-19.pdf (last visited November 22, 2019).

[19] Id.

[20] Section 401.211, F.S.

[21] Department of Health, *Emergency Medical Services System*, available at http://www.floridahealth.gov/licensing-and-regulation/ems-system/index.html (last visited December 11, 2019). The Act is codified at ss. 401.2101 – 401.465, F.S.

[22] Section 401.245(2), F.S. The Council consists of 15 members appointed by the State Surgeon General, except that state agency representatives are appointed by the respective agency heads. Members are typically appointed for four year terms, with the chair being designated by the State Surgeon General and Secretary of Health. Additional members include six ex officio representatives appointed by various other state agency heads.

[23] Section 401.245(1), F.S.

[24] *Id.*

treatment protocols and emergency medical services personnel education and training requirements;
- Providing a forum for discussing significant issues facing the emergency medical services and trauma care communities;
- Assisting the DOH in setting program priorities; and
- Providing feedback to the DOH on the administration and performance of the emergency medical services program.

Licensure

Current law requires providers of basic or advanced life support transportation services to be licensed by the DOH in their respective fields.[25] Basic life support (BLS) service refers to any emergency medical service that uses only basic life support techniques.[26] BLS includes basic non-invasive interventions to reduce morbidity and mortality associated with out-of-hospital medical and traumatic emergencies.[27] The services provided may include stabilization and maintenance of airway and breathing, pharmacological interventions, trauma care, and transportation to an appropriate medical facility.[28]

Advanced life support (ALS) service refers to any emergency medical or non-transport service that uses advanced life support techniques.[29] ALS includes the assessment or treatment of a person by a qualified individual, such as a paramedic, who is trained in the use of techniques such as the administration of drugs or intravenous fluid, endotracheal intubation, telemetry, cardiac monitoring, and cardiac defibrillation.[30]

To be licensed as a BLS or ALS service, an applicant must comply with the following requirements:

- The ambulances, equipment, vehicles, personnel, communications systems, staffing patterns, and services of the applicant meet the statutory requirement and administrative rules for either a BLS service or an ALS service, whichever is applicable;
- Have adequate insurance coverage or certificate of self-insurance for claims arising out of injury to or death of persons and damage to the property of others resulting from any cause for which the owner of such business or service would be liable; and
- A Certificate of Public Convenience and Necessity from each county in which the applicant will operate.[31]

DOH must establish rules for ground ambulance or vehicle design and construction that is at least equal to those recommended by the United States General Services Administration.[32] The federal guideline went into effect in 1974 and was for use by federal agencies and federal grant recipients purchasing ambulances.[33] This federal standard was to be discontinued in 2016, however, it was recently updated in July 2019.[34] Many states use the federal recommendations as there were no standards for ambulance design.[35] In recent years, however, at least two other organizations have created standards: the Commission on Accreditation of Ambulance Services and the National Fire Protection Association.[36]

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[25] Section 401.25(1), F.S.
[26] Section 401.23(8), F.S.
[27] Section 401.23(7), F.S., and U.S. Department of Transportation, National Highway Safety Administration, *National EMS Scope of Practice Model* 23-24, *available at* www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf (last visited December 11, 2019).
[28] *Id.*
[29] Section 401.23(2), F.S.
[30] Section 401.23(1), F.S.
[31] Section 401.25(2), F.S.
[32] Section 401.35, F.S.
[33] Richard Huff, NREMT-B, *Competing Ambulance Safety Standards Await State Adoption*, 40 J EMER. MED. SERV. (Jan. 26, 2015), available at https://www.jems.com/2015/01/26/competing-ambulance-safety-standards-await-state-adoption/ (last visited December 11, 2019).
[34] Id., and SafeAmbulances.org, Ground Ambulance Standards and EMS Safety Resource, *General Services Administration*, available at https://www.safeambulances.org/organizations/gsa/ (last visited December 11, 2019).
[35] Id.
[36] *Supra* note 33.

In addition to the general licensure requirement, DOH provides a list of the equipment and supplies with which each BLS vehicle must be equipped and maintained and the equipment and medication with which each ALS vehicle must be equipped and maintained by rule.[37] Current law requires the list of equipment and supplies established by DOH in rule, be at least as comprehensive as those listed in the most current edition of the American College of Surgeons, Committee on Trauma, list of essential equipment for ambulances.[38] The American College of Surgeons developed this list more than 40 years ago, and in 2000, it jointly produced a list of standardized ambulance equipment with the American College of Emergency Physicians. Since that time, the joint document has been updated and has included participation by the National Association of EMS Physicians, Federal Emergency Medical Services for Children Stakeholder Group, National Association of State EMS Officials, Emergency Nurses Association, and endorsed by the American Academy of Pediatrics.[39]

Radiation Machines

A radiation machine is a device designed to produce, or which produces, ionizing radiation or nuclear particles when such machine is operated.[40] An example of ionizing radiation is an x-ray.[41] DOH must inspect any hospital, health care facility, or other place in the state that has a radiation machine installed to determine if DOH-established measures are being met.[42] Such standards address:[43]

- Radiation machine performance, surveys, calibrations, and spot checks;
- Requirements for quality assurance programs and quality control programs;
- Standards for facility electrical systems, safety alarms, radiation-monitoring equipment, and dosimetry systems;
- Requirements for visual and aural communication with patients;
- Procedures for establishing radiation safety committees for a facility; and
- Qualifications of persons who cause a radiation machine to be used, who operate a radiation machine, and who ensure that a radiation machine complies with DOH requirements.

DOH is authorized to collect an annual fee for the registration and inspection of radiation machines. These fees are deposited to the Radiation Protection Trust Fund to cover the costs of salaries and expenses related to its radiation regulation responsibilities and must exclude costs associated with supervision and program administration.[44] Florida Statutes establishes the minimum and maximum annual fee and inspection frequency:[45]

Radiation Machine Use	**Inspection Frequency**	**Annual Fee for First Machine** (Min. Allowable – Max. Allowable)	**Annual Fee for Each Additional Machine** (Min. Allowable – Max. Allowable)
Practice of medicine, osteopathic medicine, chiropractic medicine, or naturopathic medicine	Every 2 years	$83 - $145	$36 - $85
Practice of veterinary medicine	Every 3 years	$28 - $50	$19 - $34

[37] Rule 64J-1.002(4) F.A.C. (Basic Life Support Service License – Ground); Rule 64J-1.003(7), F.A.C. (Advanced Life Support Service License – Ground).
[38] Section 401.35, F.S.
[39] American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, Emergency Medical Services for Children, Emergency Nurses Association, National Association of EMS Physicians & National Association of State EMS Officials, *Equipment for Ground Ambulances*, PREHOSPITAL EMERGENCY CARE, 18:1, 92-97, (Oct. 2013), available at https://www.tandfonline.com/doi/pdf/10.3109/10903127.2013.851312 (last visited December 11, 2019).
[40] Section 404.031, F.S.
[41] Centers for Disease Control and Prevention, *Radiation and Your Health*, (last rev. Dec. 7, 2015), available at https://www.cdc.gov/nceh/radiation/ionizing_radiation.html#whatis (last visited November 25, 2019).
[42] Section 404.22, F.S.
[43] Id. Rule 64E-5, F.A.C., specifies the radiation machine standards established by DOH.
[44] Section 404.22(5), F.S.
[45] Section 404.22(5)(b), F.S.

Educational or industrial Purposes	Every 3 years	$26 - $47	$12 - $23
Practice of dentistry or podiatric medicine	Every 4 to 5 years	$16 - $31	$5 - $11
Machines that accelerate particles and are used in the healing arts	Annually	$153 - $258	$87 - $148
Machines that accelerate particles and used for educational or industrial purposes	Every 2 years	$46 - $81	$26 - $48

If a radiation machine fails inspection, DOH may re-inspect the machine and charge a re-inspection fee in accordance with the fee schedule above.[46]

According to DOH, technological advances since the enactment of this inspection program has resulted in a variety of providers using radiation machines in a manner that was not originally contemplated.[47] For example, dentists and podiatric physicians now use machines that were previously used only by medical doctors.[48] Based on the current statutory requirements, these radiation machines used in the practice of dentistry or podiatric medicine may only be inspected every four to five years, rather than every two years, if they are operated by medical doctors.

Health Care Professional Licensure

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[49] MQA works in conjunction with 22 boards and 4 councils to license and regulate 7 types of health care facilities and more than 40 health care professions.[50] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for MQA.

General Licensure Requirements

There are general licensure provisions that apply to all licensure applications, regardless of profession. For example, all applicants for licensure must apply in writing on an application form approved by DOH or electronically on a web-based application form.[51] Additionally, an applicant must provide his or her social security number for identification purposes.[52] However, an applicant is not required to provide his or her date of birth as DOH is not currently authorized to collect this information.

[46] Id.
[47] Department of Health, *Agency Legislative Analysis of Proposed Legislation on Radiation Machines*, on file with the Health Quality Subcommittee.
[48] Id.
[49] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[50] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2018-2019*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf (last visited November 22, 2019).
[51] Section 456.013, F.S.
[52] Id.

If, at the time of application, an applicant has not been issued a social security number because he or she is not a U.S. citizen or resident, DOH may process the application using a unique personal identification number.[53] If the applicant is eligible for a license, the applicable board, or DOH when there is no board, may issue a temporary license to the applicant.[54] The temporary license is only valid for 30 days unless the applicant submits a social security number. On average, it takes about two weeks to receive a social security number once all required documentation is submitted to the U.S. Social Security Administration.[55] If the Social Security Administration is unable to immediately verify immigration documents with the U.S. Citizenship and Immigration Services, it may take an additional two weeks to issue the social security number.[56]

Health Care Licensure and Student Loans

Student loans are funds that are lent to students or parents to pay for higher education. Student loans may come from private sources, such as banks or other financial institutions, or from a state or the federal government.[57]

The Office of Student Financial Assistance (OSFA) within the Florida Department of Education (DOE) is responsible for administering state and federally funded programs and serves as the guarantor agency for certain federally-backed student loans.[58] The DOE is directed to exert every lawful and reasonable effort to collect all delinquent unpaid and uncanceled student loans.[59]

Increase in Defaults on Student Loans

An estimated 41.5 million Americans owe more than $1.2 trillion in outstanding federal loan debt. This is more than triple the $340 billion in student loan debt owed by Americans in 2001.[60] With this increase in student loan debt owed by Americans, there has been an increase in the number of people who are defaulting on or failing to pay their student loans. For most federal loans, default generally occurs when a payment has not been made for 270 days.[61] In 2018, 41,013 borrowers who attended Florida schools had defaulted on their federal student loans used to attend institutions ranging from universities to trade schools.[62]

Disciplining Professional Licenses for Defaulting on Student Loans

In the 1990s, as a result of a rising number of students defaulting on their federally-backed student loans, the federal government urged state legislators to send a message to students, post-secondary institutions, and lenders that high levels of default would not be tolerated. The federal government recommended that states take the following steps to curb student loan default:[63]

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[53] Id.
[54] Id.
[55] U.S. Social Security Administration, *Apply for your Social Security Number While Applying for Your Work Permit*, available at https://www.ssa.gov/ssnvisa/ebe.html (last visited November 25, 2019).
[56] Id.
[57] Consumer Financial Protection Bureau, *Student Loans: Choosing a loan that's right for you*, https://www.consumerfinance.gov/paying-for-college/choose-a-student-loan/#o1 (last visited Dec. 4, 2019).
[58] Office of Student Financial Assistance, *Mission Statement*, http://www.floridastudentfinancialaid.org/FFELP/mission_statement/mission_statement_052606.html (last visited on Nov. 26, 2019).
[59] S. 1009.95, F.S.
[60] Laura Feiveson, Alvaro Mezza, and Kamila Sommer, *Student Loan Debt and Aggregate Consumption Growth*, Board of Governors of the Federal Reserve System, (February 21, 2018), https://www.federalreserve.gov/econres/notes/feds-notes/student-loan-debt-and-aggregate-consumption-growth-20180221.htm (last visited on Nov. 26, 2019).
[61] United States Department of Education, Federal Student Aid, *Glossary, Default,* https://studentaid.ed.gov/sa/glossary#letter_d (last visited Nov. 26, 2019).
[62] Florida Business Daily, *41,013 borrowers in default on student loans after attending Florida schools,* May 17, 2018, https://flbusinessdaily.com/stories/511416784-41-013-borrowers-in-default-on-student-loans-after-attending-florida-schools (last visited Nov. 26, 2019).
[63] Mary Farrell, *Reducing Student Loan Defaults: A Plan for Action*, Department of Education at 63 (March 21, 1991) https://files.eric.ed.gov/fulltext/ED323879.pdf (last visited Nov. 26, 2019).

- Enact a state tax-refund offset program;
- Enact a wage garnishment program;
- Deny professional licenses to defaulters until they take steps towards repayment;
- Screen potential applicants for state jobs to prevent the hiring of loan defaulters who have not entered into repayment agreements; and
- Ensure that information available to state agencies such as the Department of Motor Vehicles, the tax department, and the unemployment commission is available to the state's guarantee agency.

As a result, many states, including Florida, began adopting various forms of disciplinary licensing laws for defaulting on government-backed student loans. By 2010, about half of the states had some form of disciplinary licensing laws for defaulting on government-backed student loans. Since then, based on shifting concerns, there has been a trend to reduce or eliminate such laws. Currently, approximately 15 states, including Florida, still have some form of such laws.[64]

Federal Attempts to Prohibit State Disciplinary Licensing Laws

Recently, there have been attempts at the national level to prohibit state disciplinary licensing laws for defaulting on government-backed student loans. Bills were introduced in the United States Congress in 2018 and 2019 that would prohibit states from disciplining or denying state-issued licenses for defaulting on government-backed student loans.[65]

DOH Disciplinary Laws

Section 456.072(1)(k), F.S., authorizes DOH to discipline a health care practitioner for failing to perform any statutory or legal obligation placed upon a health care practitioner, which specifically includes failing to repay a government-backed student loan or comply with a service scholarship obligation. If DOH finds that a health care practitioner has defaulted on his or her student loans or failed to comply with a service scholarship, at a minimum, DOH must:

- Suspend the practitioner's license until he or she agrees to new loan repayment terms or resumes the scholarship obligation;
- Place the practitioner on probation for the duration of the student loan or scholarship obligation period; and
- Impose a fine equal to 10 percent of the defaulted loan amount.

Every month, DOH must obtain a list from USHHS of Florida-licensed health care practitioners who have defaulted on government-backed student loans.[66] Upon learning that a health care practitioner has defaulted on such a student loan, DOH must notify the practitioner that he or she has 45 days to provide DOH with proof of a new repayment plan, or such practitioner will be subject to an emergency order suspending the practitioner's license. Also, DOH may proceed with additional disciplinary action against the practitioner, regardless if he or she provides proof of entering a new repayment plan.[67]

During the 2017-2018 Fiscal Year, DOH handled 247 cases against health care practitioners for defaulting on student loans, and during the 2018-2019 Fiscal Year, DOH handled 722 cases.[68]

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[64] Andrew Wagner, *Licensing Suspension for Student Loan Forgiveness*, NCSL (Oct. 1, 2018) http://www.ncsl.org/research/labor-and-employment/license-suspension-for-student-loan-defaulters.aspx (last visited Nov. 26, 2019).
[65] Protecting JOBs Act, S.3065, 115th Congress (2017-2018); Protecting JOBs Act, H.R.6156 115th Congress (2017-2018); Protecting JOBs Act, S.609, 116th Congress (2019-2020).
[66] Section 456.0721, F.S.
[67] Section 456.074(4), F.S.
[68] E-mail correspondence with Gary Landry, Office of Legislative Planning, Department of Health, dated Oct. 30, 2019, on file with the Health Quality Subcommittee.

Case Status	2017-18 FY	2018-19 FY
Mediated	88	332
Dismissed	27	75
Discipline Imposed	23	36
No Probable Cause Found	9	41
Licensee is No Longer Licensed	54	55
Licensee is Deceased	3	2
Still Open	43	160
Complaint Withdrawn by DOE	0	21
Total	**247**	**722**

Medical Faculty Certificates

The Board of Medicine may issue a medical faculty certificate to a qualified physician to practice in conjunction with a full-time faculty appointment at one of the following accredited medical school and its affiliated clinical facilities or teaching hospitals:[69]

- University of Florida;
- University of Miami;
- University of South Florida;
- Florida State University;
- Florida International University;
- University of Central Florida;
- Mayo Clinic College of Medicine and Science in Jacksonville, Florida;
- Florida Atlantic University; or
- Johns Hopkins All Children's Hospital in St. Petersburg, Florida

Although the applicant does not have to sit for and successfully pass a national examination, the applicant must meet specified statutory criteria for the medical faculty certificate.

There is no limit on the number of initial certificates a medical school or teaching institution may receive. However, the number of medical faculty certificates that may be renewed by each medical school or teaching institution is statutorily limited.[70] All medical schools, except the Mayo Clinic College of Medicine in Jacksonville, Florida, are limited to 30 renewed medical faculty certificates. The Mayo Clinic College of Medicine is limited to 10 renewed medical faculty certificates. The H. Lee Moffitt Cancer Center and Research Institute is also permitted to have up to 30 renewed faculty certificates.[71]

An annual review of each medical faculty certificate recipient is made by the dean of the certificate recipient's accredited 4-year medical school and reported to the BOM within the DOH on an annual basis.[72] Currently, there are 62 physicians holding a medical faculty certificate.[73]

Board Certification of Physicians

[69] Section 458.3145, F.S.
[70] Section 458.3145(4), F.S.
[71] *Id.*
[72] Section 458.3145(5), F.S.
[73] *Supra* note 50.

Medical licensure of physicians sets the minimum competency requirements to diagnose and treat patients; it is not specialty specific.[74] Medical specialty certification is a voluntary process that gives a physician a way to develop and demonstrate expertise in a particular specialty or subspecialty.[75]

Board Certification and Florida Licensure

DOH does not license a physician by specialty or subspecialty based upon board certification; however, ch. 458 and ch. 459, F.S., limit which physicians may hold themselves out as board-certified specialists. An allopathic physician licensed under ch. 458, F.S., may not hold himself or herself out as a board-certified specialist unless he or she has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties (ABMS) or other recognizing agency[76] approved by the allopathic board.[77]

Under Florida law, an allopathic physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the allopathic board.[78] Similarly, an osteopathic physician licensed under ch. 459, F.S., may not hold himself or herself out as a board-certified specialist unless he or she has successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME) and is certified as a specialist by a certifying agency[79] approved by the board.[80] These limitations on advertising are set out in rule 64B8-11.001, F.A.C. for allopathic physicians and rule 64B15-14.001, F.A.C., for osteopathic physicians.

Osteopathic Residencies

Following graduation from an AOA-approved medical school, osteopathic physicians (DOs) must complete an approved 12-month internship.[81] Interns rotate through hospital departments, including internal medicine, family practice, and surgery. They may then choose to complete a residency program in a specialty area, which requires two to six years of additional training.[82]

Florida law requires DOs to complete an AOA-approved residency for licensure.[83] However, the Board of Osteopathic Medicine will accept a residency accredited by the ACGME[84] for licensure if the applicant demonstrates good cause, such as:[85]

- Personal limitation created by a documented physical or medical disability;
- Unique documented opportunity otherwise unavailable that meets a practice area of critical need;
- Documented legal restriction which requires the physical presence in a particular state or local area;
- Documented unusual or exceptional family circumstances which limit training opportunities;
- The previous program met all AOA requirements, but due to documented circumstances beyond the control of the applicant, was discontinued;

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[74] American Board of Physician Specialties, *Not All Physicians are Board Certified in the Specialties They Practice*, available at https://www.abpsus.org/physician-board-certified-specialties (last visited November 25, 2019).
[75] Id.
[76] The allopathic board has approved the specialty boards of the ABMS as recognizing agencies. Rule 64B8-11.001(1)(f), F.A.C.
[77] Section 458.3312, F.S.
[78] Id.
[79] The osteopathic board has approved the specialty boards of the ABMS and AOA as recognizing agencies. Rule 64B15-14.001(h), F.A.C.
[80] Section 459.0152, F.S.
[81] Florida Osteopathic Medical Association, *Osteopathic Education*, available at https://www.foma.org/osteopathic-education.html (last visited November 25, 2019).
[82] Id.
[83] Section 459.055(1)(l), F.S.
[84] The Accreditation Council for Graduate Medical Education sets the standards for U.S. graduate medical education (residency and fellowship) programs and accredits such programs based on compliance with these standards. In 2017-2018, there were 830 ACGME-accredited institutions sponsoring more than 11,000 residency and fellowship programs. *See* Accreditation Council for Graduate Medical Education, *What We Do*, available at https://www.acgme.org/What-We-Do/Overview (last visited November 25, 2019).
[85] Rule 64B15-16, F.A.C.

- Documented inability to relocate to another geographic area with undue hardship; or
- Documented inability to obtain an AOA internship.

Single Graduate Medical Education Accreditation System

In 2014, the ACGME, AOA, and American Association of Colleges of Osteopathic Medicine entered into a Memorandum of Understanding to transition to a single accreditation system for graduate medical education (GME).[86] Under this agreement, graduates of all allopathic and osteopathic medical schools complete residencies or fellowships in ACGME-accredited programs.[87] On July 1, 2015, the AOA and the ACGME began transitioning to a single GME accreditation system.[88]

The parties to this agreement indicate that a single accreditation system will:[89]

- Establish and maintain consistent evaluation and accountability for the competency of resident physicians across all accredited GME programs;
- Eliminate duplication in GME accreditation;
- Achieve efficiencies and cost savings for institutions that sponsor both AOA-accredited and ACGME-accredited programs; and
- Ensure all residency and fellowship applicants are eligible to enter all accredited programs in the nation and can transfer from one accredited program to another without repeating training or causing a sponsoring institution to lose Medicare funding.

The AOA will cease accrediting GME programs on June 30, 2020.[90] The single accreditation system requires all training programs to be ACGME-accredited by that date. If a program is solely AOA-accredited, the program must apply for ACGME accreditation or stop accepting trainees by June 30, 2020.[91] However, the terms of the agreement allow the AOA to extend a program's accreditation if the program has made a good faith effort to obtain ACGME accreditation but has not transitioned to ACGME accreditation by June 30, 2020.[92]

Chiropractic Assistants

There are two types of chiropractic assistants: certified and registered.[93] A certified chiropractic assistant is an allied health professional who, under supervision, performs tasks or a combination of tasks traditionally performed by a chiropractic physician.[94] A registered chiropractic assistant is a professional, multi-skilled person dedicated to assisting in all aspects of chiropractic medical practice under the direct supervision of a chiropractic physician or certified chiropractic assistant.[95]

A registered chiropractic assistant voluntarily registers with the Board of Chiropractic Medicine.[96] There are no educational or eligibility standards set in statute or rule for such registration. However, a person who becomes a registered chiropractic assistant must adhere to ethical and legal standards of

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[86] American Association of Colleges of Osteopathic Medicine, *Single GME Accreditation System*, available at https://www.aacom.org/news-and-events/single-gme-accreditation-system (last visited November 25, 2019).
[87] Accreditation Council for Graduate Medical Education, *Single GME Accreditation System*, available at https://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System (last visited November 25, 2019).
[88] Id.
[89] Accreditation Council for Graduate Medical Education, *Frequently Asked Questions: Single Accreditation System*, available at https://www.acgme.org/Portals/0/PDFs/Nasca-Community/FAQs.pdf (last visited November 25, 2019).
[90] American Osteopathic Association, *Single GME Resident FAQs*, available at https://osteopathic.org/residents/resident-resources/residents-single-gme/single-gme-resident-faqs/ (last visited November 25, 2019).
[91] Id.
[92] Id.
[93] Sections 460.4165 and 460.4166, F.S.
[94] Rule 64B2-18(5), F.A.C.
[95] Section 460.4166(1), F.S.
[96] Section 460.4166(3), F.S.

professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.[97] A registered chiropractic assistant may:[98]

- Prepare patients for the chiropractic physician's care;
- Take vital signs;
- Observe and report patients' signs and symptoms;
- Administer basic first aid;
- Assist with patient examinations or treatments other than manipulations or adjustments;
- Operate office equipment;
- Collect routine laboratory specimens as directed by the chiropractic physician or certified chiropractic assistant;
- Administer nutritional supplements as directed by the chiropractic physician or certified chiropractic assistant; and
- Perform office procedures under the direct supervision of by the chiropractic physician or certified chiropractic assistant.

There are 3,991 registered chiropractic assistants.[99] DOH does not regulate the practice of registered chiropractic assistants.

Board of Nursing

Rulemaking Authority

The Board of Nursing has the authority to adopt rules to implement ch. 464, F.S., which regulates the practice of nursing in this state.[100] The Board of Nursing oversees the licensure and practice of certified nursing assistants, licensed practical nurses, registered nurses, and advanced registered nurse practitioners.

Certified Nursing Assistants

Certified Nursing Assistants (CNAs) provide care and assist individuals with tasks relating to the activities of daily living, such as those associated with personal care, nutrition and hydration, maintaining mobility, toileting, safety and cleaning, end-of-life care, cardiopulmonary resuscitation and emergency care.[101] An applicant for certification as a CNA must complete an approved training program, pass a competency examination, and pass a background screening.[102] A CNA who is certified in another state, is listed on that state's CNA registry[103] and has not been found to have committed abuse, neglect, or exploitation in that state, is eligible for certification by endorsement in Florida. However, a CNA from a territory of the United States or the District of Columbia is not eligible for certification by endorsement.

The Board of Nursing may discipline a CNA for two violations:[104]

- Obtaining or attempting to obtain certification or an exemption, or possessing or attempting to possess certification or letter of exemption, by bribery, misrepresentation, deceit, or through an error of the board; or
- Intentionally violating any provision of ch. 464, F.S., the practice act for nursing professions, ch. 456, F.S., the general licensing act, or the rules adopted by the Board of Nursing.

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[97] *Supra* note 95.
[98] Section 460.4166, F.S.
[99] *Supra* note 50.
[100] Section 464.006, F.S.
[101] Section 464.201(5), F.S.
[102] Section 464.203, F.S. *See also* Department of Health, Board of Nursing, *Certified Nursing Assistant (CNA) by Examination*, available at http://floridasnursing.gov/licensing/certified-nursing-assistant-examination/ (last visited November 25, 2019). An applicant who fails the competency examination 3 times, may not take the exam again until he or she completes an approved training program.
[103] A CNA Registry is a listing of CNAs who received certification and maintain an active certification. (Rule 64B9-15.004, F.A.C.)
[104] Section 464.204, F.S.

When seeking to discipline a CNA for violating the nurse practice act, the general licensing act, or a rule adopted thereunder, the Board of Nursing must prove that such violation is intentional. Therefore, if the Board of Nursing cannot prove intent or if a CNA acts negligently, the Board of Nursing is unable to discipline the CNA.

Florida Center for Nursing

The Florida Center for Nursing (center) was created in 2001[105] to address the issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse workforce issues. The center collects and analyzes nursing workforce data, develops and disseminates a strategic plan for nursing, develops and implements reward and recognition activities for nurses, and promotes nursing excellence programs, image building, and recruit into the profession.[106]

In 2009, the Legislature created a statutory framework for approving nursing education programs, which was revised in 2010 and 2014.[107] In 2014, the Legislature directed the center and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to produce an annual report to the Governor and Legislature on nursing education programs until January 2020.[108] In 2017, the report became the sole responsibility of the center.[109]

The annual report includes data and measurements on:[110]

- The number of programs and slots available;
- The number of applications, qualified applicants, and accepted students;
- The number of program graduates;
- Program retention rates;
- Graduate passage rates on the National Council of State Boards of Nursing Licensure Examination;
- The number of graduates who become employed in the state; and
- The programs progress in meeting accreditation requirements.

The report also evaluates the Board of Nursing's implementation of the program approval process and accountability processes.[111]

Dentistry

Examination for Licensure

Any person wishing to practice dentistry in this state must apply to DOH and meet specified requirements. Section 466.006, F.S., requires dentistry licensure applicants to sit for and pass the following licensure examinations:

- The National Board of Dental Examiners dental examination (NBDE);
- A written examination on Florida laws and rules regulating the practice of dentistry; and

[105] Chapter 2001-277, L.O.F., codified at s. 466.0195, F.S.
[106] Id. *See also*, Florida Center for Nursing, *Our History*, available at https://www.flcenterfornursing.org/AboutUs/OurHistory.aspx (last visited December 2, 2019).
[107] Chapters 2009-168, 2010-37, and 2014-92, L.O.F., respectively.
[108] Chapter 2014-92, L.O.F.
[109] Chapter 2017-134, L.O.F.
[110] Section 464.019(10), F.S.
[111] Id.

- 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.[112]

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.[113] 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.[114] DOH indicates that there is confusion on whether these programs may include specialty or advanced education programs.[115]

Any person wishing to be licensed as a dental hygienist must apply to DOH and meet the following qualifications:[116]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[117] and
- Obtain a passing score on the:
    - Dental Hygiene National Board Examination;
    - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by DOH for such purpose; and
    - A written examination on Florida laws and rules regulating the practice of dental hygiene.

According to DOH, limiting the grading to Florida-licensed dentists and dental hygienists has created a shortage of dentists and dental hygienists available to grade the examinations.[118]

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[119] in this state, without supervision.[120] In Fiscal Year 2018-2019, the Board of Dentistry issued 50 health access dental licenses.[121]

With this license, a dentist who holds a valid, active license in good state issued by another state, the District of Columbia, or a U.S. territory may practice in a health access setting if the dentist:[122]

- Applies to the Board of Dentistry and pays the appropriate fee;
- Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

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[112] 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.
[113] Section 466.006(2), F.S.
[114] Section 466.006(3), F.S.
[115] Department of Health, *2020 Agency Legislative Analysis for SB 230*, on file with the Health Quality Subcommittee. SB 230 is substantively similar to HB 713.
[116] Section 466.007, F.S.
[117] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma, which must be reviewed and approved by the Board of Dentistry.
[118] *Supra* note 115, at p. 4.
[119] Section 466.003(14), F.S., defines "health access setting" as a program or institution operated by the Department of Children and Families, Department of Health, Department of Juvenile Justice, a nonprofit health care center, a Head Start center, a federally-qualified health center or a lookalike, a school-based prevention program, a clinic operated by an accredited college of dentistry, or certain accredited dental hygiene program.
[120] Chapter 2008-64, L.O.F., codified at s. 466.0067, F.S.
[121] *Supra* note 50.
[122] Section 466.0067, F.S.

- Submits proof of graduation from an accredited dental school;
- Submits documentation that the dentist has completed, or will obtain prior to licensure, continuing education equivalent to Florida's requirement for dentists for the last full reporting biennium;
- Submits proof of successful passage of parts I and II of the National Board of Dental Examiners and a state or regional clinical dental examination approved by the Board of Dentistry;
- Has never had a license revoked in another state, the District of Columbia, or a U.S. territory;
- Has never failed the Florida dental licensing examination, unless the dentist was reexamined and received a license to practice in Florida;
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the databank; and
- Submits proof that he or she has been actively engaged in the clinical practice of dentistry providing direct patient care for the five years immediately preceding application, or proof of 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[123]. A licensee must meet the same continuing education requirements as a Florida-licensed dentists.[124] Additionally, a licensee must continue to meet all the requirements met for initial license.[125]

The Board of Dentistry may revoke a health access dental license if the licensee is terminated from employment at the health access setting, practices outside of the health access setting, fails the Florida dental examination, or is found to have violated the Dental Practice Act, other than a minor violation or a citation offense.[126]

The program is scheduled for repeal effective January 1, 2020, unless reenacted by the Legislature.[127]

Adverse Incident Reporting

Dentists and dental hygienists certified by DOH to administer anesthesia must report, in writing, any adverse incident that occurs to the Board of Dentistry within 48 hours by registered mail.[128] An adverse incident in an office setting is defined as any mortality that occurs during or as the result of a dental procedure, or an incident that results in a temporary or permanent physical or mental injury the requires hospitalization or emergency room treatment of a patient as a direct result of the use of general anesthesia,[129] deep sedation,[130] moderate sedation,[131] pediatric moderate sedation,[132] minimal

[123] Section 466.00671, F.S.
[124] Id.
[125] Id.
[126] Section 466.00672, F.S.
[127] Section 466.00673, F.S.
[128] Rule 64B5-14.006, F.A.C.
[129] General anesthesia is a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command. (Rule 64B5-14.001(2), F.A.C.)
[130] Deep sedation is a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including either or both the inability to continually maintain an airway independently or to respond appropriately to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic method or combination thereof. (Rule 64B5-14.001(3), F.A.C.)
[131] Moderate sedation is a depressed level of consciousness produced by the administration of pharmacologic substances, that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command. (Rule 64B5-14.001(4), F.A.C.)
[132] Pediatric moderate sedation is a depressed level of consciousness produced by the administration of pharmacologic substances, that retains a child patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command. (Rule 64B5-14.001(5), F.A.C.)

sedation,[133] nitrous oxide,[134] or local anesthesia.[135] The dentist must file a complete written report with the Board of Dentistry within 30 days.[136]

Allopathic and osteopathic physicians are statutorily required to report adverse incidents in office practice settings.[137] Although required by rule, there is no statutory requirement that dentists or dental hygienists report adverse incidents that occur in the office practice settings.

Dental Laboratories

A dental laboratory is a facility that supplies or manufactures artificial substitutes for natural teeth, or that furnishes, supplies, constructs, reproduces, or repairs a prosthetic denture, bridge, or appliance to be worn in the human mouth or that otherwise holds itself out as a dental laboratory.[138] Dental laboratories must biennially register with DOH, and the owner or at least one employee must complete 18 hours on continuing education each biennium.[139] A dental laboratory must:[140]

- Maintain and make available to DOH a copy of the laboratory's registration;
- Be clean and in good repair;
- Properly dispose of all waste materials at the end of each day in accordance with local restrictions;
- Maintain the original or a copy of a prescription from a dentist for each appliance or artificial restorative oral device authorizing its construction or repair for 4 years;
- Maintain a written policy and procedure manual on sanitation; and
- Have a designated receiving area.

A dental laboratory may not have dental chairs, x-ray machines, or anesthetics, sedatives, or medicinal drugs.[141] A dental laboratory may not solicit or advertise to the general public.[142]

DOH inspects dental laboratories at least once each year, and such inspections may occur with or without notice.[143]

Athletic Trainers

Athletic trainers provide service and care to individuals related to the prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury, illness, or other condition involving exercise, sport, recreation, or related physical activity.[144] To be licensed as an athletic trainer, an applicant must:[145]

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[133] Minimal sedation involves the perioperative use of medication to relieve anxiety before or during a dental procedure and does not produce a depressed level of consciousness and maintains the patient's ability to maintain an airway independently and to respond appropriately to physical and verbal stimulation. (Rule 64B5-14.001(10), F.A.C.)
[134] The use of nitrous oxide produces an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command. (Rule 64B5-14.001(6), F.A.C.)
[135] Local anesthesia involves the loss of sensation of pain in a specific area of the body. (Rule 64B5-14.001(7), F.A.C.)
[136] *Supra* note 128.
[137] *See* ss. 458.351 and 459.026, F.S.
[138] Section 466.031, F.S.
[139] Section 466.032, F.S. However, dental laboratories that are located in another state or country that provides services to a Florida-licensed dentist is not required to register with the state and may provide services to a dentist in this state.
[140] Rule 64B27-1.001, F.A.C.
[141] Id. Personal prescriptions are permissible.
[142] Section 466.035, F.S.
[143] Rule 64B27-1.001(1), F.S.
[144] Section 468.701(2), F.S.
[145] Section 468.707, F.S.

- Hold a bachelor's degree or higher from an accredited athletic training degree program and pass the national examination to be certified by the Board of Certification;[146]
- If graduated before 2004, hold a current certification from the Board of Certification;
- Hold a current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator at the professional rescue level; and
- Pass a background screening.

Prior to 2004, athletic trainers could obtain training through a Board of Certification internship program to qualify for licensure.[147] Current law does not allow applicants who completed such an internship prior to 2004 to qualify for licensure.

An athletic trainer must renew his or her license biennially. During each biennial renewal period, an athletic trainer must complete at least 24 hours of continuing education, hold a current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator, and a current certification from the Board of Certification.[148] Although licensees must show current certification from the Board of Certification, there is no statutory requirement that a licensee maintain such certification without lapse and in good standing.

An athletic trainer must practice under the direction of an allopathic, osteopathic, or chiropractic physician,[149] and may provide care such as:[150]

- Injury prevention, recognition, and evaluation;
- First aid and emergency care;
- Injury management and treatment;
- Rehabilitation through the use of safe and appropriate physical rehabilitation practices;
- Conditioning;
- Performance of tests and measurements to prevent, evaluate, and monitor acute and chronic injuries;
- Therapeutic exercises;
- Massage;
- Cryotherapy and thermotherapy;
- Therapy using other agents such as water, electricity, light, or sound; and
- The application of topical prescription medications at the direction of a physician.

The physician must communicate his or her direction through oral or written prescriptions or protocols, and the athletic trainer must provide service or care in the manner dictated by the physician.[151] A licensed athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or service that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.[152]

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[146] The Board of Certification is a not-for-profit credentialing agency to provide a certification program for the entry level athletic training profession. *See* Board of Certification for the Athletic Trainer, *What is the BOC?*, available at http://www.bocatc.org/about-us#what-is-the-boc (last visited December 2, 2019).
[147] *Supra* note 115, at p. 4.
[148] Section 468.711, F.S.
[149] Section 468.713, F.S.
[150] Rule 64B33-4.001, F.A.C.
[151] *Supra* note 149.
[152] Section 468.701(1), F.S.

Orthotists and Prosthetists

The Board of Orthotists and Prosthetists oversees the licensure and regulation of orthotists[153] and prosthetists.[154] A person applying for licensure must first apply to DOH to take the appropriate licensure examination. The board may accept the exam results of a national orthotic or prosthetic, standards organization in lieu of administering the state exam.[155] The board must verify that an applicant for licensure examination meets the following requirements:[156]

- Has completed the application form and paid all applicable fees;
- Is of good moral character;
- Is 18 years of age or older;
- Has completed the appropriate educational preparation, including practical training requirements; and
- Has successfully completed an appropriate clinical internship in the professional area for which the license is sought.

In addition to the requirements listed above, an applicant must meet the following requirements for each license he or she is seeking:[157]

- A Bachelor of Science degree in Orthotics and Prosthetics from a regionally accredited college or university from an accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs, or a bachelor's degree with a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent;
- An internship of one year of qualified experience or a residency program recognized by the board;
- Completion of the mandatory classes;[158] and
- Passage of the state orthotic examination or board-approved orthotic examination if applying for an orthotist license, or the state prosthetic examination or board-approved examination if applying for a prosthetist license.

Currently, a person who qualifies to be registered as both an orthotist and a prosthetist must obtain two separate registrations.

Massage Therapy

Massage Therapists

To be licensed as a massage therapist, an applicant must:[159]

- Be at least 18 years of age or have received a high school diploma or graduate equivalency diploma;
- Complete a course of study at a board-approved massage school or apprentice program;

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[153] An orthotist is a health care professional who evaluates, formulates treatment, measures, designs, fabricates, assembles, fits, adjusts, services or provides necessary training to accomplish the fitting of an orthosis or pedorthics (s. 468.80(9)-(10), F.S.)
[154] An orthotist is a health care professional who evaluates, formulates treatment, measures, designs, fabricates, assembles, fits, adjusts, services or provides necessary training to accomplish the fitting of a prosthesis (s. 468.80(15)-(16), F.S.)
[155] Section 468.803(4), F.S. The Board has approved the American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC) exam for orthotist and prosthetist applicants (r. 64B14-4.001, F.A.C.)
[156] Section 468.803(2), F.S.
[157] Section 468.803(5), F.S. Licenses must be renewed biennially.
[158] Pursuant to r. 64B14-5.005, F.A.C., mandatory courses include two hours on Florida laws and rules, two hours on the prevention of medical errors, one hour on infection disease control, and a CPR certification course.
[159] Section 480.041, F.S. DOH must deny an application if the applicant has been convicted or found guilty of, or entered a plea of nolo contedere to a crime related to prostitution or a felony offense related to certain other crimes.

- Pass a board-approved examination;[160] and
- Pass a background screening.

In the 2017-2018 fiscal year, 3,380 individuals were granted licensure, 13 of which qualified for licensure by completing an approved Florida apprenticeship program.[161] Massage therapy education has become more formalized and massage therapists are trained in licensed massage schools. Florida is one of a very small number of states that continue to allow apprenticeship as an acceptable course of study for licensure as a massage therapist.[162]

Colonic Irrigation Apprenticeship Programs

A massage therapist, a massage apprentice, or a student in a board-approved massage therapy school may study colonic irrigation[163] under the direct supervision of a sponsor.[164] The sponsor must be licensed to practice massage, authorized to practice colonic irrigation, and have practiced colonic irrigation for at least 3 years.[165] The apprenticeship must be completed within 12 months of commencement[166] and must consist of a minimum of 100 hours of training, including 45 hours of clinical practicum with a minimum of 20 treatments given.[167] Few schools in Florida offer a colonic irrigation program so apprenticeships are the primary method of training. There are 21 individuals certified to complete an apprenticeship in colonic irrigation.[168]

Psychologists

Licensure Requirements

The Board of Psychology oversees the licensure and regulation of psychologists.[169] To receive a license to practice psychology, an individual must:[170]

- Meet one of the following educational requirements:
  - Received a doctoral-level psychological education from an accredited school in the United States or Canada and a psychology program within that institution that is accredited from an agency recognized and approved by the U.S. Department of Education;[171]
  - Received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States or Canada, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology;
  - Received and submitted, prior to July 1, 1999, certification of an augmented doctoral-level psychological education from a doctoral-level psychology program accredited by an agency recognized and approved by the U.S. Department of Education; or
  - Received and submitted, prior to August 31, 2001, certification of a doctoral-level program that at the time the applicant was enrolled and graduated maintained a standard of

[160] In r. 64B27-25.001(3), F.A.C., the Board of Massage Therapy has approved the following national licensure examinations: Massage and Bodywork Licensing Examination administered by the Federation of State Massage Therapy Boards, National Certification Board for Therapeutic Massage and Bodywork Examination, National Certification Examination for Therapeutic Massage, National Exam for State Licensure option administered by the National Certification Board for Therapeutic Massage and Bodywork, and for colonic irrigation, The National Board for Colon Hydrotherapy Examination.
[161] *Supra* note 115.
[162] Department of Health, *2019 Agency Legislative Analysis for HB 7031*, on file with the Health Quality Subcommittee.
[163] Colonic irrigation is a method of hydrotherapy used to cleanse the colon with the aid of a mechanical device and water (s. 480.033(6), F.S.).
[164] Rule 64B7-29.001, F.A.C.
[165] Id.
[166] Rule 64B7-29.007, F.A.C.
[167] Rule 64B7-25.001, F.A.C.
[168] *Supra* note 115.
[169] Section 490.004, F.S.
[170] Section 490.005(1), F.S.
[171] Section 490.003(3), F.S., defines doctoral-level education as a Psy.D, an Ed.D., or a Ph.D in psychology.

education and training comparable to the standard of training of a doctoral-level psychology program accredited by an agency recognized and approved by the U.S. Department of Education;
- Complete 2 years or 4,000 hours of supervised experience;
- Pass the Examination for Professional Practice in Psychology;[172] and
- Pass an examination on Florida laws and rules.

The American Psychological Association (APA) is recognized by the U.S. Department of Education and the Council for Higher Education Accreditation as the national accrediting authority for professional education and training in psychology.[173] The APA no longer accredits programs in Canada.[174]

An applicant who holds an active, valid license in another state may also qualify for licensure in this state if at the time the license was issued, the requirements were substantially equivalent to or more stringent than those in Florida at that time.[175] Such individuals must have 20 years of experience as a licensed psychologist in any jurisdiction of the U.S. within the 25 years preceding the date of application. DOH indicates that under this standard, a law-to-law comparison is difficult and applicants who may otherwise qualify for licensure may be denied.[176]

School Psychologists

To be licensed as a school psychologist, an applicant must:[177]

- Hold a doctorate, specialist, or equivalent degree from a program primarily psychological in nature and have completed 60 semester hours or 90 quarter hours of graduate study in an area related to school psychology from a college or university which at the time the applicant was enrolled and graduated was accredited by an accrediting agency recognized and approved by the Commission on Recognition of Postsecondary Accreditation or an institution recognized as a member in good standing with the Association of Universities and Colleges of Canada;
- Have a minimum of 3 years of experience in school psychology, 2 of which must be supervised by a licensed school psychologist or other qualified school psychologist supervisor; and
- Pass the PRAXIS II School Psychology examination.[178]

The Commission on Recognition of Postsecondary Accreditation was dissolved in 1997, and its successor organization is the Council on Higher Education Accreditation.[179] The Association of Universities and Colleges of Canada changed its name to Universities Canada.[180]

Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

Intern Registration

To be licensed as a clinical social worker, marriage and family therapist, or mental health counselor, an applicant must meet educational requirements, complete at least 2 years of postgraduate or postmaster's clinical practice supervised by a licensed practitioner, and pass a theory and practice examination.[181]

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[172] Rule 64B19-11.001, F.A.C.
[173] American Psychological Association, *Understanding APA Accreditation*, available at http://www.apa.org/ed/accreditation/about/index.aspx (last visited December 2, 2019).
[174] *Supra* note 115 at p. 5.
[175] Section 490.006, F.S.
[176] *Supra* note 115 at p. 5.
[177] Section 490.005(2), F.S.
[178] Department of Health, *School Psychology Licensing*, available at http://www.floridahealth.gov/licensing-and-regulation/school-psychology/licensing/index.html (last visited December 2, 2019).
[179] U.S. Department of Education, *Accreditation in the U.S.*, available at https://www2.ed.gov/admins/finaid/accred/accredus.html (last visited December 2, 2019).
[180] Universities Canada, *About Us*, available at https://www.univcan.ca/about-us/ (last visited December 2, 2019).
[181] Section 491.005, F.S. A procedure for licensure by endorsement is provided in s. 491.006, F.S.

During the time in which an applicant is completing the required supervised clinical experience or internship, he or she must register with the DOH as an intern.[182] The supervised clinical experience may be met by providing at least 1,500 hours of face-to-face psychotherapy with clients, which may not be accrued in less than 100 weeks.[183]

An applicant seeking registration as an intern must:[184]

- Submit a completed application form and the nonrefundable fee to the DOH;
- Complete education requirements;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

An intern registration expires 60 months after the date of issue and may only be renewed if the candidate has passed the theory and practice examination required for full licensure.[185] DOH has no authority to extend an intern registration beyond the 60 months if there are extenuating circumstances.

Marriage and Family Therapists

Marriage and family therapy incorporates marriage and family therapy, psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[186] An applicant seeking licensure as a mental health counselor must:[187]

- Possess a master's degree from an accredited program;
- Complete 36 semester hours of graduate coursework that includes a minimum of 3 semester hours of graduate-level coursework in:
    - The dynamics of marriage and family systems;
    - Marriage therapy and counseling theory;
    - Family therapy and counseling theory and techniques;
    - Individual human development theories throughout the life cycle;
    - Personality or general counseling theory and techniques;
    - Psychosocial theory; and
    - Substance abuse theory and counseling techniques.
- Complete at least one graduate-level course of 3 semester hours in legal, ethical, and professional standards;
- Complete as least one graduate-level course of 3 semester hours in diagnosis, appraisal, assessment, and testing for individual or interpersonal disorder or dysfunction;
- Complete at least one graduate-level course of 3 semester hours in behavioral research;
- Complete at least one supervised clinical practicum, internship, or field experience in a marriage and family counseling setting, during which the student provided 180 direct client contact hours of marriage and family therapy services;
- Complete two years of post-master's supervised experience under the supervision of a licensed marriage and family therapist with five years of experience or the equivalent who is a qualified supervisor as determined by the board;
- Pass a board-approved examination; and

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[182] Section 491.0045, F.S.
[183] Rule 64B4-2.001, F.A.C.
[184] Section 491.0045(2), F.S.
[185] Section 491.0045(6), F.S.
[186] Id.
[187] Section 491.005(3), F.S. An individual may qualify for a dual license in marriage and family therapy if he or she passes an examination in marriage and family therapy and has held an active license for at least three years as a psychologist, clinical social worker, mental health counselor, or advanced registered nurse practitioner who is determined by the Board of Nursing to be a specialist in psychiatric mental health (s. 491.0057, F.S.)

- Demonstrate knowledge of laws and rules governing the practice.

DOH must verify that an applicant's education matches the specified courses and hours as outlined in statute. However, there are organizations that accredit marriage and family therapy education programs, including the Commission on Accreditation for Marriage and Family Therapy Education and the Council for the Accreditation of Counseling and Related Educational Programs that establish the minimum standards to meet the requirements to practice the profession.[188]

Mental Health Counselors

A mental health counselor is an individual who uses scientific and applied behavioral science theories, methods, and techniques to describe, prevent, and treat undesired behavior and enhance mental health and human development and is based on research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation.[189] To qualify for licensure as a mental health counselor, an individual must:[190]

- Have a master's degree from a mental health counseling program accredited by the Council of the Accreditation of Counseling and Related Educational Programs, or a program related to the practice of mental health counseling that includes coursework and a 1,000-hour practicum, internship, or fieldwork of at least 60 semester hours that meet certain requirements;
- Have at least two years of post-master's supervised clinical experience in mental health counseling;
- Pass an examination from the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors; and
- Pass an eight-hour course on Florida laws and rules approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.[191]

Currently, an applicant for a mental health counselor license must, by rule, pass the National Clinical Mental Health Counseling Examination. Current law refers to an outdated mental health counseling examination.

Effect of Proposed Changes

CS/HB 713 makes numerous changes to programs under DOH and professions regulated under the Division of Medical Quality Assurance within DOH.

HIV/AIDS

The bill expands DOH's authority to establish patient care centers for individuals who carry HIV rather than limiting patient care centers to those who have been diagnosed with AIDS. The inclusion of HIV providers into the network has a planning focus, not a service delivery focus. That planning, with this change, is more inclusive of persons living with HIV.[192]

Emergency Medical Transportation Services

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[188] *See* Commission on Accreditation for Marriage and Family Therapy Education, *What Are the Benefits of COAMFTE Accreditation*, available at https://www.coamfte.org/COAMFTE/Accreditation/About_Accreditation.aspx (last visited December 2, 2019), and Council for the Accreditation of Counseling and Related Educational Programs, *About CACREP*, available at https://www.cacrep.org/about-cacrep/ (last visited December 2, 2019).

[189] Sections 491.003(6) and (9), F.S.

[190] Section 491.005(4), F.S.

[191] Section 491.005(4), F.S., and r. 64B4-3.0035, F.A.C.

[192] Email correspondence with Ty Gentle, Office of Budget and Revenue Management, Department of Health, dated Jan. 21, 2020, on file with the Health Care Appropriations Subcommittee.

The bill repeals a requirement that DOH rules on ground ambulance be at least as comprehensive as the standards published by the American College of Surgeons. DOH may use any standard it deems appropriate to develop the list of required equipment for licensed ground ambulances. The bill also repeals the requirement that DOH's rules on ambulance or vehicle design be at least equal to those recommended by the U.S. General Services Administration and requires that the rules be based on national standards recognized by DOH.

Radiation Machines

The bill revises the inspection schedule and fee structure for radiation machines. Currently, DOH is prohibited from including the costs of supervision and program administration from the radiation machine inspection fee. The bill authorizes DOH to include a prorated share of the costs of supervision and program administration in establishing the inspection fee. The bill also authorizes DOH to include the prorated costs of central services in the inspection fee.

DOH retains the authority to establish fees by rule; however, the bill repeals the current statutory minimum and maximum fees for each category of radiation machine. DOH must assess fees according to the number of machines possessed by the registrant. The inspection fee for the first machine must include all costs as if it was the only machine and each additional radiation machine is charged a fee that includes the accrued incremental costs of the inspection.

The bill revises the types of radiation machines and the inspection schedule as follows:

Radiation Machine Use	Inspection Frequency
Intentionally exposes a person to useful beam[193] and has a peak voltage greater than 80 kilovolts used in, but not limited to, the practice of medicine, chiropractic medicine, osteopathic medicine, or naturopathic medicine	Every 2 years
Intentionally exposes a person to useful beam and has a peak voltage equal to or less than 80 kilovolts used in, but not limited to, practice of dentistry or podiatric medicine	Every 5 years
Therapeutic purposes, accelerates particles and used in the healing hearts or veterinary medicine	Annually
Accelerates particles but does not expose a person to the useful beam	Every 2 years
Not intended to expose a person to the useful beam and is not otherwise described above	Every 3 years

If a radiation machine use falls into more than one of the categories listed above, the radiation machine must be inspected at the most frequent schedule.

The bill also establishes minimum criteria for radiation machines that are used to intentionally expose persons to the useful beam. Such radiation machine must:

- Be operated and maintained in accordance with the manufacturer's standards or nationally recognized consensus standards accepted by DOH;
- Be operated at the lowest exposure that will achieve the intended purpose of the exposure; and
- Not be modified in a manner that causes the original parts to operate outside the manufacturer's design specifications or the parameters approved for the radiation machine and its components by the U.S. Food and Drug Administration.

[193] "Useful beam" means the radiation emanating from the tube housing port or the radiation head and passing through the aperture of the beam-limiting device when the exposure controls are in a mode to cause the system to produce radiation. *See* r. 64E-5.501, F.A.C.

Conrad 30 Program

The bill authorizes DOH to adopt rules to implement the Conrad 30 Waiver program in this state. This allows DOH to set guidelines in addition to those required by federal law. The bill also directs DOH to develop strategies to maximize federal and state resources to recruit physicians to practice in medically underserved and rural areas in the state.

General Licensure Requirements

The bill requires the application for licensure to include the applicant's date of birth, in addition to the currently required social security number. This will provide DOH an additional method to verify the identity of an individual applicant.

The bill also authorizes DOH to issue a temporary license to an eligible applicant, who has accepted a position with an accredited residency, internship, or fellowship program in Florida and who has submitted an application for registration for such position under s. 458.345, F.S., or s. 459.021, F.S., which expires 60 days, rather than 30 days, after issuance unless the applicant obtains and submits a social security number to DOH.

Student Loans

The bill expressly states that failing to repay a government-backed student loan does not constitute grounds for licensure discipline and repeals the requirement that DOH must issue an emergency order suspending a health care practitioner's license for a student loan default absent timely proof of a new repayment plan. DOH no longer has to obtain a monthly list from the USHHS of the Florida health care practitioners who have defaulted on their student loans. The bill also repeals DOH's authority to discipline a health care practitioner for failing to comply with a scholarship obligation and the associated mandatory disciplinary action.

Medical Faculty Certificates

The bill expands the current medical faculty certificate eligibility by allowing a medical faculty certificate to be issued without examination to an individual who has been offered and accepted a full-time faculty appointment to teach at Nova Southeastern University and Lake Erie College of Osteopathic Medicine. The Board of Medicine may issue up to 30 medical faculty certificates to each of the institutions.

Dermatology

Currently, dermatology is the only physician specialty that statutorily requires the allopathic board to review and authorize the recognizing agency. The bill repeals the prohibition against a physician holding himself or herself out as a board-certified dermatologist unless the recognizing agency is triennially reviewed and reauthorized by the Board of Medicine.

Osteopathic Physician Licensure

To qualify for licensure as an osteopathic physician, an applicant must currently complete a resident internship approved by the Board of Trustees of the American Osteopathic Association or an internship program approved by the osteopathic board. The bill requires that such internship or residency be approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education, and repeals the authority of the osteopathic board to approve an internship program.

Registered Chiropractic Assistants

Currently, registered chiropractic assistants may voluntarily register with DOH. The bill repeals this voluntary registration, thereby eliminating registered chiropractic assistants.

Nursing

The bill authorizes the Board of Nursing to adopt rules related to disciplinary procedures and the standards of practice for CNAs. The bill authorizes CNA applicants who are licensed in other territories of the United States or the District of Columbia to qualify for licensure by endorsement. The bill also authorizes the Board of Nursing to discipline CNAs for any violation of a law or rule regulating CNA practice, repealing the requirement that such violation be intentional.

The bill extends the date of the scheduled sunset of the annual report on nursing education programs produced by the Florida Center for Nursing from January 30, 2020, to January 30, 2025.

Dentistry

Dental Licensure

Current law requires that a dental licensure applicant who does not attend an accredited dental school must submit proof that he or she completed at least 2 academic years at a full-time supplemental general dentistry program approved by the American Dental Association.[194] The bill clarifies that a supplemental dentistry program does not include an advanced dental education program in a dental specialty.

The bill repeals a requirement that a Florida-licensed dentist grade the American Dental Licensing Examination, and that either a Florida-licensed dentist or dental hygienist grade Dental Hygienist Examination produced by the American Board of Dental Examiners, Inc., for applicants for licensure in this state. Therefore, dentists or dental hygienist licensed in other states may grade such licensure examinations.

Health Access Dental Licenses

The bill revives, reenacts, and repeals the scheduled January 1, 2020 sunset of health access dental licenses.

Dental Adverse Incidents

Dentists and dental hygienists are currently required to submit adverse incidents related to the administration of anesthesia under rules adopted by the Board of Dentistry. The bill statutorily requires a dentist to report an adverse incident that occurs in his or her office to DOH in writing by certified mail and postmarked within 48 hours after the incident occurs. The bill defines an adverse incident as any death that occurs during or as a result of a dental procedure, or a temporary or permanent physical or mental injury that requires hospitalization or emergency room treatment as a result of the use of general anesthesia, deep sedation, conscious sedation, pediatric conscious sedation, oral sedation, minimal sedation, nitrous oxide, or local anesthesia.

The bill also requires a dentist to report any death or other adverse incident that occurs in the dentist's outpatient facility to the Board of Dentistry in writing by certified mail within 48 hours of such occurrence. Within 30 days, the dentist must file a complete report with the Board of Dentistry.

The bill requires a certified dental hygienist who holds a certificate to administer local anesthesia to notify the Board of Dentistry in writing by registered mail within 48 hours of an adverse incident that was related to or the result of the administration of local anesthesia. The dental hygienist must file a complete report with the Board of Dentistry within 30 days.

[194] Section 466.006(3)(b), F.S.

DOH must review each adverse incident report to determine whether the incident involved conduct by a health care practitioner that warrants disciplinary action by the applicable regulatory board. A dentist or dental hygienist who fails to timely and completely report adverse incidents as required is subject to disciplinary action by the Board of Dentistry.

Dental Laboratories

The bill authorizes an employee or independent contractor of a dental laboratory to engage in onsite consultations with a dentist during a dental procedure if such person is acting as an agent of the dental laboratory. The bill also requires DOH to biennially inspect dental laboratories, rather than annually as currently required by rule.

Athletic Trainers

The bill requires athletic trainers to work within her or his scope of practice as defined by the Board of Athletic Training in rule. The bill adds another route to licensure by authorizing individuals who hold a bachelor's degree, completed a Board of Certification internship, and hold a certification from the Board of Certification to be eligible for licensure.

The bill establishes that a licensed athletic trainer must maintain his or her certification from the Board of Certification in good standing to be eligible for licensure renewal. The bill authorizes the Board of Athletic Training to establish rules for the supervision of an athletic training student.

Orthotics and Prosthetics

The bill authorizes the Board of Orthotists and Prosthetists to issue a single registration for prosthetics and orthotics practice. Currently, an individual must hold two separate registrations: one as a prosthetist and one as an orthotist. For purposes of resident registration, DOH may recognize a dual certificate in prosthetics and orthotics for an applicant who holds a bachelor's degree from a regionally accredited college or university. The bill also authorizes the completion of a dual residency program to qualify for the licensure examination.

Massage Therapy

The bill limits apprenticeships to only those in colonic irrigations. A licensed massage therapist practicing colonic irrigation must supervise a colonic irrigation apprentice. The bill eliminates a massage therapy apprenticeship as a path to licensure. However, if an individual has been issued a license as a massage therapy apprentice before July 1, 2020, he or she may continue to perform massage therapy until the license expires. A massage therapist apprentice may apply for full licensure upon completion of the apprenticeship and before July 1, 2023.

The bill authorizes the Board of Massage Therapy to designate a national examination for licensure and repeals provisions requiring DOH to develop a licensure examination.

Psychologists

The bill requires psychology programs within educational institutions to be accredited by the American Psychological Association (APA), which is recognized as the national accrediting authority for professional education and training in psychology by the U.S. Department of Education and the Council for Higher Education Accreditation.[195] The bill replaces references to the Commission on Recognition of Postsecondary Accreditation to its successor organization, the Council for Higher Education Accreditation.[196] For applicants for licensure who obtained their education in Canada, the bill requires those applicants to demonstrate that they have completed a program comparable to APA-accredited programs.

The bill repeals a provision that allowed an applicant for licensure by endorsement to hold a license from another state that has licensure standards that are equivalent or more stringent than Florida to qualify for licensure. However, an individual may apply for licensure by endorsement if he or she has a doctoral degree in psychology and has practiced for at least 10 years of the last 25 years, rather than 20 years as required in current law.

The bill repeals obsolete provisions related to applicants for licensure prior to July 1, 1999.

Licensed Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

Intern Registration

The bill authorizes the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to make a one-time exception to the 60-month limit on an internship registration. Such exceptions may only be granted in an emergency or hardship case, as defined by rule. The bill deletes obsolete language related to biennial renewals of intern registrations.

Marriage and Family Therapists

The bill requires that an applicant for licensure hold a master's degree with an emphasis in marriage and family therapy from a program accredited by the Commission of Accreditation for Marriage and Family Therapy Education or a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs. An applicant may also qualify for licensure if he or she holds a master's degree in a closely related field and has completed graduated courses approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. The bill eliminates specified coursework and clinical experience required for licensure that is currently enumerated in statute.

To be licensed as a marriage and family therapist, s. 491.005(3), F.S., requires an applicant to complete two years of clinical experience. However, later in the same paragraph, it states the clinical experience required is three years. The bill corrects the scrivener's error in the paragraph to clarify that two years of clinical experience is required for licensure.

Licensed Mental Health Counselors

The bill updates the name of the organization that administers the licensure examination for mental health counseling licensure applicants to the National Board for Certified Counselors or its successor. This will conform the law to current practice.[197] The bill revises the content areas that must be included in

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[195] American Psychological Association, *Understanding APA Accreditation*, available at http://www.apa.org/ed/accreditation/about/index.aspx (last visited January 21, 2019).
[196] U.S. Department of Education, *Accreditation in the U.S.*, available at https://www2.ed.gov/admins/finaid/accred/accredus.html (last visited January 21, 2019).
[197] *Supra* note 115.

educational programs used to qualify for licensure to include substance abuse; legal, ethical, and professional standards issues in the practice of mental health counseling; and diagnostic processes.

The bill reduces the number of hours required for the clinical practicum or internship from 1,000 hours to 700 hours to conform the number of hours to the accreditation standards established by the Council for Accreditation of Counseling and Related Educational Programs. The bill requires the clinical practicum or internship to include at least 280 hours of direct client services.

The bill requires that applicants who apply for licensure after July 1, 2025, to hold a master's degree from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs.

Licensure by Endorsement

The bill repeals educational requirements for applicants for licensure by endorsement. Such applicant qualifies for licensure if he or she holds a valid, active license to practice in another state for 3 of the 5 years preceding the date of application, passes an equivalent licensure examination, and is not under investigation for and has not been found to have committed any act that would constitute a licensure violation in Florida.

The bill clarifies that DOH may deny or impose penalties on the license of a certified master social worker who violates the practice act or ch. 456, F.S., the general regulatory statute by deleting an inaccurate reference to psychologists. This will alleviate confusion regarding the authority of DOH to impose such discipline or deny a license.

The bill deletes obsolete language and makes other technical and conforming changes.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0042, F.S., relating to patient care for persons with HIV infection.
Section 2: Amends s. 381.4018, F.S., relating to physician workforce assessment and development.
Section 3: Amends s. 401.35, F.S., relating to rules.
Section 4: Amends s. 404.22, F.S., relating to radiation machines and components; inspection.
Section 5: Amends s. 456.013, F.S., relating to department; general licensing provisions.
Section 6: Amends s, 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 7: Repeals s. 456.0721, F.S., relating to practitioners in default on student loans or scholarship obligations; investigation; report.
Section 8: Amends s. 456.074, F.S., relating to certain health care practitioners; immediate suspension of license.
Section 9: Amends s. 458.3145, F.S., relating to medical faculty certificate.
Section 10: Amends s. 458.3312, F.S., relating to specialties.
Section 11: Amends s. 459.0055, F.S., relating to general licensure requirements.
Section 12: Repeals s. 460.4166, F.S., relating to certified chiropractic physician's assistants.
Section 13: Amends s. 464.019, F.S., relating to approval of nursing education programs.
Section 14: Amends s. 464.202, F.S., relating to duties and powers of the board.
Section 15: Amends s. 464.203, F.S., relating to certified nursing assistants; certification requirement.
Section 16: Amends s. 464.204, F.S., relating to denial, suspension, or revocation of certification; disciplinary actions.
Section 17: Amends s. 466.006, F.S., relating to examination of dentists.
Section 18: Amends s. 466.0067, F.S., relating to application for health access dental license.
Section 19: Amends s. 466.00671, F.S., relating to renewal of the health access dental license.
Section 20: Amends s. 466.00672, F.S., relating to revocation of health access dental licenses.
Section 21: Amends s. 466.007, F.S., relating to examination of dental hygienists.
Section 22: Amends s. 466.017, F.S., relating to prescription of drugs; anesthesia.
Section 23: Amends s. 466.031, F.S., relating to "dental laboratory" defined.

Section 24: Amends s. 466.036, F.S., relating to information; periodic inspections; equipment and supplies.
Section 25: Amends s. 468.701, F.S., relating to definitions.
Section 26: Amends s. 468.707, F.S., relating to licensure requirements.
Section 27: Amends s. 468.711, F.S., relating to renewal of license; continuing education.
Section 28: Amends s. 468.713, F.S., relating to responsibilities of athletic trainers.
Section 29: Amends s. 468.723, F.S., relating to exemptions.
Section 30: Amends s. 468.803, F.S., relating to license, registration, and examination requirements.
Section 31: Amends s. 480.033, F.S., relating to definitions.
Section 32: Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure; endorsement.
Section 33: Repeals s. 480.042, F.S., relating to examinations.
Section 34: Amends s. 490.003, F.S., relating to definitions.
Section 35: Amends s. 490.005, F.S., relating to licensure by examination.
Section 36: Amends s. 490.006, F.S., relating to licensure by endorsement.
Section 37: Amends s. 491.0045, F.S., relating to intern registration; requirements.
Section 38: Amends s. 491.005, F.S., relating to licensure by examination.
Section 39: Amends s. 491.006, F.S., relating to licensure or certification by endorsement.
Section 40: Amends s. 491.007, F.S., relating to renewal of license, registration, or certificate.
Section 41: Amends s. 491.009, F.S., relating to discipline.
Section 42: Amends s. 491.0046, F.S., relating to provisional license; requirements.
Section 43: Amends s. 945.42, related to definitions; ss. 945.40-945.49, F.S.
Section 44: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

DOH will experience a recurring decrease in revenue due to the loss of the 10% fine imposed on student loan default cases. In Fiscal Year 2018-2019 DOH received $461 in fine revenue.[198]

DOH will experience a loss of revenue from biennial registration fees due to the deregulation of registered chiropractic assistants. The estimated biennial loss of revenue is approximately $166,125.[199] However, the loss of revenue will be offset by eliminating the cost of registering chiropractic assistants.

DOH may experience a loss of revenue due to the authorization of a single prosthetist-orthotist registration. It is unknown how many single registrations may be issued but it is estimated the loss of revenue will be insignificant.

DOH may experience an increase in revenue if DOH includes a prorated share of the costs of supervision, program administration, and central services in its radiation machine inspection fee. DOH has indicated its current fees are sufficient and no changes are foreseen.[200]

2. Expenditures:

The bill will have an insignificant, negative fiscal impact on DOH related to various rulemaking provisions. The bill authorizes DOH, or the appropriate regulatory board, to adopt or amend rules related to emergency medical transportation services, radiation machine inspections, Conrad 30 Waiver program, general licensure requirements, medical faculty certificates, dermatology, osteopathic

[198] Email correspondence with Daniel Leon, Office of Legislative Planning, Department of Health, dated Jan. 22, 2020, on file with the Health Care Appropriations Subcommittee
[199] *Supra* note 115.
[200] Id.

physician licensure, disciplinary guidelines and standards of practice for CNAs, dental licensure, athletic trainer licensure and supervision, massage therapy, psychology, licensed clinical social work, marriage and family therapy, and mental health counseling. Additionally, DOH will need to repeal adopted rules related to the deregulation of registered chiropractic assistants. Current resources are adequate to absorb these costs.

DOH may experience an increase in workload related to reviewing and investigating dental adverse incidents for disciplinary action. It is unknown how many adverse incidents may be reported, however, current resources are estimated to be adequate to absorb these costs.

DOH will experience a reduction in workload and costs due to the repeal of DOH's authority to discipline a health care practitioner for failing to repay government-backed student loans, changing the inspections of dental laboratories from annual to biennial, repealing the registration of chiropractic assistants, and reviewing and determining whether an applicant for osteopathic medicine licensure has demonstrated good cause completing an ACGME-accredited residency instead of an AOA-approved residency.

DOH will also incur costs associated with making minor changes to its LEIDS licensure system to reflect changes made in the bill, which current resources are adequate to absorb.[201]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals who voluntarily registered as chiropractic assistants will no longer have to pay fees associated with such registration.

Individuals who wish to obtain a single prosthetist-orthotist registration may save money because they will no longer have to obtain separate prosthetic and orthotic registrations.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

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, Art. VII, s. 19 of the Florida Constitution may apply if the provision in the bill that repeals the statutory minimum and maximum inspection fees

[201] Id.

for radiation machines and authorizes DOH to establish inspection fees, including the prorated share of costs of supervision, administration costs, and central services is interpreted to be an increased or new state fee.

Additionally, the bill appears to implicate Art. VII, s. 19 of the Florida Constitution because the bill reenacts the health access dental license and authorizes the Board of Dentistry to establish application and licensure fees.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority for DOH or the applicable regulatory boards to adopt rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 11, 2019, the Health Quality Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Revised DOH rulemaking authority relating to the minimum standards for ground ambulance and vehicle equipment, supplies, design, and construction;
- Removed references to particular association standards and recommendations that DOH must consider when developing rules for ground ambulances and vehicles;
- Required DOH to adopt rules based on national standards for ambulance and vehicle design and construction;
- Repealed a requirement that DOH discipline a licensee for failing to repay a student loan;
- Repealed a requirement that DOH obtain a monthly list from the U.S. Department of Health and Human Services of health care practitioners who have defaulted on their student loans; and
- Repealed a requirement that DOH issue an emergency order suspending the license of a health care practitioner who defaults on a student loan unless the licensee timely submits proof of a payment plan.

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

A bill to be entitled

An act relating to the Department of Health; amending s. 381.0042, F.S.; revising the purpose of patient care networks from serving patients with acquired immune deficiency syndrome to serving those with human immunodeficiency virus; conforming provisions to changes made by the act; deleting obsolete language; amending s. 381.4018, F.S.; requiring the Department of Health to develop strategies to maximize federal-state partnerships that provide incentives for physicians to practice in medically underserved or rural areas; authorizing the department to adopt certain rules; amending s. 401.35, F.S.; revising provisions relating to the applicability of rules to certain licensees; deleting a requirement that the department base rules governing medical supplies and equipment required in ambulances and emergency medical services vehicles on a certain association's standards; deleting a requirement that the department base rules governing ambulance or vehicle design and construction on a certain agency's standards and instead requiring the department to base such rules on national standards recognized by the department; amending s. 404.22, F.S.; revising the method by which registration fees for radiation machines are assessed

by the department; revising provisions relating to the fee schedule and frequency of inspections for certain radiation machines; requiring that certain radiation machines meet specified criteria; amending s. 456.013, F.S.; revising health care practitioner licensure application requirements; authorizing the board or department to issue a temporary license to certain applicants which expires after 60 days; amending s. 456.072, F.S.; conforming provisions to changes made by the act; repealing s. 456.0721, F.S., relating to health care practitioners in default on student loan or scholarship obligations; amending s. 456.074, F.S.; conforming provisions to changes made by the act; amending s. 458.3145, F.S.; revising the list of individuals who may be issued a medical faculty certificate without examination; amending s. 458.3312, F.S.; removing a prohibition against physicians representing themselves as board-certified specialists in dermatology unless the recognizing agency is reviewed and reauthorized on a specified basis by the Board of Medicine; amending s. 459.0055, F.S.; revising licensure requirements for a person seeking licensure or certification as an osteopathic physician; repealing s. 460.4166, F.S., relating to registered chiropractic assistants; amending s.

464.019, F.S.; extending through 2025 the Florida Center for Nursing's responsibility to study and issue an annual report on the implementation of nursing education programs; amending s. 464.202, F.S.; requiring the Board of Nursing to adopt rules that include disciplinary procedures and standards of practice for certified nursing assistants; amending s. 464.203, F.S.; revising certification requirements for nursing assistants; amending s. 464.204, F.S.; revising grounds for board-imposed disciplinary sanctions; amending s. 466.006, F.S.; revising certain examination requirements for applicants seeking dental licensure; reviving, reenacting, and amending s. 466.0067, F.S., relating to the application for a health access dental license; reviving, reenacting, and amending s. 466.00671, F.S., relating to the renewal of such a license; reviving and reenacting s. 466.00672, F.S., relating to the revocation of such a license; amending s. 466.007, F.S.; revising requirements for examinations of dental hygienists; amending s. 466.017, F.S.; requiring dentists and certified registered dental hygienists to report in writing certain adverse incidents to the department within a specified timeframe; providing for disciplinary action by the Board of Dentistry for

violations; defining the term "adverse incident"; authorizing the board to adopt rules; amending s. 466.031, F.S.; making technical changes; authorizing an employee or an independent contractor of a dental laboratory, acting as an agent of that dental laboratory, to engage in onsite consultation with a licensed dentist during a dental procedure; amending s. 466.036, F.S.; revising the frequency of dental laboratory inspections during a specified period; amending s. 468.701, F.S.; revising the definition of the term "athletic trainer"; deleting a requirement that is relocated to another section; amending s. 468.707, F.S.; revising athletic trainer licensure requirements; amending s. 468.711, F.S.; requiring certain licensees to maintain certification in good standing without lapse as a condition of renewal of their athletic trainer licenses; amending s. 468.713, F.S.; requiring that an athletic trainer work within a specified scope of practice; relocating an existing requirement that was stricken from another section; amending s. 468.723, F.S.; requiring the direct supervision of an athletic training student to be in accordance with rules adopted by the Board of Athletic Training; amending s. 468.803, F.S.; revising orthotic, prosthetic, and pedorthic licensure,

registration, and examination requirements; amending s. 480.033, F.S.; revising the definition of the term "apprentice"; amending s. 480.041, F.S.; revising qualifications for licensure as a massage therapist; specifying that massage apprentices licensed before a specified date may continue to perform massage therapy as authorized under their licenses; authorizing massage apprentices to apply for full licensure upon completion of their apprenticeships, under certain conditions; repealing s. 480.042, F.S., relating to examinations for licensure as a massage therapist; amending s. 490.003, F.S.; revising the definition of the terms "doctoral-level psychological education" and "doctoral degree in psychology"; amending s. 490.005, F.S.; revising requirements for licensure by examination of psychologists and school psychologists; amending s. 490.006, F.S.; revising requirements for licensure by endorsement of psychologists and school psychologists; amending s. 491.0045, F.S.; exempting clinical social worker interns, marriage and family therapist interns, and mental health counselor interns from registration requirements, under certain circumstances; amending s. 491.005, F.S.; revising requirements for the licensure by examination of marriage and family therapists; revising requirements

for the licensure by examination of mental health counselors; amending s. 491.006, F.S.; revising requirements for licensure by endorsement or certification for specified professions; amending s. 491.007, F.S.; removing a biennial intern registration fee; amending s. 491.009, F.S.; authorizing the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling or, under certain circumstances, the department to enter an order denying licensure or imposing penalties against an applicant for licensure under certain circumstances; amending ss. 491.0046 and 945.42, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 381.0042, Florida Statutes, is amended to read:

381.0042 Patient care for persons with HIV infection.—The department may establish human immunodeficiency virus ~~acquired immune deficiency syndrome~~ patient care networks in each region of the state where the number ~~numbers~~ of cases of ~~acquired immune deficiency syndrome and other~~ human immunodeficiency virus transmission ~~infections~~ justifies the establishment of cost-effective regional patient care networks. Such networks

shall be delineated by rule of the department which shall take into account natural trade areas and centers of medical excellence that specialize in the treatment of human immunodeficiency virus ~~acquired immune deficiency syndrome~~, as well as available federal, state, and other funds. Each patient care network shall include representation of persons with human immunodeficiency virus infection; health care providers; business interests; the department, including, but not limited to, county health departments; and local units of government. Each network shall plan for the care and treatment of persons with human immunodeficiency virus ~~acquired immune deficiency syndrome and acquired immune deficiency syndrome related complex~~ in a cost-effective, dignified manner that ~~which~~ emphasizes outpatient and home care. Once per ~~each~~ year, ~~beginning April 1989,~~ each network shall make its recommendations concerning the needs for patient care to the department.

Section 2. Subsection (3) of section 381.4018, Florida Statutes, is amended to read:

381.4018 Physician workforce assessment and development.—

(3) GENERAL FUNCTIONS.—The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the

department shall:

(a) Monitor, evaluate, and report on the supply and distribution of physicians licensed under chapter 458 or chapter 459. The department shall maintain a database to serve as a statewide source of data concerning the physician workforce.

(b) Develop a model and quantify, on an ongoing basis, the adequacy of the state's current and future physician workforce as reliable data becomes available. Such model must take into account demographics, physician practice status, place of education and training, generational changes, population growth, economic indicators, and issues concerning the "pipeline" into medical education.

(c) Develop and recommend strategies to determine whether the number of qualified medical school applicants who might become competent, practicing physicians in this state will be sufficient to meet the capacity of the state's medical schools. If appropriate, the department shall, working with representatives of appropriate governmental and nongovernmental entities, develop strategies and recommendations and identify best practice programs that introduce health care as a profession and strengthen skills needed for medical school admission for elementary, middle, and high school students, and improve premedical education at the precollege and college level in order to increase this state's potential pool of medical students.

(d) Develop strategies to ensure that the number of graduates from the state's public and private allopathic and osteopathic medical schools is adequate to meet physician workforce needs, based on the analysis of the physician workforce data, so as to provide a high-quality medical education to students in a manner that recognizes the uniqueness of each new and existing medical school in this state.

(e) Pursue strategies and policies to create, expand, and maintain graduate medical education positions in the state based on the analysis of the physician workforce data. Such strategies and policies must take into account the effect of federal funding limitations on the expansion and creation of positions in graduate medical education. The department shall develop options to address such federal funding limitations. The department shall consider options to provide direct state funding for graduate medical education positions in a manner that addresses requirements and needs relative to accreditation of graduate medical education programs. The department shall consider funding residency positions as a means of addressing needed physician specialty areas, rural areas having a shortage of physicians, and areas of ongoing critical need, and as a means of addressing the state's physician workforce needs based on an ongoing analysis of physician workforce data.

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract

physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas, in otherwise medically underserved areas, or in rural areas. Strategies shall also consider the use of state programs, such as the Medical Education Reimbursement and Loan Repayment Program pursuant to s. 1009.65, which provide for education loan repayment or loan forgiveness and provide monetary incentives for physicians to relocate to underserved areas of the state.

(g) Coordinate and enhance activities relative to physician workforce needs, undergraduate medical education, graduate medical education, and reentry of retired military and other physicians into the physician workforce provided by the Division of Medical Quality Assurance, area health education center networks established pursuant to s. 381.0402, and other offices and programs within the department as designated by the State Surgeon General.

(h) Work in conjunction with and act as a coordinating body for governmental and nongovernmental stakeholders to address matters relating to the state's physician workforce assessment and development for the purpose of ensuring an adequate supply of well-trained physicians to meet the state's future needs. Such governmental stakeholders shall include, but need not be limited to, the State Surgeon General or his or her

designee, the Commissioner of Education or his or her designee, the Secretary of Health Care Administration or his or her designee, and the Chancellor of the State University System or his or her designee, and, at the discretion of the department, other representatives of state and local agencies that are involved in assessing, educating, or training the state's current or future physicians. Other stakeholders shall include, but need not be limited to, organizations representing the state's public and private allopathic and osteopathic medical schools; organizations representing hospitals and other institutions providing health care, particularly those that currently provide or have an interest in providing accredited medical education and graduate medical education to medical students and medical residents; organizations representing allopathic and osteopathic practicing physicians; and, at the discretion of the department, representatives of other organizations or entities involved in assessing, educating, or training the state's current or future physicians.

(i) Serve as a liaison with other states and federal agencies and programs in order to enhance resources available to the state's physician workforce and medical education continuum.

(j) Act as a clearinghouse for collecting and disseminating information concerning the physician workforce and medical education continuum in this state.

The department may adopt rules to implement this subsection, including rules that establish guidelines to implement the federal Conrad 30 Waiver Program created under s. 214(l) of the Immigration and Nationality Act.

Section 3. Paragraphs (c) and (d) of subsection (1) of section 401.35, Florida Statutes, are amended to read:

401.35 Rules.—The department shall adopt rules, including definitions of terms, necessary to carry out the purposes of this part.

(1) The rules must provide at least minimum standards governing:

(c) Ground ambulance and vehicle equipment and supplies that a licensee with a valid vehicle permit under s. 401.26 is required to maintain to provide basic or advanced life support services ~~at least as comprehensive as those published in the most current edition of the American College of Surgeons, Committee on Trauma, list of essential equipment for ambulances, as interpreted by rules of the department~~.

(d) Ground ambulance or vehicle design and construction based on national standards recognized by the department and ~~at least equal to those most currently recommended by the United States General Services Administration as~~ interpreted by department rules ~~of the department~~.

Section 4. Subsection (5) of section 404.22, Florida Statutes, is amended, and subsection (7) is added to that

section, to read:

404.22 Radiation machines and components; inspection.—

(5)(a) The department may charge and collect reasonable fees annually for the registration and inspection of radiation machines pursuant to this section. Such fees shall include the registration fee provided in s. 404.131 and shall be deposited into the Radiation Protection Trust Fund. Registration shall be on an annual basis. Registration shall consist of having the registrant file, on forms prescribed and furnished by the department, information which includes, but is not limited to: type and number of radiation machines, location of radiation machines, and changes in ownership. The department shall establish by rule a fee schedule based upon the actual costs incurred by the department in carrying out its registration and inspection responsibilities, including the salaries, expenses, and equipment of inspectors, and a prorated share of all ~~but excluding~~ costs of supervision, ~~and~~ program administration, and central services. Fees shall be assessed according to the number of radiation machines possessed by the registrant, with the fee associated with the first radiation machine to include all costs as if it was the only machine registered. The fee for each additional radiation machine shall include the incremental costs associated with determining that each additional machine complies with the standards as set forth in this chapter and the rules adopted hereunder. The fee schedule shall reflect

differences in the frequency and complexity of inspections necessary to ensure that the radiation machines are functioning in accordance with the applicable standards developed pursuant to this chapter and rules adopted pursuant hereto.

(b) The fee schedule and frequency of inspections shall be determined as follows:

1. Radiation machines that have a peak voltage greater than 80 kilovolts, are used to intentionally expose natural persons to the useful beam, and ~~which~~ are used in, but not limited to, the practice of medicine, chiropractic medicine, osteopathic medicine, or naturopathic medicine shall be inspected at least once every 2 years~~, but not more than annually, for an annual fee which is not less than $83 or more than $145 for the first radiation machine within an office or facility and not less than $36 or more than $85 for each additional radiation machine therein~~.

~~2. Radiation machines which are used in the practice of veterinary medicine shall be inspected at least once every 3 years for an annual fee which is not less than $28 or more than $50 for the first radiation machine within an office or facility and not less than $19 or more than $34 for each additional radiation machine therein.~~

~~3. Radiation machines which are used for educational or industrial purposes shall be inspected at least once every 3 years for an annual fee which is not less than $26 or more than~~

~~$47 for the first radiation machine within an office or facility and not less than $12 or more than $23 for each additional radiation machine therein.~~

2.~~4.~~ Radiation machines that have a peak voltage equal to or less than 80 kilovolts, are used to intentionally expose natural persons to the useful beam, and ~~which~~ are used in, but not limited to, the practice of dentistry or podiatric medicine shall be inspected at least once every 5 years but not more often than once every 4 years ~~for an annual fee which is not less than $16 or more than $31 for the first radiation machine within an office or facility and not less than $5 or more than $11 for each additional radiation machine therein~~.

3.~~5.~~ Radiation machines that are used for therapeutic purposes or that ~~which~~ accelerate particles and are used in the healing arts or veterinary medicine shall be inspected at least annually ~~for an annual fee which is not less than $153 or more than $258 for the first radiation machine within an office or facility and not less than $87 or more than $148 for each additional radiation machine therein~~.

4.~~6.~~ Radiation machines that ~~which~~ accelerate particles and do not expose natural persons to the useful beam ~~are used for educational or industrial purposes~~ shall be inspected at least once every 2 years ~~for an annual fee which is not less than $46 or more than $81 for the first radiation machine within an office or facility and not less than $26 or more than $48 for~~

~~each additional radiation machine therein~~.

5. Radiation machines that are not intended to expose natural persons to the useful beam and are not otherwise described in this paragraph shall be inspected at least once every 3 years.

6.~~7.~~ If a radiation machine fails to meet the applicable standards upon initial inspection, the department may reinspect the radiation machine and charge a reinspection fee in accordance with the same schedule of fees adopted under paragraph (a) ~~as in subparagraphs 1.-6~~.

(c) Radiation machines that meet more than one of the criteria listed in paragraph (b) shall be inspected at the most frequent schedule applicable.

(7) Radiation machines that are used to intentionally expose natural persons to the useful beam must meet the following criteria:

(a) Be operated and maintained in accordance with the manufacturer's standards or nationally recognized consensus standards accepted by the department.

(b) Be operated at the lowest exposure that will achieve the intended purpose of the exposure.

(c) Not be modified in a manner that causes the original parts to operate outside the original manufacturer's design specifications or the parameters approved for the radiation machine and its components by the United States Food and Drug

Administration.

Section 5. Paragraphs (a) and (b) of subsection (1) of section 456.013, Florida Statutes, are amended to read:

456.013 Department; general licensing provisions.—

(1)(a) Any person desiring to be licensed in a profession within the jurisdiction of the department must ~~shall~~ apply to the department in writing ~~to take the licensure examination~~. The application must ~~shall~~ be made on a form prepared and furnished by the department. The application form must be available on the Internet, ~~World Wide Web~~ and the department may accept electronically submitted applications. The application shall require the social security number and date of birth of the applicant, except as provided in paragraphs (b) and (c). The form shall be supplemented as needed to reflect any material change in any circumstance or condition stated in the application which takes place between the initial filing of the application and the final grant or denial of the license and which might affect the decision of the department. If an application is submitted electronically, the department may require supplemental materials, including an original signature of the applicant and verification of credentials, to be submitted in a nonelectronic format. An incomplete application shall expire 1 year after initial filing. In order to further the economic development goals of the state, and notwithstanding any law to the contrary, the department may enter into an

agreement with the county tax collector for the purpose of appointing the county tax collector as the department's agent to accept applications for licenses and applications for renewals of licenses. The agreement must specify the time within which the tax collector must forward any applications and accompanying application fees to the department.

(b) If an applicant has not been issued a social security number by the Federal Government at the time of application because the applicant is not a citizen or resident of this country, the department may process the application using a unique personal identification number. If such an applicant is otherwise eligible for licensure, the board, or the department when there is no board, may issue a temporary license to the applicant~~,~~ which shall expire 30 days after issuance unless a social security number is obtained and submitted in writing to the department. A temporary license issued under this paragraph to an applicant who has accepted a position with an accredited residency, internship, or fellowship program in this state and is applying for registration under s. 458.345 or s. 459.021 shall expire 60 days after issuance unless the applicant obtains a social security number and submits it in writing to the department. Upon receipt of the applicant's social security number, the department shall issue a new license, which shall expire at the end of the current biennium.

Section 6. Paragraph (k) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

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

(k) Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan is not ~~or failing to comply with service scholarship obligations shall be~~ considered a failure to perform a statutory or legal obligation~~, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount~~. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.

Section 7. Section 456.0721, Florida Statutes, is repealed.

Section 8. Subsection (4) of section 456.074, Florida Statutes, is amended to read:

456.074 Certain health care practitioners; immediate suspension of license.—

~~(4) Upon receipt of information that a Florida-licensed health care practitioner has defaulted on a student loan issued or guaranteed by the state or the Federal Government, the department shall notify the licensee by certified mail that he or she shall be subject to immediate suspension of license unless, within 45 days after the date of mailing, the licensee provides proof that new payment terms have been agreed upon by all parties to the loan. The department shall issue an emergency order suspending the license of any licensee who, after 45 days following the date of mailing from the department, has failed to provide such proof. Production of such proof shall not prohibit the department from proceeding with disciplinary action against the licensee pursuant to s. 456.073.~~

Section 9. Subsection (1) of section 458.3145, Florida Statutes, is amended to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who:

(a) Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization;

(b) Holds a valid, current license to practice medicine in another jurisdiction;

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed $500;

(d) Has completed an approved residency or fellowship of at least 1 year or has received training which has been determined by the board to be equivalent to the 1-year residency requirement;

(e) Is at least 21 years of age;

(f) Is of good moral character;

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331;

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry; and

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at:

1. The University of Florida;

2. The University of Miami;

3. The University of South Florida;

4. The Florida State University;

5. The Florida International University;

6. The University of Central Florida;

7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida;

8. The Florida Atlantic University; ~~or~~

9. The Johns Hopkins All Children's Hospital in St. Petersburg, Florida;

10. Nova Southeastern University; or

11. Lake Erie College of Osteopathic Medicine.

Section 10. Section 458.3312, Florida Statutes, is amended to read:

458.3312 Specialties.—A physician licensed under this chapter may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the board. However, a physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician. ~~A physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the Board of Medicine.~~

Section 11. Subsection (1) of section 459.0055, Florida Statutes, is amended to read:

459.0055 General licensure requirements.—

(1) Except as otherwise provided herein, any person desiring to be licensed or certified as an osteopathic physician

pursuant to this chapter shall:

(a) Complete an application form and submit the appropriate fee to the department;

(b) Be at least 21 years of age;

(c) Be of good moral character;

(d) Have completed at least 3 years of preprofessional postsecondary education;

(e) Have not previously committed any act that would constitute a violation of this chapter, unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;

(f) Not be under investigation in any jurisdiction for an act that would constitute a violation of this chapter. If, upon completion of such investigation, it is determined that the applicant has committed an act that would constitute a violation of this chapter, the applicant is ineligible for licensure unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;

(g) Have not had an application for a license to practice osteopathic medicine denied or a license to practice osteopathic medicine revoked, suspended, or otherwise acted against by the licensing authority of any jurisdiction unless the board determines that the grounds on which such action was taken do

not adversely affect the applicant's present ability and fitness to practice osteopathic medicine. A licensing authority's acceptance of a physician's relinquishment of license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician, shall be considered action against the osteopathic physician's license;

(h) Not have received less than a satisfactory evaluation from an internship, residency, or fellowship training program, unless the board determines that such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine. Such evaluation shall be provided by the director of medical education from the medical training facility;

(i) Have met the criteria set forth in s. 459.0075, s. 459.0077, or s. 459.021, whichever is applicable;

(j) Submit to the department a set of fingerprints on a form and under procedures specified by the department, along with a payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant;

(k) Demonstrate that ~~he or~~ she or he is a graduate of a medical college recognized and approved by the American Osteopathic Association;

(l) Demonstrate that she or he has successfully completed

an internship or residency ~~a resident internship~~ of not less than 12 months in a program accredited ~~hospital approved~~ for this purpose by ~~the Board of Trustees of~~ the American Osteopathic Association or the Accreditation Council for Graduate Medical Education ~~any other internship program approved by the board upon a showing of good cause by the applicant~~. This requirement may be waived for an applicant who matriculated in a college of osteopathic medicine during or before 1948; and

(m) Demonstrate that she or he has obtained a passing score, as established by rule of the board, on all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board no more than 5 years before making application in this state or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than 5 years after the applicant obtained a passing score on the examination conducted by the National Board of Osteopathic Medical Examiners or other substantially similar examination approved by the board.

Section 12. Section 460.4166, Florida Statutes, is repealed.

Section 13. Subsection (10) of section 464.019, Florida Statutes, is amended to read:

464.019 Approval of nursing education programs.—

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing

shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30, through January 30, 2025 ~~2020~~. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing.

(a) The Florida Center for Nursing shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

1. The number of programs and student slots available.

2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

3. The number of program graduates.

4. Program retention rates of students tracked from program entry to graduation.

5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.

6. The number of graduates who become employed as

practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board's implementation of the:

1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1)~~,~~ the number of program applications approved and denied by the board under subsection (2)~~,~~ the number of denials of program applications reviewed under chapter 120~~,~~ and a description of the outcomes of those reviews.

2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the reports required by this subsection.

Section 14. Section 464.202, Florida Statutes, is amended to read:

464.202 Duties and powers of the board.—The board shall

maintain, or contract with or approve another entity to maintain, a state registry of certified nursing assistants. The registry must consist of the name of each certified nursing assistant in this state; other identifying information defined by board rule; certification status; the effective date of certification; other information required by state or federal law; information regarding any crime or any abuse, neglect, or exploitation as provided under chapter 435; and any disciplinary action taken against the certified nursing assistant. The registry shall be accessible to the public, the certificateholder, employers, and other state agencies. The board shall adopt by rule testing procedures for use in certifying nursing assistants and shall adopt rules regulating the practice of certified nursing assistants, including disciplinary procedures and standards of practice, and specifying the scope of practice authorized and the level of supervision required for the practice of certified nursing assistants. The board may contract with or approve another entity or organization to provide the examination services, including the development and administration of examinations. The board shall require that the contract provider offer certified nursing assistant applications via the Internet, and may require the contract provider to accept certified nursing assistant applications for processing via the Internet. The board shall require the contract provider to provide the

preliminary results of the certified nursing examination on the date the test is administered. The provider shall pay all reasonable costs and expenses incurred by the board in evaluating the provider's application and performance during the delivery of services, including examination services and procedures for maintaining the certified nursing assistant registry.

Section 15. Paragraph (c) of subsection (1) of section 464.203, Florida Statutes, is amended to read:

464.203 Certified nursing assistants; certification requirement.—

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days before applying for a certificate to practice and the person's background screening results are not retained in the clearinghouse created under s. 435.12, the board shall waive the requirement that the applicant successfully pass an additional background screening pursuant to s. 400.215. The person must also meet one of the following requirements:

(c) Is currently certified in another state <u>or territory of the United States or in the District of Columbia</u>; is listed

on that jurisdiction's ~~state's~~ certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that jurisdiction ~~state~~.

Section 16. Paragraph (b) of subsection (1) of section 464.204, Florida Statutes, is amended to read:

464.204 Denial, suspension, or revocation of certification; disciplinary actions.—

(1) The following acts constitute grounds for which the board may impose disciplinary sanctions as specified in subsection (2):

(b) ~~Intentionally~~ Violating any provision of this chapter, chapter 456, or the rules adopted by the board.

Section 17. Subsections (3) and (4) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(3) If an applicant is a graduate of a dental college or school not accredited in accordance with paragraph (2)(b) or of a dental college or school not approved by the board, the applicant is not entitled to take the examinations required in this section to practice dentistry until she or he satisfies one of the following:

(a) Completes a program of study, as defined by the board by rule, at an accredited American dental school and demonstrates receipt of a D.D.S. or D.M.D. from said school; or

(b) Submits proof of having successfully completed at

least 2 consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this paragraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty.

(4) Notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations, to be licensed as a dentist in this state, an applicant must successfully complete both of the following:

(a) A written examination on the laws and rules of the state regulating the practice of dentistry.~~;~~

(b)~~1.~~ A practical or clinical examination, which must ~~shall~~ be the American Dental Licensing Examination produced by the American Board of Dental Examiners, Inc., or its successor entity, if any, that is administered in this state ~~and graded by dentists licensed in this state and employed by the department for just such purpose~~, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American

Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally. A passing score on the American Dental Licensing Examination administered in this state ~~and graded by dentists who are licensed in this state~~ is valid for 365 days after the date the official examination results are published.

1.~~2.a.~~ As an alternative to such practical or clinical examination ~~the requirements of subparagraph 1.~~, an applicant may submit scores from an American Dental Licensing Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results shall be recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination administered out of state ~~out-of-state~~ shall be the same as the passing score for the American Dental Licensing Examination administered in this state ~~and graded by dentists who are licensed in this state~~. The examination results are valid for 365 days after the date the official examination results are published. The applicant must have completed the examination after October 1, 2011.

~~b.~~ This subparagraph may not be given retroactive application.

2.~~3.~~ If the date of an applicant's passing American Dental Licensing Examination scores from an examination previously administered in a jurisdiction other than this state under

subparagraph 1. ~~subparagraph 2.~~ is older than 365 days, ~~then~~ such scores are ~~shall~~ nevertheless ~~be recognized as~~ valid for the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

a.~~(I)~~ The applicant completed the American Dental Licensing Examination after October 1, 2011.

~~(II)~~ This sub-subparagraph may not be given retroactive application;

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this sub-subparagraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty;

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico;

d. The applicant submits proof that he or she has never been reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name removed from the data banks of these agencies;

e.(I)(A) ~~In the 5 years immediately preceding the date of application for licensure in this state,~~ The applicant submits ~~must submit~~ proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico in the 5 years immediately preceding the date of application for licensure in this state;~~,~~ or~~,~~

(B) If the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant submits ~~must submit~~ proof of having been engaged in the full-time practice of dentistry since the date of his or her initial

licensure.

(II) As used in this section, "full-time practice" is defined as a minimum of 1,200 hours per year for each and every year in the consecutive 5-year period or, when ~~where~~ applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(C) Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(III) The board shall develop rules to determine what type of proof of full-time practice is required and to recoup the cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

(C) Submitted by the applicant under oath with penalties of perjury attached;

(D) Further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice; and

(E) Specifically found by the board to be both credible and admissible.

(IV) An affidavit of only the applicant is not acceptable proof of full-time practice unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath;

f. The applicant submits ~~must submit~~ documentation that he or she has completed, or will complete before he or she is licensed~~, prior to licensure~~ in this state, continuing education equivalent to this state's requirements for the last full reporting biennium;

g. The applicant proves ~~must prove~~ that he or she has never been convicted of, or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession in any jurisdiction;

h. The applicant has ~~must~~ successfully passed ~~pass~~ a written examination on the laws and rules of this state regulating the practice of dentistry and ~~must successfully pass~~

the computer-based diagnostic skills examination; and

i. The applicant submits ~~must submit~~ documentation that he or she has successfully completed the applicable examination administered by the Joint Commission on National Dental Examinations or its successor organization ~~National Board of Dental Examiners dental examination~~.

Section 18. Notwithstanding the January 1, 2020, repeal of section 466.0067, Florida Statutes, that section is revived, reenacted, and amended, to read:

466.0067 Application for health access dental license.—The Legislature finds that there is an important state interest in attracting dentists to practice in underserved health access settings in this state and further, that allowing out-of-state dentists who meet certain criteria to practice in health access settings without the supervision of a dentist licensed in this state is substantially related to achieving this important state interest. Therefore, notwithstanding the requirements of s. 466.006, the board shall grant a health access dental license to practice dentistry in this state in health access settings as defined in s. 466.003 to an applicant who ~~that~~:

(1) Files an appropriate application approved by the board;

(2) Pays an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure fee. The fees specified in this subsection may not differ from

an applicant seeking licensure pursuant to s. 466.006;

(3) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(4) Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;

(5) Submits documentation that she or he has completed, or will obtain before ~~prior to~~ licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006 for the last full reporting biennium before applying for a health access dental license;

(6) Submits proof of her or his successful completion of parts I and II of the dental examination by the National Board of Dental Examiners and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;

(7) Currently holds a valid, active~~,~~ dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another of the United States, the District of Columbia, or a United States territory;

(8) Has never had a license revoked from another of the United States, the District of Columbia, or a United States territory;

(9) Has never failed the examination specified in s.

466.006, unless the applicant was reexamined pursuant to s. 466.006 and received a license to practice dentistry in this state;

(10) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank;

(11) Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and

(12) Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a).

Section 19. Notwithstanding the January 1, 2020, repeal of section 466.00671, Florida Statutes, that section is revived, reenacted, and amended to read:

466.00671 Renewal of the health access dental license.—

(1) A health access dental licensee shall apply for renewal each biennium. At the time of renewal, the licensee shall sign a statement that she or he has complied with all continuing education requirements of an active dentist licensee. The board shall renew a health access dental license for an

applicant who ~~that~~:

(a) Submits documentation, as approved by the board, from the employer in the health access setting that the licensee has at all times pertinent remained an employee;

(b) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

(c) Has paid a renewal fee set by the board. The fee specified herein may not differ from the renewal fee adopted by the board pursuant to s. 466.013. The department may provide payment for these fees through the dentist's salary, benefits, or other department funds;

(d) Has not failed the examination specified in s. 466.006 since initially receiving a health access dental license or since the last renewal; and

(e) Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank.

(2) The board may undertake measures to independently verify the health access dental licensee's ongoing employment status in the health access setting.

Section 20. Notwithstanding the January 1, 2020, repeal of section 466.00672, Florida Statutes, that section is revived and reenacted to read:

466.00672 Revocation of health access dental license.—

(1) The board shall revoke a health access dental license upon:

(a) The licensee's termination from employment from a qualifying health access setting;

(b) Final agency action determining that the licensee has violated any provision of s. 466.027 or s. 466.028, other than infractions constituting citation offenses or minor violations; or

(c) Failure of the Florida dental licensure examination.

(2) Failure of an individual licensed pursuant to s. 466.0067 to limit the practice of dentistry to health access settings as defined in s. 466.003 constitutes the unlicensed practice of dentistry.

Section 21. Paragraph (b) of subsection (4) and paragraph (a) of subsection (6) of section 466.007, Florida Statutes, are amended to read:

466.007 Examination of dental hygienists.—

(4) Effective July 1, 2012, to be licensed as a dental hygienist in this state, an applicant must successfully complete the following:

(b) A practical or clinical examination approved by the board. The examination shall be the Dental Hygiene Examination produced by the American Board of Dental Examiners, Inc. (ADEX) or its successor entity, if any, if the board finds that the successor entity's clinical examination meets or exceeds the

provisions of this section. The board shall approve the ADEX Dental Hygiene Examination if the board has attained and continues to maintain representation on the ADEX House of Representatives, the ADEX Dental Hygiene Examination Development Committee, and such other ADEX Dental Hygiene committees as the board deems appropriate through rulemaking to ensure that the standards established in this section are maintained organizationally. The ADEX Dental Hygiene Examination or the examination produced by its successor entity is a comprehensive examination in which an applicant must demonstrate skills within the dental hygiene scope of practice on a live patient and any other components that the board deems necessary for the applicant to successfully demonstrate competency for the purpose of licensure. ~~The ADEX Dental Hygiene Examination or the examination by the successor entity administered in this state shall be graded by dentists and dental hygienists licensed in this state who are employed by the department for this purpose.~~

(6)(a) A passing score on the ADEX Dental Hygiene Examination administered out of state must ~~shall~~ be considered the same as a passing score for the ADEX Dental Hygiene Examination administered in this state ~~and graded by licensed dentists and dental hygienists~~.

Section 22. Subsections (9) through (15) are added to section 466.017, Florida Statutes, to read:

466.017 Prescription of drugs; anesthesia.—

(9) Any adverse incident that occurs in an office maintained by a dentist must be reported to the department. The required notification to the department must be submitted in writing by certified mail and postmarked within 48 hours after the incident occurs.

(10) A dentist practicing in this state must notify the board in writing by certified mail within 48 hours after any adverse incident that occurs in the dentist's outpatient facility. A complete written report must be filed with the board within 30 days after the incident occurs.

(11) Any certified registered dental hygienist administering local anesthesia must notify the board in writing by registered mail within 48 hours after any adverse incident that was related to or the result of the administration of local anesthesia. A complete written report must be filed with the board within 30 days after the mortality or other adverse incident.

(12) A failure by the dentist or dental hygienist to timely and completely comply with all the reporting requirements in this section is the basis for disciplinary action by the board pursuant to s. 466.028(1).

(13) The department shall review each adverse incident and determine whether it involved conduct by a health care professional subject to disciplinary action, in which case s. 456.073 applies. Disciplinary action, if any, shall be taken by

the board under which the health care professional is licensed.

(14) As used in subsections (9)-(13), the term "adverse incident" means any mortality that occurs during or as the result of a dental procedure, or an incident that results in a temporary or permanent physical or mental injury that requires hospitalization or emergency room treatment of a dental patient which occurs during or as a direct result of the use of general anesthesia, deep sedation, moderate sedation, pediatric moderate sedation, oral sedation, minimal sedation (anxiolysis), nitrous oxide, or local anesthesia.

(15) The board may adopt rules to administer this section.

Section 23. Section 466.031, Florida Statutes, is amended to read:

466.031 ~~"~~Dental laboratories ~~laboratory" defined~~.—

(1) As used in this chapter, the term "dental laboratory" ~~as used in this chapter:~~

~~(1)~~ includes any person, firm, or corporation that ~~who~~ performs for a fee of any kind, gratuitously, or otherwise, directly or through an agent or an employee, by any means or method, or ~~who in any way~~ supplies or manufactures artificial substitutes for the natural teeth;~~, or who~~ furnishes, supplies, constructs, or reproduces or repairs any prosthetic denture, bridge, or appliance to be worn in the human mouth; or ~~who~~ in any way represents ~~holds~~ itself ~~out~~ as a dental laboratory.

~~(2)~~ The term does not include a ~~Excludes any~~ dental

laboratory technician who constructs or repairs dental prosthetic appliances in the office of a licensed dentist exclusively for that ~~such~~ dentist ~~only and~~ under her or his supervision and work order.

(2) An employee or independent contractor of a dental laboratory, acting as an agent of that dental laboratory, may engage in onsite consultation with a licensed dentist during a dental procedure.

Section 24. Section 466.036, Florida Statutes, is amended to read:

466.036 Information; periodic inspections; equipment and supplies.—The department may require from the applicant for a registration certificate to operate a dental laboratory any information necessary to carry out the purpose of this chapter, including proof that the applicant has the equipment and supplies necessary to operate as determined by rule of the department, and shall require periodic inspection of all dental laboratories operating in this state at least once each biennial registration period. Such inspections must ~~shall~~ include, but need not be limited to, inspection of sanitary conditions, equipment, supplies, and facilities on the premises. The department shall specify dental equipment and supplies that are not allowed ~~permitted~~ in a registered dental laboratory.

Section 25. Subsection (1) of section 468.701, Florida Statutes, is amended to read:

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

(1) "Athletic trainer" means a person licensed under this part who has met the requirements of ~~under~~ this part, including the education requirements established ~~as set forth~~ by the Commission on Accreditation of Athletic Training Education or its successor organization and necessary credentials from the Board of Certification. ~~An individual who is licensed as an athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.~~

Section 26. Section 468.707, Florida Statutes, is amended to read:

468.707 Licensure requirements.—Any person desiring to be licensed as an athletic trainer shall apply to the department on a form approved by the department. An applicant shall also provide records or other evidence, as determined by the board, to prove he or she has met the requirements of this section. The department shall license each applicant who:

(1) Has completed the application form and remitted the required fees.

(2) ~~For a person who applies on or after July 1, 2016,~~ Has submitted to background screening pursuant to s. 456.0135. The board may require a background screening for an applicant whose

license has expired or who is undergoing disciplinary action.

(3)(a) Has obtained, at a minimum, a bachelor's ~~baccalaureate or higher~~ degree from a college or university professional athletic training degree program accredited by the Commission on Accreditation of Athletic Training Education or its successor organization recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the board, or recognized by the Board of Certification, and has passed the national examination to be certified by the Board of Certification; or~~.~~

(b)~~(4)~~ Has obtained, at a minimum, a bachelor's degree, has completed the Board of Certification internship requirements, and holds ~~If graduated before 2004, has~~ a current certification from the Board of Certification.

(4)~~(5)~~ Has current certification in both cardiopulmonary resuscitation and the use of an automated external defibrillator set forth in the continuing education requirements as determined by the board pursuant to s. 468.711.

(5)~~(6)~~ Has completed any other requirements as determined by the department and approved by the board.

Section 27. Subsection (3) of section 468.711, Florida Statutes, is amended to read:

468.711 Renewal of license; continuing education.—

(3) If initially licensed after January 1, 1998, the

licensee must be currently certified by the Board of Certification or its successor agency and maintain that certification in good standing without lapse.

Section 28. Section 468.713, Florida Statutes, is amended to read:

468.713 Responsibilities of athletic trainers.—

(1) An athletic trainer shall practice under the direction of a physician licensed under chapter 458, chapter 459, chapter 460, or otherwise authorized by Florida law to practice medicine. The physician shall communicate his or her direction through oral or written prescriptions or protocols as deemed appropriate by the physician for the provision of services and care by the athletic trainer. An athletic trainer shall provide service or care in the manner dictated by the physician.

(2) An athletic trainer shall work within his or her allowable scope of practice as specified in board rule under s. 468.705. An athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide or that he or she is otherwise prohibited by law from providing.

Section 29. Subsection (2) of section 468.723, Florida Statutes, is amended to read:

468.723 Exemptions.—This part does not prohibit ~~prevent~~ or restrict:

(2) An athletic training student acting under the direct supervision of a licensed athletic trainer. For purposes of this subsection, "direct supervision" means the physical presence of an athletic trainer so that the athletic trainer is immediately available to the athletic training student and able to intervene on behalf of the athletic training student. The supervision must comply with board rule ~~in accordance with the standards set forth by the Commission on Accreditation of Athletic Training Education or its successor~~.

Section 30. Subsections (1), (3), and (4) of section 468.803, Florida Statutes, are amended to read:

468.803 License, registration, and examination requirements.—

(1) The department shall issue a license to practice orthotics, prosthetics, or pedorthics, or a registration for a resident to practice orthotics or prosthetics, to qualified applicants. Licenses to practice ~~shall be granted independently in~~ orthotics, prosthetics, or pedorthics must be granted independently, but a person may be licensed in more than one such discipline, and a prosthetist-orthotist license may be granted to persons meeting the requirements for licensure both as a prosthetist and as an orthotist ~~license~~. Registrations to practice ~~shall be granted independently in~~ orthotics or prosthetics must be granted independently, and a person may be registered in both disciplines ~~fields~~ at the same time or

jointly in orthotics and prosthetics as a dual registration.

(3) A person seeking to attain the ~~required~~ orthotics or prosthetics experience required for licensure in this state must be approved by the board and registered as a resident by the department. Although a registration may be held in both disciplines ~~practice fields~~, for independent registrations the board may ~~shall~~ not approve a second registration until at least 1 year after the issuance of the first registration. Notwithstanding subsection (2), a person ~~an applicant~~ who has been approved by the board and registered by the department in one discipline ~~practice field~~ may apply for registration in the second discipline ~~practice field~~ without an additional state or national criminal history check during the period in which the first registration is valid. Each independent registration or dual registration is valid for 2 years after ~~from~~ the date of issuance unless otherwise revoked by the department upon recommendation of the board. The board shall set a registration fee not to exceed $500 to be paid by the applicant. A registration may be renewed once by the department upon recommendation of the board for a period no longer than 1 year, as such renewal is defined by the board by rule. The ~~registration~~ renewal fee may ~~shall~~ not exceed one-half the current registration fee. To be considered by the board for approval of registration as a resident, the applicant must have one of the following:

(a) A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs. ~~or, at~~

(b) A minimum of~~,~~ a bachelor's degree from a regionally accredited college or university and a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board. ~~; or~~

(c) A minimum of a bachelor's degree from a regionally accredited college or university and a dual certificate in both orthotics and prosthetics from programs recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

~~(b) A Bachelor of Science or higher-level postgraduate degree in Orthotics and Prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.~~

(4) The department may develop and administer a state examination for an orthotist or a prosthetist license, or the

board may approve the existing examination of a national standards organization. The examination must be predicated on a minimum of a baccalaureate-level education and formalized specialized training in the appropriate field. Each examination must demonstrate a minimum level of competence in basic scientific knowledge, written problem solving, and practical clinical patient management. The board shall require an examination fee not to exceed the actual cost to the board in developing, administering, and approving the examination, which fee must be paid by the applicant. To be considered by the board for examination, the applicant must have:

(a) For an examination in orthotics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics internship of 1 year of qualified experience, as determined by the board, or an orthotic residency or dual residency program recognized by the board.

(b) For an examination in prosthetics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from a regionally accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from a regionally accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved prosthetics internship of 1 year of qualified experience, as determined by the board, or a prosthetic residency or dual residency program recognized by the board.

Section 31. Subsection (5) of section 480.033, Florida Statutes, is amended to read:

480.033 Definitions.—As used in this act:

(5) "Apprentice" means a person approved by the board to study colonic irrigation ~~massage~~ under the instruction of a licensed massage therapist practicing colonic irrigation.

Section 32. Subsections (1) and (2) of section 480.041, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(1) Any person is qualified for licensure as a massage

therapist under this act who:

(a) Is at least 18 years of age or has received a high school diploma or high school equivalency diploma;

(b) Has completed a course of study at a board-approved massage school ~~or has completed an apprenticeship program~~ that meets standards adopted by the board; and

(c) Has received a passing grade on a national ~~an~~ examination designated ~~administered~~ by the board ~~department~~.

(2) Every person desiring to be examined for licensure as a massage therapist must ~~shall~~ apply to the department in writing upon forms prepared and furnished by the department. Such applicants are ~~shall be~~ subject to ~~the provisions of~~ s. 480.046(1). ~~Applicants may take an examination administered by the department only upon meeting the requirements of this section as determined by the board.~~

(8) A person issued a license as a massage apprentice before July 1, 2020, may continue that apprenticeship and perform massage therapy as authorized under that license until it expires. Upon completion of the apprenticeship, which must occur before July 1, 2023, a massage apprentice may apply to the board for full licensure and be granted a license if all other applicable licensure requirements are met.

Section 33. Section 480.042, Florida Statutes, is repealed.

Section 34. Subsection (3) of section 490.003, Florida

Statutes, is amended to read:

490.003 Definitions.—As used in this chapter:

(3) ~~(a) Prior to July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology" mean a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from:~~

~~1. An educational institution which, at the time the applicant was enrolled and graduated, had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and~~

~~2. A psychology program within that educational institution which, at the time the applicant was enrolled and graduated, had programmatic accreditation from an accrediting agency recognized and approved by the United States Department of Education or was comparable to such programs.~~

~~(b)~~ Effective July 1, 1999, "doctoral-level psychological education" and "doctoral degree in psychology" mean a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at~~:~~

~~1.~~ an educational institution that ~~which~~, at the time the applicant was enrolled and graduated:

(a) ~~,~~ Had institutional accreditation from an agency recognized and approved by the United States Department of

Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and

(b)~~2.~~ ~~A psychology program within that educational institution which, at the time the applicant was enrolled and graduated,~~ Had programmatic accreditation from the American Psychological Association ~~an agency recognized and approved by the United States Department of Education~~.

Section 35. Paragraph (b) of subsection (1) and paragraph (b) of subsection (2) of section 490.005, Florida Statutes, are amended to read:

490.005 Licensure by examination.—

(1) Any person desiring to be licensed as a psychologist shall apply to the department to take the licensure examination. The department shall license each applicant who the board certifies has:

(b) Submitted proof satisfactory to the board that the applicant has received:

1. ~~Received~~ Doctoral-level psychological education~~, as defined in s. 490.003(3)~~; or

2. ~~Received~~ The equivalent of a doctoral-level psychological education, as defined in s. 490.003(3), from a program at a school or university located outside the United States of America ~~and Canada,~~ which was officially recognized by the government of the country in which it is located as an institution or program to train students to practice

professional psychology. The applicant has the burden of establishing that this requirement has ~~the requirements of this provision have~~ been met ~~shall be upon the applicant;~~

~~3. Received and submitted to the board, prior to July 1, 1999, certification of an augmented doctoral-level psychological education from the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the United States Department of Education; or~~

~~4. Received and submitted to the board, prior to August 31, 2001, certification of a doctoral-level program that at the time the applicant was enrolled and graduated maintained a standard of education and training comparable to the standard of training of programs accredited by a programmatic agency recognized and approved by the United States Department of Education. Such certification of comparability shall be provided by the program director of a doctoral-level psychology program accredited by a programmatic agency recognized and approved by the United States Department of Education~~.

(2) Any person desiring to be licensed as a school psychologist shall apply to the department to take the licensure examination. The department shall license each applicant who the department certifies has:

(b) Submitted satisfactory proof to the department that the applicant:

1. Has received a doctorate, specialist, or equivalent degree from a program primarily psychological in nature and has completed 60 semester hours or 90 quarter hours of graduate study, in areas related to school psychology as defined by rule of the department, from a college or university which at the time the applicant was enrolled and graduated was accredited by an accrediting agency recognized and approved by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~ or from an institution that ~~which~~ is ~~publicly recognized as~~ a member in good standing with the Association of Universities and Colleges of Canada.

2. Has had a minimum of 3 years of experience in school psychology, 2 years of which must be supervised by an individual who is a licensed school psychologist or who has otherwise qualified as a school psychologist supervisor, by education and experience, as set forth by rule of the department. A doctoral internship may be applied toward the supervision requirement.

3. Has passed an examination provided by the department.

Section 36. Subsection (1) of section 490.006, Florida Statutes, is amended to read:

490.006 Licensure by endorsement.—

(1) The department shall license a person as a psychologist or school psychologist who, upon applying to the department and remitting the appropriate fee, demonstrates to

the department or, in the case of psychologists, to the board that the applicant:

~~(a) Holds a valid license or certificate in another state to practice psychology or school psychology, as applicable, provided that, when the applicant secured such license or certificate, the requirements were substantially equivalent to or more stringent than those set forth in this chapter at that time; and, if no Florida law existed at that time, then the requirements in the other state must have been substantially equivalent to or more stringent than those set forth in this chapter at the present time;~~

(a) ~~(b)~~ Is a diplomate in good standing with the American Board of Professional Psychology, Inc.; or

(b) ~~(c)~~ Possesses a doctoral degree in psychology ~~as described in s. 490.003~~ and has at least 10 ~~20~~ years of experience as a licensed psychologist in any jurisdiction or territory of the United States within the 25 years preceding the date of application.

Section 37. Subsection (6) of section 491.0045, Florida Statutes, as created by chapter 2016-80 and chapter 2016-241, Laws of Florida, is amended to read:

491.0045 Intern registration; requirements.—

(6) A registration issued on or before March 31, 2017, expires March 31, 2022, and may not be renewed or reissued. Any registration issued after March 31, 2017, expires 60 months

after the date it is issued. The board may make a one-time exception from the requirements of this subsection in emergency or hardship cases, as defined by board rule, if ~~A subsequent intern registration may not be issued unless~~ the candidate has passed the theory and practice examination described in s. 491.005(1)(d), (3)(d), and (4)(d).

Section 38. Subsections (3) and (4) of section 491.005, Florida Statutes, are amended to read:

491.005 Licensure by examination.—

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual cost of ~~to the department for~~ the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or similar national organization, the department shall issue a license as a marriage and family therapist to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b)1. Has a minimum of a master's degree with major emphasis in marriage and family therapy~~,~~ or a closely related field from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or from a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs~~,~~ and graduate courses approved by the Board of Clinical Social

~~Commission on Recognition of Postsecondary Accreditation;~~ publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada, ~~;~~ or an institution of higher education located outside the United States and Canada~~,~~ which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The applicant has the burden of establishing that the requirements of this provision have been met ~~shall be upon the applicant~~, and the board shall require documentation, such as~~, but not limited to,~~ an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs

Work, Marriage and Family Therapy, and Mental Health Counseling ~~has completed all of the following requirements:~~

~~a. Thirty-six semester hours or 48 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level course credits in each of the following nine areas: dynamics of marriage and family systems; marriage therapy and counseling theory and techniques; family therapy and counseling theory and techniques; individual human development theories throughout the life cycle; personality theory or general counseling theory and techniques; psychopathology; human sexuality theory and counseling techniques; psychosocial theory; and substance abuse theory and counseling techniques. Courses in research, evaluation, appraisal, assessment, or testing theories and procedures; thesis or dissertation work; or practicums, internships, or fieldwork may not be applied toward this requirement.~~

~~b. A minimum of one graduate-level course of 3 semester hours or 4 quarter hours in legal, ethical, and professional standards issues in the practice of marriage and family therapy or a course determined by the board to be equivalent.~~

~~c. A minimum of one graduate-level course of 3 semester hours or 4 quarter hours in diagnosis, appraisal, assessment, and testing for individual or interpersonal disorder or dysfunction; and a minimum of one 3-semester-hour or 4-quarter-hour graduate-level course in behavioral research which focuses~~

~~on the interpretation and application of research data as it applies to clinical practice. Credit for thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.~~

~~d. A minimum of one supervised clinical practicum, internship, or field experience in a marriage and family counseling setting, during which the student provided 180 direct client contact hours of marriage and family therapy services under the supervision of an individual who met the requirements for supervision under paragraph (c). This requirement may be met by a supervised practice experience which took place outside the academic arena, but which is certified as equivalent to a graduate-level practicum or internship program which required a minimum of 180 direct client contact hours of marriage and family therapy services currently offered within an academic program of a college or university accredited by an accrediting agency approved by the United States Department of Education, or an institution which is publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada or a training institution accredited by the Commission on Accreditation for Marriage and Family Therapy Education recognized by the United States Department of Education. Certification shall be required from an official of such college, university, or training institution.~~

2. If the course title that ~~which~~ appears on the

applicant's transcript does not clearly identify the content of the coursework, the applicant shall ~~be required to~~ provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

The required master's degree must have been received in an institution of higher education that, ~~which~~ at the time the applicant graduated, was~~:~~ fully accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation or~~,~~ publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada,~~,~~ or an institution of higher education located outside the United States and Canada~~,~~ which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as professional marriage and family therapists or psychotherapists. The applicant has the burden of establishing that the requirements of this provision have been

met ~~shall be upon the applicant~~, and the board shall require documentation, such as~~, but not limited to,~~ an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. An applicant with a master's degree from a program that ~~which~~ did not emphasize marriage and family therapy may complete the coursework requirement in a training institution fully accredited by the Commission on Accreditation for Marriage and Family Therapy Education recognized by the United States Department of Education.

(c) Has had at least 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field which ~~that~~ did not include all of the coursework required by subparagraph (b)1. ~~under sub-subparagraphs (b)1.a.-c.~~, credit for the post-master's level clinical experience may ~~shall~~ not commence until the

applicant has completed a minimum of 10 of the courses required by subparagraph (b)1. ~~under sub-subparagraphs (b)1.a.-c.~~, as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 2 ~~3~~ years of required experience, the applicant shall provide direct individual, group, or family therapy and counseling~~,~~ to ~~include the following categories of~~ cases including those involving~~:~~ unmarried dyads, married couples, separating and divorcing couples, and family groups that include ~~including~~ children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department ~~for this purpose~~.

(e) Has demonstrated, in a manner designated by board rule ~~of the board~~, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

~~(f)~~

For the purposes of dual licensure, the department shall license as a marriage and family therapist any person who meets the

requirements of s. 491.0057. Fees for dual licensure may ~~shall~~ not exceed those stated in this subsection.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost of ~~to the department for~~ purchase of the examination from the National Board for Certified Counselors or its successor ~~Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors or a similar national~~ organization, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b)1. Has a minimum of an earned master's degree from a mental health counseling program accredited by the Council for the Accreditation of Counseling and Related Educational Programs which ~~that~~ consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling which ~~that~~ is not accredited by the Council for the Accreditation of Counseling and Related Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet all of the following

requirements:

a. Thirty-three semester hours or 44 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling ~~in community settings; and substance abuse~~. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework addressing diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The graduate program must have emphasized the common core curricular experience ~~in legal, ethical, and professional standards issues in the practice of mental health counseling, which includes goals, objectives, and practices of professional counseling organizations, codes of ethics, legal~~

~~considerations, standards of preparation, certifications and licensing, and the role identity and professional obligations of mental health counselors. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement~~.

c. The equivalent, as determined by the board, of at least 700 ~~1,000~~ hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. Has provided additional documentation if a ~~the~~ course title that ~~which~~ appears on the applicant's transcript does not clearly identify the content of the coursework.~~,~~ The ~~applicant shall be required to provide additional~~ documentation must include, ~~including,~~ but is not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education that, ~~which~~ at the time the applicant graduated, was~~:~~ fully accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or

which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Has had at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which ~~that~~ did not include all the coursework required under sub-subparagraphs (b)1.a. and b. ~~(b)1.a.-b.~~, credit for the post-master's level clinical experience may ~~shall~~ not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b. ~~(b)1.a.-b.~~, as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department for this purpose.

(e) Has demonstrated, in a manner designated by board rule ~~of the board~~, knowledge of the laws and rules governing the

practice of clinical social work, marriage and family therapy, and mental health counseling.

Section 39. Paragraph (b) of subsection (1) of section 491.006, Florida Statutes, is amended to read:

491.006 Licensure or certification by endorsement.—

(1) The department shall license or grant a certificate to a person in a profession regulated by this chapter who, upon applying to the department and remitting the appropriate fee, demonstrates to the board that he or she:

(b)1. Holds an active valid license to practice and has actively practiced the licensed profession ~~for which licensure is applied~~ in another state for 3 of the last 5 years immediately preceding licensure;~~.~~

~~2. Meets the education requirements of this chapter for the profession for which licensure is applied.~~

2.~~3.~~ Has passed a substantially equivalent licensing examination in another state or has passed the licensure examination in this state in the profession for which the applicant seeks licensure; and~~.~~

3.~~4.~~ Holds a license in good standing, is not under investigation for an act that would constitute a violation of this chapter, and has not been found to have committed any act that would constitute a violation of this chapter.

The fees paid by any applicant for certification as a master

social worker under this section are nonrefundable.

Section 40. Subsection (3) of section 491.007, Florida Statutes, is amended to read:

491.007 Renewal of license, registration, or certificate.—

~~(3) The board or department shall prescribe by rule a method for the biennial renewal of an intern registration at a fee set by rule, not to exceed $100.~~

Section 41. Subsection (2) of section 491.009, Florida Statutes, is amended to read:

491.009 Discipline.—

(2) The board ~~department,~~ or, in the case of certified master social workers ~~psychologists~~, the department ~~board,~~ may enter an order denying licensure or imposing any of the penalties authorized in s. 456.072(2) against any applicant for licensure or any licensee who violates ~~is found guilty of violating any provision of~~ subsection (1) ~~of this section~~ or ~~who is found guilty of violating any provision of~~ s. 456.072(1).

Section 42. Subsection (2) of section 491.0046, Florida Statutes, is amended to read:

491.0046 Provisional license; requirements.—

(2) The department shall issue a provisional clinical social worker license, provisional marriage and family therapist license, or provisional mental health counselor license to each applicant who the board certifies has:

(a) Completed the application form and remitted a

nonrefundable application fee not to exceed $100, as set by board rule; and

(b) Earned a graduate degree in social work, a graduate degree with a major emphasis in marriage and family therapy or a closely related field, or a graduate degree in a major related to the practice of mental health counseling; and

(c) ~~Has~~ Met the following minimum coursework requirements:

1. For clinical social work, a minimum of 15 semester hours or 22 quarter hours of the coursework required by s. 491.005(1)(b)2.b.

2. For marriage and family therapy, 10 of the courses required by s. 491.005(3)(b)1. ~~s. 491.005(3)(b)1.a.-c.~~, as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques.

3. For mental health counseling, a minimum of seven of the courses required under s. 491.005(4)(b)1.a.-c.

Section 43. Subsection (11) of section 945.42, Florida Statutes, is amended to read:

945.42 Definitions; ss. 945.40-945.49.—As used in ss. 945.40-945.49, the following terms shall have the meanings ascribed to them, unless the context shall clearly indicate otherwise:

(11) "Psychological professional" means a behavioral

practitioner who has an approved doctoral degree in psychology as defined in s. 490.003(3) ~~s. 490.003(3)(b)~~ and is employed by the department or who is licensed as a psychologist pursuant to chapter 490.

Section 44. This act shall take effect July 1, 2020.

Amendment No. 1

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

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Rodriguez, A. M. offered the following:

Amendment (with title amendment)

Between lines 1012 and 1013, insert:

Section 22. The amendments and reenactments made by this act to sections 466.0067, 466.00671, and 466.00672, Florida Statutes, are remedial in nature and apply retroactively to January 1, 2020.

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

Remove line 69 and insert:

license; providing for retroactive applicability; amending s. 466.007, F.S.; revising

Amendment No. 2

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

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Rodriguez, A. M. offered the following:

Amendment (with title amendment)

Remove lines 299-401

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

Remove lines 24-29 and insert:

amending s. 456.013,

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		Mielke	Clark
3) Health & Human Services Committee			

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 a health care practitioner provide a printed copy of the DOH-developed pamphlet to the patient or patient's representative.

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

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[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]

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[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;

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[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:

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[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-

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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.

2. Expenditures:

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[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.

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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to nonopioid alternatives; amending s. 456.44, F.S.; revising a requirement for certain health care practitioners to inform a patient or the patient's representative of nonopioid alternatives before prescribing or ordering an opioid drug; providing an effective date.

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

Section 1. Paragraph (c) of subsection (7) of section 456.44, Florida Statutes, is amended to read:

456.44 Controlled substance prescribing.—

(7) NONOPIOID ALTERNATIVES.—

(c) Except when ~~in the provision of~~ a patient is receiving care in a hospital critical care unit or emergency department or a patient is receiving hospice services under s. 400.6095 ~~services and care, as defined in s. 395.002~~, before providing care requiring the administration of anesthesia involving the use of an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812, or prescribing or ordering ~~or prescribing, ordering, dispensing, or administering~~ an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812 for the treatment of pain, a health care practitioner who prescribes or orders an opioid

drug~~, excluding those licensed under chapter 465,~~ must:

1. Inform the patient or the patient's representative of available nonopioid alternatives for the treatment of pain, which may include nonopioid medicinal drugs or drug products, interventional procedures or treatments, acupuncture, chiropractic treatments, massage therapy, physical therapy, occupational therapy, or any other appropriate therapy as determined by the health care practitioner.

2. Discuss with the patient or the patient's representative the advantages and disadvantages of the use of nonopioid alternatives, including whether the patient is at a high risk of, or has a history of, controlled substance abuse or misuse and the patient's personal preferences.

3. Provide the patient or the patient's representative with a printed copy of the educational pamphlet described in paragraph (b).

4. Document the nonopioid alternatives considered in the patient's record.

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

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		Nobles JRN	Clark
3) Health & Human Services Committee			

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

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[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

A bill to be entitled

An act relating to recovery care services; amending s. 395.001, F.S.; revising legislative intent; amending s. 395.002, F.S.; revising and providing definitions; amending s. 395.003, F.S.; providing for licensure of recovery care centers by the Agency for Health Care Administration; creating s. 395.0171, F.S.; providing criteria for the admission of patients to recovery care centers; requiring recovery care centers to have emergency care, transfer, and discharge protocols; authorizing the agency to adopt rules; amending s. 395.1055, F.S.; conforming provisions to changes made by the act; requiring the agency to adopt rules establishing separate, minimum standards for the care and treatment of patients in recovery care centers; amending s. 395.10973, F.S.; directing the agency to enforce special-occupancy provisions of the Florida Building Code applicable to recovery care centers; amending s. 408.802, F.S.; providing applicability of the Health Care Licensing Procedures Act to recovery care centers; amending s. 408.820, F.S.; exempting recovery care centers from specified minimum licensure requirements; amending ss. 385.211, 394.4787, and 409.975, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 395.001, Florida Statutes, is amended to read:

395.001 Legislative intent.—It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, construction, maintenance, and operation of hospitals, recovery care centers, and ambulatory surgical centers by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

Section 2. Subsections (24) through (32) of section 395.002, Florida Statutes, are renumbered as subsections (26) through (34), respectively, subsections (16) and (22) are amended, and new subsections (24) and (25) are added to that section, to read:

395.002 Definitions.—As used in this chapter:

(16) "Licensed facility" means a hospital, recovery care center, or ambulatory surgical center licensed in accordance with this chapter.

(22) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital care, recovery care, or ambulatory surgical care located in such

reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07, reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

(24) "Recovery care center" means a facility the primary purpose of which is to provide recovery care services, in which a patient is admitted and discharged within 72 hours, and which is not part of a hospital.

(25) "Recovery care services" means postsurgical and postdiagnostic medical and general nursing care provided to a patient for whom acute care hospitalization is not required and uncomplicated recovery is reasonably expected. The term includes postsurgical rehabilitation services. The term does not include intensive care services, coronary care services, or critical care services.

Section 3. Paragraphs (a) and (b) of subsection (1) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to

the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital, recovery care center, or ambulatory surgical center in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital," "recovery care center," or "ambulatory surgical center" unless such facility has first secured a license under this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital," "recovery care center," or "ambulatory surgical center" as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

Section 4. Section 395.0171, Florida Statutes, is created to read:

395.0171 Recovery care center admissions; emergency care and transfer protocols; discharge planning and protocols.—

(1) Admission to a recovery care center is restricted to a patient who is in need of recovery care services and who has been certified by his or her attending or referring physician, or by a physician on staff at the facility, as medically stable

and not in need of acute care hospitalization before admission to the recovery care center.

(2) A patient may be admitted for recovery care services postdiagnosis and posttreatment or upon discharge from a hospital or an ambulatory surgical center.

(3) A recovery care center must have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital.

(4) A recovery care center must have procedures for discharge planning and discharge protocols.

(5) The agency may adopt rules to implement this section.

Section 5. Subsections (12) through (19) of section 395.1055, Florida Statutes, are renumbered as subsections (13) through (20), respectively, subsections (2) and (9) are amended, and a new subsection (12) is added to that section, to read:

395.1055 Rules and enforcement.—

(2) Separate standards may be provided for general and specialty hospitals, ambulatory surgical centers, recovery care centers, and statutory rural hospitals as defined in s. 395.602.

(9) The agency may not adopt any rule governing the design, construction, erection, alteration, modification, repair, or demolition of any public or private hospital, intermediate residential treatment facility, recovery care center, or ambulatory surgical center. It is the intent of the Legislature to preempt that function to the Florida Building

Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern hospitals, intermediate residential treatment facilities, recovery care centers, and ambulatory surgical centers.

(12) The agency shall adopt rules for recovery care centers which include fair and reasonable minimum standards for ensuring that recovery care centers have:

(a) A dietetic department, service, or other similarly titled unit, either on the premises or under contract, which shall be organized, directed, and staffed to ensure the provision of appropriate nutritional care and quality food service.

(b) Procedures to ensure the proper administration of medications. Such procedures shall address the prescribing, ordering, preparing, and dispensing of medications and appropriate monitoring of the effects of such medications on patients.

(c) A pharmacy, pharmaceutical department, or pharmaceutical service, or other similarly titled unit, on the premises or under contract.

Section 6. Subsection (3) of section 395.10973, Florida

Statutes, is amended to read:

395.10973 Powers and duties of the agency.—It is the function of the agency to:

(3) Enforce the special-occupancy provisions of the Florida Building Code which apply to hospitals, intermediate residential treatment facilities, recovery care centers, and ambulatory surgical centers in conducting any inspection authorized by this chapter and part II of chapter 408.

Section 7. Subsection (27) is added to section 408.802, Florida Statutes, to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

(27) Recovery care centers, as provided under part I of chapter 395.

Section 8. Subsection (26) is added to section 408.820, Florida Statutes, to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(26) Recovery care centers, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(10).

Section 9. Subsection (2) of section 385.211, Florida

Statutes, is amended to read:

385.211 Refractory and intractable epilepsy treatment and research at recognized medical centers.—

(2) Notwithstanding chapter 893, medical centers recognized pursuant to s. 381.925, or an academic medical research institution legally affiliated with a licensed children's specialty hospital as defined in s. 395.002(29) ~~s. 395.002(27)~~ that contracts with the Department of Health, may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC cannabis for the treatment for refractory or intractable epilepsy. The authority for recognized medical centers to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities described in this section.

Section 10. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(29) ~~s. 395.002(27)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 11. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(29) ~~s. 395.002(27)~~.

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient

nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

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

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		Nobles JRN	Clark
3) Health & Human Services Committee			

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]

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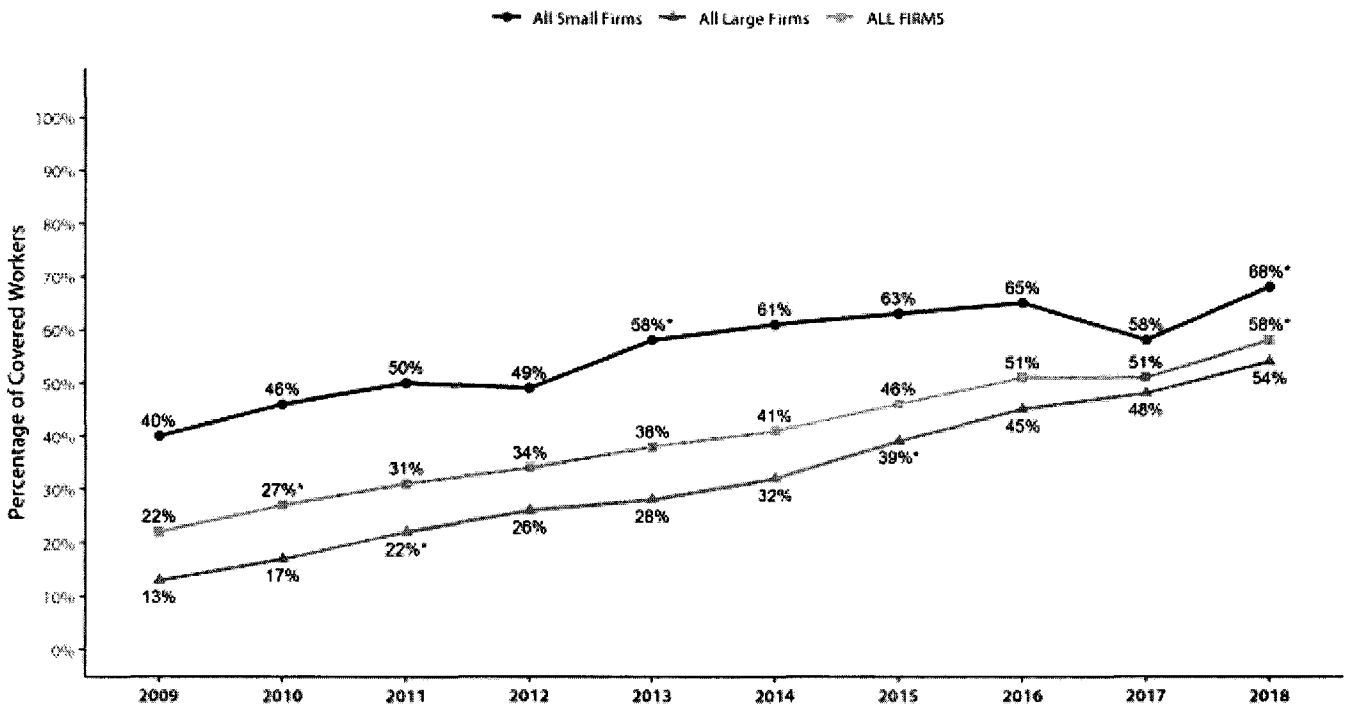
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791 (last accessed December 16, 2019).
[2] Id.
[3] Healthcare Financial Management Association, *Price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

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

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

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

National Price Transparency Studies

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

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

[9] Id.

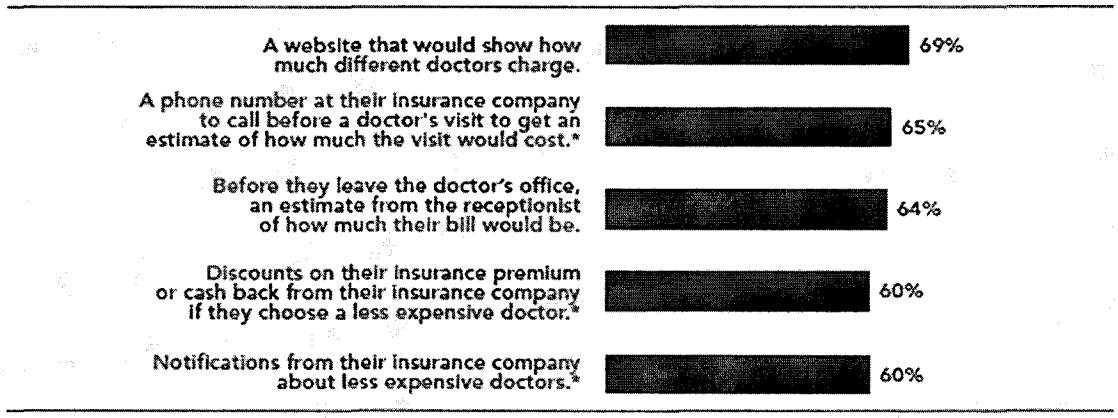
- Expand state-based all-payer health claims databases (APCDs), which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[10]

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

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

Many Americans want help managing their health care spending.

Figure 16: Percent who say the following resources would help them a lot or some with their health care spending:



Base: All respondents, N=2,010.

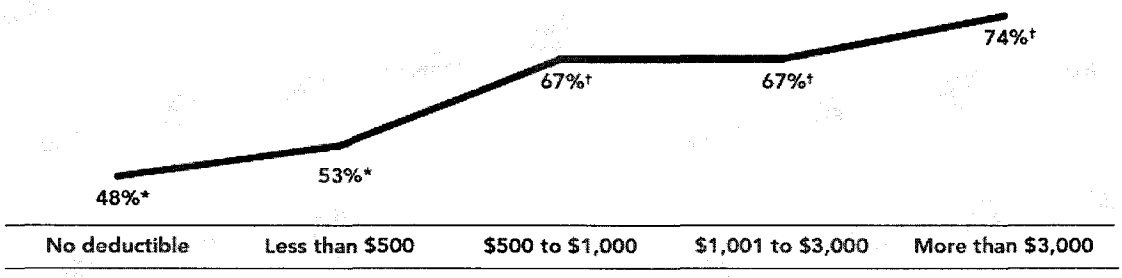
*Base: Currently have health insurance, n=1,726.

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.

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[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

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[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]

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[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:

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[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).

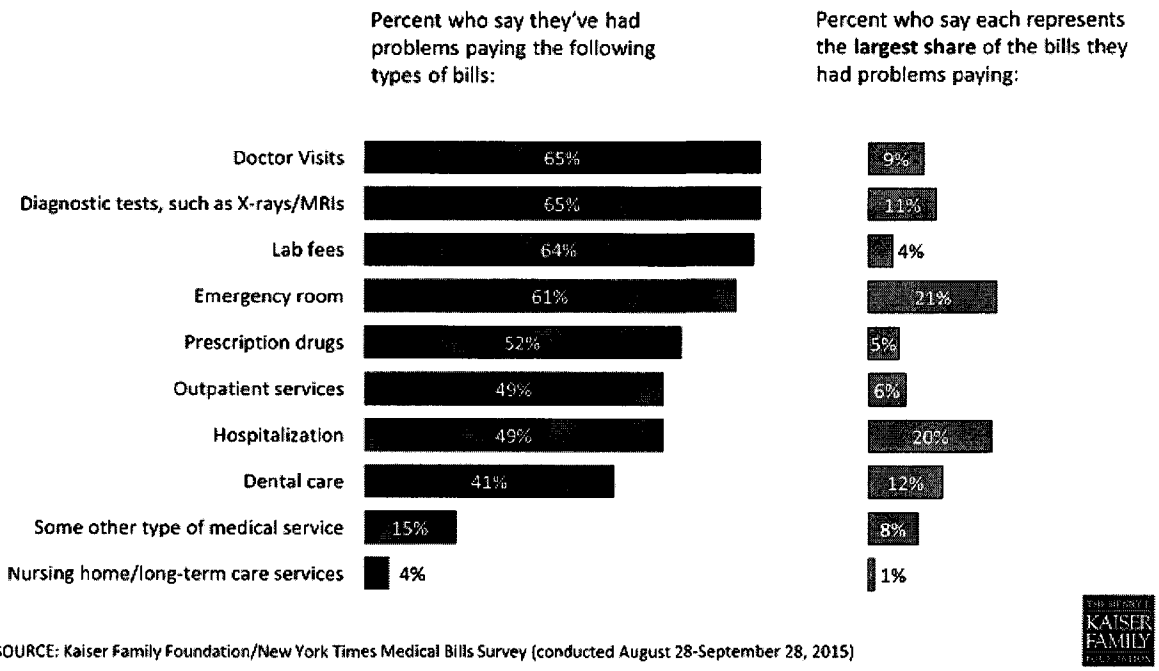
[42] The Henry J. Kaiser Family Foundation, "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." January 5, 2016. Available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/ (last accessed December 16, 2019).

[43] Id.

[44] Id.

Doctor Visits, Tests, Lab Fees Are Most Common Source of Bills, But Hospital and ER Make Up Largest Dollar Amount

AMONG THOSE WHO HAD PROBLEMS PAYING HOUSEHOLD MEDICAL BILLS IN THE PAST 12 MONTHS:



SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015)

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

A bill to be entitled

An act relating to medical billing; creating s. 222.26, F.S.; providing additional personal property exemptions from legal process for medical debts resulting from services provided in certain licensed facilities; amending s. 395.301, F.S.; requiring a licensed facility to provide a cost estimate to a patient under certain conditions; prohibiting a licensed facility from charging a patient an amount that exceeds such cost estimate by a set threshold; requiring a licensed facility to provide a patient with a written explanation of excess charges under certain circumstances; requiring a licensed facility to establish an internal grievance process for patients to dispute charges; requiring a facility to make available information necessary for initiating a grievance; requiring a facility to respond to a patient grievance within a specified timeframe; creating s. 395.3011, F.S.; prohibiting certain collection activities by a licensed facility; providing an effective date.

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

Section 1. Section 222.26, Florida Statutes, is created to

read:

222.26 Additional exemptions from legal process concerning medical debt.—If a debt is owed for medical services provided by a facility licensed under chapter 395, the following property is exempt from attachment, garnishment, or other legal process:

(1) A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle as defined in s. 320.01(1).

(2) A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption under s. 4, Art. X of the State Constitution.

Section 2. Subsection (6) of section 395.301, Florida Statutes, is renumbered as subsection (7), paragraph (b) of subsection (1) is amended, and a new subsection (6) is added to that section, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state facilities are exempt from this subsection.

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

explanation of the excess charges as part of the detailed, itemized statement or bill to the patient.

2. In the estimate, the facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. ~~Upon request,~~ The facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

~~6. The facility shall take action to educate the public that such estimates are available upon request.~~

6.~~7.~~ Failure to ~~timely~~ provide the estimate within the timeframe required in subparagraph 1. ~~pursuant to this paragraph~~ shall result in a daily fine of $1,000 until the estimate is

provided to the patient or prospective patient. The total fine may not exceed $10,000.

~~The provision of an estimate does not preclude the actual charges from exceeding the estimate.~~

(6) Each facility shall establish an internal process for reviewing and responding to grievances from patients. Such process must allow patients to dispute charges that appear on the patient's itemized statement or bill. The facility shall prominently post on its website and indicate in bold print on each itemized statement or bill the instructions for initiating a grievance and the direct contact information required to initiate the grievance process. The facility must provide an initial response to a patient grievance within 7 business days after the patient formally files a grievance disputing all or a portion of an itemized statement or bill.

Section 3. Section 395.3011, Florida Statutes, is created to read:

395.3011 Billing and collection activities.—

(1) As used in this section, the term "extraordinary collection action" means any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

(a) Selling the individual's debt to another party.

(b) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(c) Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.

(d) Actions that require a legal or judicial process, including, but not limited to:

1. Placing a lien on the individual's property;

2. Foreclosing on the individual's real property;

3. Attaching or seizing the individual's bank account or any other personal property;

4. Commencing a civil action against the individual;

5. Causing the individual's arrest; or

6. Garnishing the individual's wages.

(2) A facility shall not engage in an extraordinary collection action against an individual to obtain payment for services:

(a) Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided.

(b) Before the facility has provided the individual with an itemized statement or bill.

(c) During an ongoing grievance process as described in s. 395.301(6).

(d) Before billing any applicable insurer and allowing the insurer to adjudicate a claim.

(e) For 30 days after notifying the patient in writing, by certified mail or other traceable delivery method, that a collection action will commence absent additional action by the patient.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1147 Patient Access to Records
SPONSOR(S): Payne
TIED BILLS: **IDEN./SIM. BILLS:** SB 1882

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

SUMMARY ANALYSIS

Patient engagement in their healthcare leads to better health outcomes, reduces administrative costs and increases patient satisfaction through better communication with providers. Patient access to treatment records is necessary for active engagement to occur. The use of electronic health records, patient portals and electronic personal health records by providers and patients facilitates access and, by default engagement.

Florida has enacted laws governing patient access to records; however these laws lack standardization. The right to inspect records, whether the records have to be produced in paper form or electronically, and the timeframe to produce copies are different depending on which kind of health care facility or health care practitioner is involved.

HB 1147 allows patients, residents and legal representatives to control how they receive requested records. Health care providers and facilities may produce the requested records in paper or electronic format, upon request. However, health care providers and facilities must produce the requested records in an electronic format, including access through a web-based patient portal or submission into a patient's electronic personal health record, if the health care provider or facility maintains an electronic health recordkeeping system.

The bill also standardizes access to treatment records for patients, residents and legal representatives, excluding nursing homes residents, predominantly utilizing elements of existing law or rule. It standardizes the timeframe that health care providers and facilities must produce records or allow inspection of records. All health care practitioners and facilities must provide records within 14 days of a request. The bill also requires health care facilities and providers to allow inspection of records within 10 days.

Federal law currently requires nursing homes to provide residents with access to their records within 24 hours (excluding holidays and weekends) and a copy of any requested records within two working days of request. The bill incorporates these timelines into Florida law.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Access to Medical and Clinical Records – Federal Law

Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996, protects personal health information (PHI).[1] In 2000, the U.S. Department of Health and Human Services promulgated privacy rules which established national standards to protect medical records and other PHI.[2] These rules address, among other things, the use and disclosure of an individual's PHI.

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.[3]

HIPAA requires the disclosure of an individual's PHI to the individual who is the subject of the PHI information or his or her personal representative,[4] upon his or her request.[5] A covered entity must produce the PHI in the electronic form and format requested by the individual, if it is readily producible in such form and format.[6]

In general, HIPAA privacy rules preempt any state law that is contrary to its provisions.[7] However, if the state law is more stringent, the state law will apply.

Requirements for Long-Term Care Facilities

Access to medical and clinical records by residents of a nursing home receiving federal funding is controlled by 42 CFR s. 483.10 not HIPAA. Such nursing homes are required to provide residents with access to their records within 24 hours (excluding holidays and weekends) and a copy of any requested records within two working days of request.[8]

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[1] Pub. L. No. 104-191 (1996). Protected health information includes all individually identifiable health information held or transmitted by a covered entity or its business associate.
[2] U.S. Department of Health and Human Services, *Health Information Privacy*, available at https://www.hhs.gov/hipaa/for-professionals/privacy/index.html (last visited January 8, 2020). The rules were modified in 2002.
[3] U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule*, (last rev. May 2003), available at https://www.hhs.gov/sites/default/files/privacysummary.pdf. (last visited January 8, 2020).
[4] Supra, FN 2. A personal representative is generally a person with authority under state law to make health care decisions on behalf of an individual.
[5] Supra, FN 3. HIPAA limits the access to psychotherapy notes, certain lab results, and information compiled for legal proceedings. A covered entity may also deny access to personal health information in certain situations, such as when a health care practitioner believes access could cause harm to the individual or others.
[6] 45 CFR § 164.524(c)(2)(i).
[7] 45 C.F.R. s. 160.203.
[8] 42 CFR s. 483.10(2)(g)

Currently, all but two of the licensed nursing homes in this state receive federal funding and would be subject to these requirements.[9] The Agency for Health Care Administration cited six nursing homes for failing to meet these requirements in 2018 and five in 2019.[10]

Access to Medical and Clinical Records – Florida Law

Facilities

Chapter 408, F.S., is the core licensure act for health care facilities. Any requirement contained within this chapter applies to all health care facilities, which includes:[11]

- Laboratories authorized to perform testing under the Drug-Free Workplace Act;
- Birth centers;
- Abortion clinics;
- Crisis stabilization units;
- Short-term residential treatment facilities;
- Residential treatment facilities;
- Residential treatment centers for children and adolescents;
- Hospitals;
- Ambulatory surgical centers;
- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Nurse registries;
- Companion services or homemaker services providers;
- Adult day care centers;
- Hospices;
- Adult family-care homes;
- Homes for special services;
- Transitional living facilities;
- Prescribed pediatric extended care centers;
- Home medical equipment providers;
- Intermediate care facilities for persons with developmental disabilities;
- Health care services pools;
- Health care clinics; and,
- Multiphasic health testing centers.

Currently, Chapter 408 does not include a statute establishing standard requirements for health care facilities to produce, or allow inspection of, a patient's or resident's medical, clinical and interdisciplinary records. Rather, the requirements are in each facility licensure act and vary, sometimes greatly. Some health care facilities do not have statutory requirements related to a patient's access to records.

Hospitals, Ambulatory Surgical Centers, and Mobile Surgical Centers

After a patient has been discharged, a licensed hospital, ambulatory surgical center, and mobile surgical center (licensed facility) must, upon written request, timely provide patient records in its

[9] Correspondence from the Agency for Health Care Administration to committee staff dated March 31, 2019, on file with the Health and Human Services Committee.
[10] Correspondence from the Agency for Health Care Administration to committee staff dated January 10, 2020, on file with the Health and Human Services Committee.
[11] Ss. 408.803(11) F.S., and 408.802, F.S.

possession to the patient.[12] The records may also be released to the patient's guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of the minor, or to any other person designated in writing by such patient. A licensed facility must also allow a patient or their representative access to examine the records in its possession, but may establish reasonable terms to assure that the records will not be damaged, destroyed, or altered.[13] There is no statutorily established timeframe for when a licensed facility must provide this access.

Nursing Homes

Upon request, a nursing home must provide a competent resident with a copy of any paper and electronic records of the resident which it has in its possession.[14] Such records must include any medical records and records concerning the care and treatment of the resident performed by the nursing home, except for notes and report sections of a psychiatric nature.[15] A nursing home must provide these records within 14 days for a current resident and 30 days for a former resident.[16] A nursing home may refuse to furnish these records directly to a resident if it determines that disclosure would be detrimental to the resident's physical or mental health.[17] However, upon such a refusal, a resident may have his or her records furnished to a medical provider designated by the resident.[18]

A nursing home must also allow a resident's representative access to examine the records in its possession, but may establish reasonable terms to assure that the records will not be damaged, destroyed, or altered.[19] There is no statutorily established timeframe for when a nursing home must provide this access.

Mental Health Facilities

A clinical record is required for each patient receiving treatment for mental illness at a receiving facility[20] or treatment facility.[21] The treatment or receiving facility must release a patient's clinical records if requested by the patient, the patient's guardian or counsel or the Department of Corrections.[22] There is no statutorily timeframe for when a receiving or treatment facility must provide the requested clinical records.

Hospices

A hospice is required to release a patient's interdisciplinary record if requested by an individual authorized by the patient or by the court.[23] There is no statutorily established timeframe for when a hospice must release a patient's interdisciplinary record.

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[12] S. 395.3025, F.S. This does not apply to facilities that primarily provide psychiatric care or certain clinical records created at any licensed facility concerning certain mental health or substance abuse services.
[13] S. 395.3025(1), F.S.
[14] S. 400.145(1), F.S.
[15] Id.
[16] Id.
[17] S. 400.145(5), F.S.
[18] Id.
[19] Id.
[20] A "receiving facility" is a public or private facility or hospital designated by the Department of Children and Families to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. S. 394.455(39), F.S.
[21] S. 394.4615(1), F.S.; A "treatment facility" is a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the Department of Children and Families for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness, including facilities of the United States Government, and any private facility designated by the Department of Children and Families when rendering such services. S. 394.455(47), F.S.
[22] S. 394.4615(2), F.S.
[23] S. 400.611(3), F.S.

Practitioners

Unlike the law for health care facilities, health care practitioner law has standardized records access requirements that apply to all practitioners.[24] A practitioner must provide a copy of patient medical records to the patient if requested by the patient or his or her legal representative.[25] The patient's medical records must be released without delay for legal review.

Medical Records Held by Substance Abuse Providers

A substance abuse service provider may only release records with the written consent of the individual whom they pertain.[26] However, under limited circumstances, such as a medical emergency, the service provider may release records without the consent of the individual whom they pertain.[27] There is no statutorily established timeframe for a service provider to release requested records.

Electronic Medical Records Patient Portals

Patient portals are health care provider-owned and -operated electronic applications which give patients secure access to protected health information and allow secure methods for communicating and sharing information with health care providers.[28] These portals are typically connected to the electronic health records of a particular health care provider, practice group or institution.[29]

Portals vary in sophistication ranging from those which only allow patients to view medical records to those which allow patients to access specific-patient educational materials, schedule appointments and request prescription refills.[30] Improved access to records and health care providers can promote better informed health care decision-making and patient engagement.[31]

One of the drawbacks to patient portals is the inability of patients to have a centralized repository of their health care records. Patient portals are owned by health care providers, rather than by patients, and may not be interoperable with the electronic health records of another provider. A patient who receives treatment or services from multiple health care providers or facilities could feasibly have his or her records dispersed between multiple patient portals.

Electronic Personal Health Record

An electronic personal health record (PHR) is a patient owned electronic application through which individuals can access, manage and share health information in a private, secure and confidential

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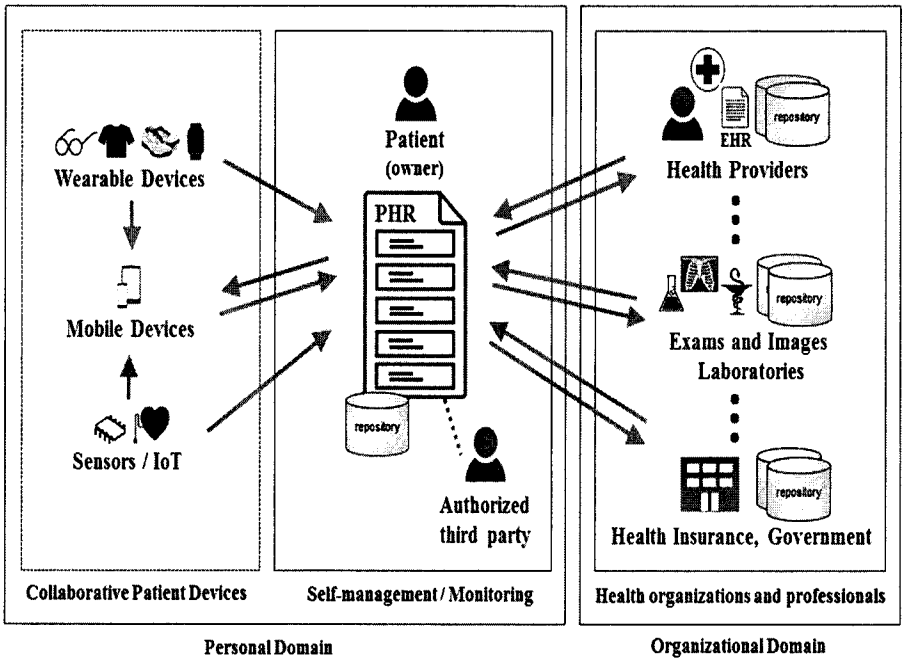
[24] A health care practitioner is any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medical practice); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathy); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry, dental hygiene, and dental laboratories); ch. 467, F.S., (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of ch. 468, F.S., (speech language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrolysis); ch. 480, F.S., (massage practice); part III or part IV of ch. 483, F.S., (clinical laboratory personnel or medical physicists); ch. 484, F.S., (dispensers of optical devices and hearing aids); ch. 486, F.S., (physical therapy practice); ch. 490, F.S., (psychological services); or ch. 491, F.S., (clinical, counseling, and psychotherapy services).
[25] S. 456.057, F.S. In lieu of copies of certain medical records related to psychiatric or psychological treatment, a practitioner may release a report of examination and treatment.
[26] S. 397.501(7)(a), F.S.
[27] Id.
[28] Kooij, Groen, van Harten, *Barriers and Facilitators Affecting Patient Portal Implementation from an Organizational Perspective: Qualitative Study*, J Med Internet Res. 2018 May; 20(5): e183, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5970285/ (last viewed January 8, 2020).
[29] Id.
[30] Griffin, Skinner, Thornhill, Weinberger, *Patient Portals: Who uses them? What features do they use? And do they reduce hospital readmissions?*, Appl Clin Inform. 2016; 7(2): 489–501, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4941855/ (last visited on January 8, 2020).
[31] Id.

environment.[32] PHRs that are offered by health plans or health care providers are subject to the HIPAA privacy rule. [33] PHRs that are offered by vendors, employers and other non-covered entities are not subject to the HIPAA privacy rule. These entities have contractual privacy policies, which may vary, but are required under federal law to notify customers in the event of a security breach.[34]

A PHR can be stand-alone or integrated. In a stand-alone PHR, the individual enters all information into the record.[35] This can be done manually by entering the medical data or by uploading medical records into the PHR. In an integrated PHR, information is submitted directly through electronic health care devices and through health care provider's electronic health records system.[36]

Integrated Personal Health Record[37]



Potential benefits of the use of a PHR, for patients, health care providers, and health care systems include:[38]

- **Empowerment of patients**. PHRs let patients verify the information in their medical record and monitor health data about themselves (very useful in chronic disease management). PHRs also provide scheduling reminders for health maintenance services.
- **Improved patient-provider relationships**. PHRs improve communication between patients and clinicians, allow documentation of interactions with patients and convey timely explanations of test results.

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[32] Tang, Ash, Bates, Overhage, and Sands, *Personal Health Records: Definitions, Benefits, and Strategies for Overcoming Barriers to Adoption*, J Am Med Inform Assoc., 2006 Mar-Apr; 13(2): 121-126, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447551/pdf/121.pdf (last visited January 8, 2020).

[33] *Personal Health Records and the HIPAA Privacy Rule*, U.S. Department of Health and Human Services, Office for Civil Rights, available at https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/healthit/phrs.pdf (last visited January 8, 2020).

[34] 16 CFR § 318.3.

[35] Id.

[36] Id.

[37] Roehrs A, da Costa CA, da Rosa Righi R, de Oliveira KSF, *Personal Health Records: A Systematic Literature Review*, J Med Internet Res 2017;19(1):e13, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5251169/ (last visited on January 8, 2020)

[38] Endsley, Kibbe, Linares, MD, Colorafi, *An Introduction to Personal Health Records*, Fam Pract Manag. 2006 May;13(5):57-62, https://www.aafp.org/fpm/2006/0500/p57.html (last visited on January 8, 2020).

- **Increased patient safety**. PHRs provide drug alerts, help identify missed procedures and services, and get important test results to patients rapidly. PHRs also give patients timely access to updated care plans.
- **Improved quality of care**. PHRs enable continuous, comprehensive care with better coordination between patients, physicians and other providers.
- **More efficient delivery of care**. PHRs help avoid duplicative testing and unnecessary services. They provide more efficient communication between patients and physicians (e.g., avoiding congested office phones).
- **Better safeguards on health information privacy**. By giving patients control of access to their records, PHRs offer more selectivity in sharing of personal health information.
- **Bigger cost savings**. Improved documentation brought about by PHRs can decrease malpractice costs. PHRs' ability to reduce duplicative tests and services is a factor here, too.

PHRs can also potentially be beneficial in ensuring continuity of care in mass evacuations situations, such as hurricanes and brushfires.[39]

There are numerous potential barriers to the adoption and use of PHRs. These include privacy and security concerns, costs, integrity, accountability, health literacy and legal and liability risk.[40]

Effect of Proposed Changes

HB 1147 allows patients, residents and legal representatives to control how they receive requested records. Health care providers and facilities may produce the requested records in paper or electronic format, upon request. However, health care providers and facilities must produce the requested records in an electronic format, including access through a web-based patient portal or submission into a patient's electronic personal health record, if the health care provider or facility maintains an electronic health recordkeeping system.

HB 1147 also standardizes access to treatment records for patients, residents and legal representatives, excluding nursing homes residents, predominantly utilizing elements of existing law or rule. It standardizes the timeframe that health care providers and facilities must produce records or allow inspection of records. All health care practitioners and facilities must provide records within 14 days of a request. The bill also requires health care facilities and providers to allow inspection of records within 10 days.

Federal law currently requires nursing homes to provide residents with access to their records within 24 hours (excluding holidays and weekends) and a copy of any requested records within two working days of request. The bill incorporates these timelines into Florida law.

The bill defines "legal representative" as a client's attorney who has been designated by the patient or resident to receive copies of the patient's or resident's medical, care and treatment, or interdisciplinary records; any legally recognized guardian of the patient or resident; any court appointed representative of the patient or resident; or any person designated by the patient or resident or by a court of competent jurisdiction to receive copies of the patient's or resident's medical, care and treatment, or interdisciplinary records. This is current definition of legal representative found in the Board of Medicine's rules.

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

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[39] Tang, Ash, Bates, Overhage, and Sands, *Personal Health Records: Definitions, Benefits, and Strategies for Overcoming Barriers to Adoption*, J Am Med Inform Assoc., 2006 Mar-Apr; 13(2): 121-126, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447551/pdf/121.pdf (last visited January 8, 2020).

[40] Vance, Tomblin, Studney, Coustasse, *Benefits and Barriers for Adoption of Personal Health Records*, 2015, https://mds.marshall.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1135&context=mgmt_faculty (last visited January 8, 2020).

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4615, F.S., relating to clinical records confidentiality.
Section 2: Amends s. 395.3025, F.S., relating to patient and personnel records.
Section 3: Amends s. 397.501, F.S., relating to rights of individuals.
Section 4: Amends s. 400.145, F.S., relating to copies of records of care and treatment of a resident.
Section 5: Creates s. 408.833, F.S., relating to client access to medical records.
Section 6: Amends s. 456.057, F.S., relating to ownership and control of patient records.
Section 7: Amends s. 316.1932, F.S., relating to tests for alcohol, chemical substances, or controlled substances.
Section 8: Amends s. 316.1933, F.S., relating to blood test for impairment or intoxication in cases of death or serious bodily injury; right to use reasonable force.
Section 9: Amends s. 395.4025, F.S., relating to trauma centers.
Section 10: Amends s. 440.185, F.S., relating to notice of injury or death.
Section 11: Provides an effective date of July 1, 2020.

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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to patient access to records; amending s. 394.4615, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request for such records; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 395.3025, F.S.; removing provisions requiring a licensed facility to furnish patient records only after discharge to conform to changes made by the act; revising provisions relating to the appropriate disclosure of patient records without consent; amending s. 397.501, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request from an individual or the individual's legal representative; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 400.145, F.S.; revising the timeframe within which a nursing home facility must provide access to and copies of resident records after receiving a request for such records; creating s. 408.833, F.S.; defining the term "legal representative"; requiring a provider to furnish and provide access to records within a specified timeframe

after receiving a request from a client or the client's legal representative; requiring that certain providers furnish such records in the manner chosen by the requester; authorizing a provider to impose reasonable terms necessary to preserve such records; providing exceptions; amending s. 456.057, F.S.; requiring certain licensed health care practitioners to furnish and provide access to copies of reports and records within a specified timeframe after receiving a request from a patient or the patient's legal representative; requiring that certain licensed health care practitioners furnish such reports and records in the manner chosen by the requester; providing a definition; authorizing such licensed health care practitioners to impose reasonable terms necessary to preserve such reports and records; amending ss. 316.1932, 316.1933, 395.4025, 429.294, and 440.185, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (3) through (11) of section 394.4615, Florida Statutes, are renumbered as subsections (4) through (12), respectively, and a new subsection (3) is added to

that section, to read:

394.4615 Clinical records; confidentiality.—

(3) Within 14 working days after receiving a request made in accordance with paragraphs (2)(a)-(c), a service provider must furnish clinical records in its possession. A service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider who maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

Section 2. Subsections (4) through (11) of section 395.3025, Florida Statutes, are renumbered as subsections (2) through (9), respectively, and subsections (1), (2), and (3), paragraph (e) of present subsection (4), paragraph (a) of present subsection (7), and present subsection (8) of that section, are amended to read:

395.3025 Patient and personnel records; copy costs ~~copies~~; examination.—

(1) ~~Any licensed facility shall, upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment or treated thereat, or to any such person's guardian, curator, or personal representative, or~~

~~in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided the person requesting such records agrees to pay a charge.~~ The exclusive charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. ~~The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed, or altered.~~

~~(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other~~

~~licensed facility which are governed by the provisions of s. 394.4615.~~

~~(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.~~

(2)~~(4)~~ Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:

(e) The Department of Health ~~agency~~ upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department ~~agency~~ and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department ~~agency~~ requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department ~~agency~~ or the appropriate regulatory board. However, the department ~~agency~~ must make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

(5)~~(7)~~(a) If the content of any record of patient treatment is provided under this section, the recipient~~, if other than the patient or the patient's representative,~~ may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(6)~~(8)~~ Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (2) and (3) ~~(1)-(5)~~.

Section 3. Paragraphs (a) through (j) of subsection (7) of section 397.501, Florida Statutes, are redesignated as paragraphs (c) through (l), respectively, and new paragraphs (a) and (b) are added to that subsection, to read:

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

(7) RIGHT TO ACCESS AND CONFIDENTIALITY OF INDIVIDUAL RECORDS.—

(a) Within 14 working days after receiving a written request from an individual or an individual's legal representative, a service provider shall furnish a true and correct copy of all records in the possession of the service provider. A service provider may furnish the requested records in paper form or, upon request, in an electronic format. A service provider who maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record. For the purpose of this section, the term "legal representative" has the same meaning as provided in s. 408.833.

(b) Within 10 working days after receiving such a request from an individual or an individual's legal representative, a service provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 4. Subsection (1) of section 400.145, Florida Statutes, is amended to read:

400.145 Copies of records of care and treatment of resident.—

(1) Upon receipt of a written request that complies with

the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this section, a nursing home facility shall furnish to a competent resident, or to a representative of that resident who is authorized to make requests for the resident's records under HIPAA or subsection (2), copies of the resident's paper and electronic records that are in possession of the facility. Such records must include any medical records and records concerning the care and treatment of the resident performed by the facility, except for progress notes and consultation report sections of a psychiatric nature. The facility shall provide a resident with access to the requested records within 24 hours, excluding weekends and holidays, and provide copies of the requested records within 2 ~~14~~ working days after receipt of a request relating to a current resident or within 30 working days after receipt of a request relating to a former resident.

Section 5. Section 408.833, Florida Statutes, is created to read:

408.833 Client access to medical records.—

(1) For the purpose of this section, the term "legal representative" means an attorney who has been designated by a client to receive copies of the client's medical, care and treatment, or interdisciplinary records; a legally recognized guardian of the client; a court-appointed representative of the client; or a person designated by the client or by a court of

competent jurisdiction to receive copies of the client's medical, care and treatment, or interdisciplinary records.

(2) Within 14 working days after receiving a written request from a client or client's legal representative, a provider shall furnish a true and correct copy of all records, including medical, care and treatment, and interdisciplinary records, as applicable, in the possession of the provider. A provider may furnish the requested records in paper form or, upon request, in an electronic format. A provider who maintains an electronic health record system shall furnish the requested records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

(3) Within 10 working days after receiving a request from a client or a client's legal representative, a provider shall provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

(4) This section does not apply to:

(a) Records maintained at a licensed facility, as defined in s. 395.002, the primary function of which is to provide psychiatric care to its patients, or to records of treatment for

any mental or emotional condition at any other licensed facility which are governed by s. 394.4615;

(b) Records of substance abuse impaired persons which are governed by s. 397.501; or

(c) Records of a resident of a nursing home facility.

Section 6. Subsection (6) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(6)(a) Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any patient ~~person~~ shall, upon request of such patient ~~person~~ or the patient's ~~person's~~ legal representative, furnish, within 14 working days after such request ~~in a timely manner, without delays for legal review~~, copies of all reports and records relating to such examination or treatment, including X-rays ~~X rays~~ and insurance information. A health care practitioner may furnish the requested reports and records in paper form or, upon request, in an electronic format. A health care practitioner who maintains an electronic health record system shall furnish the requested reports and records in the manner chosen by the requester which must include electronic format, access through a web-based patient portal, or submission

through a patient's electronic personal health record. For the purpose of this section, the term "legal representative" means a patient's attorney who has been designated by the patient to receive copies of the patient's medical records, a legally recognized guardian of the patient, a court-appointed representative of the patient, or any other person designated by the patient or by a court of competent jurisdiction to receive copies of the patient's medical records.

(b) Within 10 working days after receiving a written request by a patient or a patient's legal representative, a healthcare practitioner must provide access to examine the original reports and records, or microforms or other suitable reproductions of the reports and records in the healthcare practitioner's possession. The healthcare practitioner may impose any reasonable terms necessary to ensure that the reports and records will not be damaged, destroyed, or altered.

(c) ~~However,~~ When a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies may ~~shall~~ not be conditioned upon payment of a fee for services rendered.

Section 7. Paragraph (f) of subsection (1) of section 316.1932, Florida Statutes, is amended to read:

316.1932 Tests for alcohol, chemical substances, or controlled substances; implied consent; refusal.—

(1)

(f)1. The tests determining the weight of alcohol in the defendant's blood or breath shall be administered at the request of a law enforcement officer substantially in accordance with rules of the Department of Law Enforcement. Such rules must specify precisely the test or tests that are approved by the Department of Law Enforcement for reliability of result and ease of administration, and must provide an approved method of administration which must be followed in all such tests given under this section. However, the failure of a law enforcement officer to request the withdrawal of blood does not affect the admissibility of a test of blood withdrawn for medical purposes.

2.a. Only a physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, acting at the request of a law enforcement officer, may withdraw blood for the purpose of determining its alcoholic content or the presence of chemical substances or controlled substances therein. However, the failure of a law enforcement officer to request the withdrawal of blood does not affect the admissibility of a test

of blood withdrawn for medical purposes.

b. Notwithstanding any provision of law pertaining to the confidentiality of hospital records or other medical records, if a health care provider, who is providing medical care in a health care facility to a person injured in a motor vehicle crash, becomes aware, as a result of any blood test performed in the course of that medical treatment, that the person's blood-alcohol level meets or exceeds the blood-alcohol level specified in s. 316.193(1)(b), the health care provider may notify any law enforcement officer or law enforcement agency. Any such notice must be given within a reasonable time after the health care provider receives the test result. Any such notice shall be used only for the purpose of providing the law enforcement officer with reasonable cause to request the withdrawal of a blood sample pursuant to this section.

c. The notice shall consist only of the name of the person being treated, the name of the person who drew the blood, the blood-alcohol level indicated by the test, and the date and time of the administration of the test.

d. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act affects the authority to provide notice under this section, and the health care provider is not considered to have breached any duty owed to the person under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act by providing notice or failing to

provide notice. It shall not be a breach of any ethical, moral, or legal duty for a health care provider to provide notice or fail to provide notice.

e. A civil, criminal, or administrative action may not be brought against any person or health care provider participating in good faith in the provision of notice or failure to provide notice as provided in this section. Any person or health care provider participating in the provision of notice or failure to provide notice as provided in this section shall be immune from any civil or criminal liability and from any professional disciplinary action with respect to the provision of notice or failure to provide notice under this section. Any such participant has the same immunity with respect to participating in any judicial proceedings resulting from the notice or failure to provide notice.

3. The person tested may, at his or her own expense, have a physician, registered nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, or other person of his or her own choosing administer an independent test in addition to the test administered at the direction of the law enforcement officer for the purpose of determining the amount of alcohol in the person's blood or breath or the presence of chemical substances or controlled substances at the time alleged, as shown by chemical analysis of his or her blood or

urine, or by chemical or physical test of his or her breath. The failure or inability to obtain an independent test by a person does not preclude the admissibility in evidence of the test taken at the direction of the law enforcement officer. The law enforcement officer shall not interfere with the person's opportunity to obtain the independent test and shall provide the person with timely telephone access to secure the test, but the burden is on the person to arrange and secure the test at the person's own expense.

4. Upon the request of the person tested, full information concerning the results of the test taken at the direction of the law enforcement officer shall be made available to the person or his or her attorney. Full information is limited to the following:

a. The type of test administered and the procedures followed.

b. The time of the collection of the blood or breath sample analyzed.

c. The numerical results of the test indicating the alcohol content of the blood and breath.

d. The type and status of any permit issued by the Department of Law Enforcement which was held by the person who performed the test.

e. If the test was administered by means of a breath testing instrument, the date of performance of the most recent

required inspection of such instrument.

Full information does not include manuals, schematics, or software of the instrument used to test the person or any other material that is not in the actual possession of the state. Additionally, full information does not include information in the possession of the manufacturer of the test instrument.

5. A hospital, clinical laboratory, medical clinic, or similar medical institution or physician, certified paramedic, registered nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, or other person assisting a law enforcement officer does not incur any civil or criminal liability as a result of the withdrawal or analysis of a blood or urine specimen, or the chemical or physical test of a person's breath pursuant to accepted medical standards when requested by a law enforcement officer, regardless of whether or not the subject resisted administration of the test.

Section 8. Paragraph (a) of subsection (2) of section 316.1933, Florida Statutes, is amended to read:

316.1933 Blood test for impairment or intoxication in cases of death or serious bodily injury; right to use reasonable force.—

(2)(a) Only a physician, certified paramedic, registered

nurse, licensed practical nurse, other personnel authorized by a hospital to draw blood, or duly licensed clinical laboratory director, supervisor, technologist, or technician, acting at the request of a law enforcement officer, may withdraw blood for the purpose of determining the alcoholic content thereof or the presence of chemical substances or controlled substances therein. However, the failure of a law enforcement officer to request the withdrawal of blood shall not affect the admissibility of a test of blood withdrawn for medical purposes.

1. Notwithstanding any provision of law pertaining to the confidentiality of hospital records or other medical records, if a health care provider, who is providing medical care in a health care facility to a person injured in a motor vehicle crash, becomes aware, as a result of any blood test performed in the course of that medical treatment, that the person's blood-alcohol level meets or exceeds the blood-alcohol level specified in s. 316.193(1)(b), the health care provider may notify any law enforcement officer or law enforcement agency. Any such notice must be given within a reasonable time after the health care provider receives the test result. Any such notice shall be used only for the purpose of providing the law enforcement officer with reasonable cause to request the withdrawal of a blood sample pursuant to this section.

2. The notice shall consist only of the name of the person being treated, the name of the person who drew the blood, the

blood-alcohol level indicated by the test, and the date and time of the administration of the test.

3. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act affects the authority to provide notice under this section, and the health care provider is not considered to have breached any duty owed to the person under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any applicable practice act by providing notice or failing to provide notice. It shall not be a breach of any ethical, moral, or legal duty for a health care provider to provide notice or fail to provide notice.

4. A civil, criminal, or administrative action may not be brought against any person or health care provider participating in good faith in the provision of notice or failure to provide notice as provided in this section. Any person or health care provider participating in the provision of notice or failure to provide notice as provided in this section shall be immune from any civil or criminal liability and from any professional disciplinary action with respect to the provision of notice or failure to provide notice under this section. Any such participant has the same immunity with respect to participating in any judicial proceedings resulting from the notice or failure to provide notice.

Section 9. Subsection (13) of section 395.4025, Florida Statutes, is amended to read:

395.4025 Trauma centers; selection; quality assurance; records.—

(13) Patient care, transport, or treatment records or reports, or patient care quality assurance proceedings, records, or reports obtained or made pursuant to this section, s. 395.3025(2)(f) ~~s. 395.3025(4)(f)~~, s. 395.401, s. 395.4015, s. 395.402, s. 395.403, s. 395.404, s. 395.4045, s. 395.405, s. 395.50, or s. 395.51 must be held confidential by the department or its agent and are exempt from the provisions of s. 119.07(1). Patient care quality assurance proceedings, records, or reports obtained or made pursuant to these sections are not subject to discovery or introduction into evidence in any civil or administrative action.

Section 10. Subsection (1) of section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 408.833 ~~s. 400.145~~, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 11. Subsection (4) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(4) Additional reports with respect to such injury and of the condition of such employee, including copies of medical reports, funeral expenses, and wage statements, shall be filed by the employer or carrier to the department at such times and in such manner as the department may prescribe by rule. In carrying out its responsibilities under this chapter, the department or agency may by rule provide for the obtaining of any medical records relating to medical treatment provided pursuant to this chapter, notwithstanding the provisions of ss. 90.503 and 395.3025(2) ~~395.3025(4)~~.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 6059 Specialty Hospitals
SPONSOR(S): Fitzenhagen
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	9 Y, 4 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee		Nobles JRN	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A specialty hospital, rather than treating all conditions for all populations as a general hospital does, instead offers:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.

Florida law bans certain types of specialty hospitals. It prohibits licensure of a hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties; or for which more than 65 percent of discharges are for care of certain cardiac, orthopedic, or cancer-related diseases and disorders.

The bill repeals the prohibition on licensure of a specialty hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties; or for which more than 65% of discharges are for care of certain cardiac, orthopedic, or cancer-related diseases and disorders.

Due to federal law, this repeal would have no impact on specialty hospitals that are partly or wholly owned by physicians.

The bill does not appear to have a fiscal impact local government, but does have a negative fiscal impact to the Agency for Health Care Administration.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Licensure

Hospitals are regulated by AHCA under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[2]

Hospitals must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is $1,565.13 per hospital or $31.46 per bed, whichever is greater.[3] The inspection fee is $8.00 to $12.00 per bed, but at a minimum $400.00 per facility.[4]

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.[5] The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.
- All hospitals submit such data as necessary to conduct certificate-of-need reviews required under part I of chapter 408, F.S.;
- Each hospital has a quality improvement program designed according to standards established by their current accrediting organization;
- Licensed facilities make available on their internet websites, and in a hard copy format upon request, a description of and a link to the patient charge and performance outcome data collected from licensed facilities;
- All hospitals providing organ transplantation, neonatal intensive care services, inpatient psychiatric services, inpatient substance abuse services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by the agency.[6]

The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

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[1] S.395.002(12), F.S.
[2] Id.
[3] Rule 59A-3.066(3), F.A.C.
[4] S. 395.0161(3)(a), F.S.
[5] S. 395.1055(2), F.S.
[6] S. 395.1055(1), F.S.

Specialty Hospitals

A specialty hospital, rather than treating all conditions for all populations as a general hospital does, instead offers:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.[7]

Specialty hospitals may not provide any service or regularly serve any population group other than those services or groups specified in its license.[8]

Florida law bans certain types of specialty hospitals.[9] Florida law prohibits the licensure of a hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties.[10] Florida law also prohibits the licensure of hospitals if 65 percent of more of the hospital's discharges are for the diagnostic care and treatment of patients who have:

- Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5[11];
- Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8[12];
- Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or antineoplastic chemotherapy or immunotherapy; or
- Any combination of the above discharges.[13]

Florida law exempts from the ban hospitals classified as an exempt cancer center hospital pursuant to federal rule 42 C.F.R. s. 412.23(f)[14] as of December 31, 2005.[15] Two hospitals qualify for this exemption: H. Lee Mofitt Cancer and Research Institute Hospital, Inc., and the University of Miami Hospital and Clinics.[16]

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[7] S. 395.002(27), F.S.
[8] S. 395.003(6)(a), F.S.
[9] S. 395.003(8), F.S.
[10] S. 395.003(8)(b), F.S
[11] Major Diagnostic Category 5 is for diseases and disorders of the circulatory system.
[12] Major Diagnostic Category 8 is for diseases and disorders of the musculoskeletal system and connective tissue.
[13] S. 395.003(8)(a), F.S
[14] 42 C.F.R., s. 412.23(f)(1) *General Rule*- If a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems: (i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983; (ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a state operating a demonstration project, the classification is made on or before December 31, 1991; (iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center; and (iv) It shows that at least 50% of its total discharges have a principal diagnosis that reflects a finding or neoplastic disease.
(2) *Alternative*- A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria in paragraph (f)(1) above is classified as a cancer hospital and is excluded from the prospective payment systems if it meets the criteria set forth in paragraph (f)(1)(i) above and the hospital is: (i) Licensed for fewer than 50 acute care beds as of August 5, 1997; (ii) Is located in a state that as of December 19, 1989, was not operating a demonstration project; and (iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50% of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease.
[15] S. 395.003(8)(c), F.S
[16] Centers for Medicare & Medicaid Services, *PPS-Exempt Cancer Hospitals*, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp (last viewed December 19, 2019).

Florida law also exempts from the ban a hospital licensed as of June 1, 2004, if the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004.[17] H. Lee Mofitt Cancer and Research Institute Hospital, Inc., also qualifies for this exemption.

Physician Owned Hospitals

Under the federal Patient Protection and Affordable Care Act (PPACA), Medicare-certified hospitals that are partly or wholly owned by physicians as of December 31, 2010, are barred from increasing their aggregate percentage of physician ownership and expanding their number of operating and procedure rooms and beds unless they qualify for an exemption. Federal law also prohibits physicians from referring Medicaid or Medicare patients to any hospital in which they have an ownership share if the hospital was formed after December 31, 2010. A study of physician-owned hospitals found that the ban on Medicare and Medicaid reimbursement effectively banned the formation of new physician-owned hospitals.[18]

Effect of Proposed Changes

Specialty Hospitals

The bill repeals the prohibition on the licensure of a hospital that restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties. The bill also repeals the prohibition on the licensure of specialty hospitals whose discharges are over 65 percent or more of the following:

- Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5;
- Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8;
- Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or antineoplastic chemotherapy or immunotherapy; or
- Any combination of the above discharges.

As a result, non-physician-owned specialty hospitals would be permitted to dedicate up to 100 percent of their services to the diagnosis and treatment of cardiac, orthopedic, or cancer related diseases and disorders, and new specialty hospitals could be licensed.

Due to the PPACA ban on physician-owned hospitals, the bill would not result in additional physician-owned specialty hospitals.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 2: Provides an effective date of July 1, 2020.

[17] S. 395.003(9), F.S.
[18] Elizabeth Plummer and William Wempe, *The Affordable Care Act's Effects on the Formation, Expansion, and Operation of Physician Owned Hospitals*, Health Affairs 2016; 35(8). Prior to the restrictions going into effect, there was a surge in the formation of physician owned hospitals in Texas that receded almost immediately afterwards. Between 2004 and 2009, 64 new physician owned hospitals were formed, representing just under 66% of all new for-profit hospitals in the state. In 2010, 20 new physician-owned hospitals were formed, amounting to more than 83% of new Texas hospitals. From 2011 through 2013, after the restrictions went into effect, only 9 new physician owned hospitals were formed, accounting for 41% of new for-profit hospitals. As of June 2016, all physician owned hospitals formed after 2011 were either sold or in bankruptcy proceedings.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Applicants for licensure as a specialty hospital will be subject to the current Plans and Construction project review fee of $2,000[19] plus $100 per hour for building plan reviews[20], an application fee of at least $1,500[21], and a licensure inspection fee of $400[22].

   Licensure and inspection fees would be collected every two years.

2. Expenditures:

   The number of hospitals that might seek licensure as a specialty hospital is unknown. AHCA has indicated that as a result of the potential increased workload, additional FTEs will be needed for the bureau to continue to perform plans review timely.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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[19] S. 395.0163(2), F.S.
[20] Id.
[21] Rule 59A-3.066(3), F.A.C.
[22] Rule 59A-3.253(4), F.A.C.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to specialty hospitals; amending s. 395.003, F.S.; removing provisions relating to the prohibition of licensure for certain hospitals that serve specific populations; providing an effective date.

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

Section 1. Subsections (8), (9), and (10) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

~~(8) A hospital may not be licensed or relicensed if:~~

~~(a) The diagnosis-related groups for 65 percent or more of the discharges from the hospital, in the most recent year for which data is available to the Agency for Health Care Administration pursuant to s. 408.061, are for diagnosis, care, and treatment of patients who have:~~

~~1. Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5;~~

~~2. Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8;~~

~~3. Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or~~

~~antineoplastic chemotherapy or immunotherapy; or~~

~~4. Any combination of the above discharges.~~

~~(b) The hospital restricts its medical and surgical services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties.~~

~~(c) A hospital classified as an exempt cancer center hospital pursuant to 42 C.F.R. s. 412.23(f) as of December 31, 2005, is exempt from the licensure restrictions of this subsection.~~

~~(9) A hospital licensed as of June 1, 2004, shall be exempt from subsection (8) as long as the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004. Any transfer of beds, or other agreements that result in the establishment of a hospital or hospital services within the intent of this section, shall be subject to subsection (8). Unless the hospital is otherwise exempt under subsection (8), the agency shall deny or revoke the license of a hospital that violates any of the criteria set forth in that subsection.~~

~~(10) The agency may adopt rules implementing the licensure requirements set forth in subsection (8). Within 14 days after rendering its decision on a license application or revocation, the agency shall publish its proposed decision in the Florida Administrative Register. Within 21 days after publication of the agency's decision, any authorized person may file a request for~~

~~an administrative hearing. In administrative proceedings challenging the approval, denial, or revocation of a license pursuant to subsection (8), the hearing must be based on the facts and law existing at the time of the agency's proposed agency action. Existing hospitals may initiate or intervene in an administrative hearing to approve, deny, or revoke licensure under subsection (8) based upon a showing that an established program will be substantially affected by the issuance or renewal of a license to a hospital within the same district or service area.~~

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

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Fitzenhagen offered the following:

Amendment (with title amendment)

Between lines 60 and 61, insert:

For the 2020-2021 fiscal year, 2.0 full-time equivalent positions, with associated salary rate of 128,000, are authorized and the sums of $211,290 in recurring and $18,294 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing this act.

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

Amendment No. 1

Remove lines 5-6 and insert:

serve specific populations; providing an appropriation; providing an effective date.

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		Nobles JRN	Clark

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

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		Nobles	Clark

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

A bill to be entitled

An act relating to recovery care center fees; amending s. 395.003, F.S.; providing for licensure of recovery care centers by the Agency for Health Care Administration; amending s. 408.802, F.S.; adding recovery care centers to the entities licensed, registered, or certified by the agency; providing a contingent effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (1) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital, recovery care center, or ambulatory surgical center in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital," "recovery care center," or "ambulatory surgical

center" unless such facility has first secured a license under this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital," "recovery care center," or "ambulatory surgical center" as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

Section 2. Subsection (27) is added to section 408.802, Florida Statutes, to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

(27) Recovery care centers, as provided under part I of chapter 395.

Section 3. This act shall take effect on the same date that HB 827 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.