Health Care Appropriations Subcommittee

Tuesday, February 04, 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, February 04, 2020 12:00 pm
End Date and Time:	Tuesday, February 04, 2020 03:00 pm
Location:	Sumner Hall (404 HOB)
Duration:	3.00 hrs

Consideration of the following bill(s):

HB 163 Homelessness by Altman
HB 559 Institutional Formularies Established by Nursing Home Facilities by Byrd
CS/HB 767 Assisted Living Facilities by Health Market Reform Subcommittee, Grant, M.
HB 833 Program of All-Inclusive Care for the Elderly by Rommel
CS/HB 945 Children's Mental Health by Children, Families & Seniors Subcommittee, Silvers
HB 1183 Home Medical Equipment Providers by Maggard
HB 1273 Dentistry and Dental Hygiene by Buchanan
HB 1341 Massage Therapy by Goff-Marcil
HB 1443 Certification for Prescriptive Authority by Santiago
HB 6031 Florida Kidcare Program by Pigman

NOTICE FINALIZED on 01/31/2020 4:10PM by SPB

The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Jose Oliva
Speaker

MaryLynn Magar
Chair

AGENDA
Tuesday, February 04, 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 bill(s):**

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IV. **Closing Remarks/Adjournment**

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 163 Homelessness
SPONSOR(S): Altman & others
TIED BILLS: **IDEN./SIM. BILLS:** SB 68

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

SUMMARY ANALYSIS

The Office of Homelessness (State Office) in the Department of Children and Families (DCF) provides coordination on issues relating to homelessness. DCF is required to establish local coalitions of providers, government entities, businesses and other parties which plan, network, coordinate, and monitor the delivery of services to the homeless.

Local agencies address homelessness through services planned and carried out at the local level. Many agencies receive funding through the federal Department of Housing and Urban Development (HUD), based on a federal definition of "homeless" and compliance with various federal requirements relating to formation and operation of continuums of care, information technology systems, and priority populations for use of grant funds.

The State Office's roles include but are not limited to awarding state funded grants.

HB 163 revises the state's approach to homelessness by adopting the federal definition for "homeless" and aligning other state requirements with HUD requirements. The bill also changes the roles of the State Office and the requirements for its award of challenge grants and grants-in-aid. For instance, the bill reduces the amount of matching funds or in-kind support required for a challenge grant recipient from 100% to 25%, increases the maximum percentage of grant funds that a Continuum of Care lead agency may spend on its administrative costs from 8% to 10%, and changes preference for funding to be to lead agencies for continuums of care that have a demonstrated ability to move households out of homelessness.

The 17-member Council on Homelessness develops recommendations on how to reduce homelessness statewide and advises the State Office. HB 163 adds a representative each from the Florida Housing Coalition and the Department of Elder Affairs to the council.

The bill amends sections of law outlining two approaches to housing services, Rapid ReHousing and Housing First. It requires that individuals and families being considered for Rapid ReHousing assistance be assessed and prioritized through the continuum of care's coordinated entry system. The bill also removes the program element indicating a benefit for an individual to have a background check and complete rehabilitation for any addiction to substances when participating in Housing First services.

The bill does not appear to have a fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Homelessness

In 1987, Congress enacted the Stewart B. McKinney Homeless Assistance Act, which created a number of new grant programs to address the needs of the homeless, including food, shelter, health care, and education.[1] In 2000, the Act was renamed the McKinney-Vento Homeless Assistance Act.[2] At that time, the McKinney-Vento Act's definition of "homeless"[3] was sometimes described as requiring an individual to be literally homeless in order to receive assistance.[4] In 2009, Congress enacted the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. The HEARTH Act amended the definition of "homeless" to include:

- An individual or family who lacks a fixed, regular, and adequate nighttime residence;
- An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements, including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing; and
- An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided.[5]

Additional changes made by the HEARTH Act to the definition of "homeless" transition from the literal meaning of homelessness toward housing instability as a form of homelessness. It now includes situations where a person is at imminent risk of homelessness or where a family or unaccompanied youth is living unstably. Imminent risk includes situations where a person must leave their current housing within 14 days with no other place to go and no resources or support networks to obtain housing. Instability includes families with children and unaccompanied youth who:

- Are defined as homeless under other federal programs;
- Have experienced a long-term period without living independently in permanent housing;
- Have moved frequently; and
- Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.[6]

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[1] The Stewart B. McKinney Homeless Assistance Act of 1987, Pub. L. 100-77, July 22, 1987, 101 Stat. 482, 42 U.S.C. § 11301.
[2] The McKinney-Vento Homeless Assistance Act Pub. L. 106-400, October 30, 2000, 114 Stat. 1675, 42 U.S.C. § 11301.
[3] 42 U.S.C. § 11302 (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is—(A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
[4] See, for example, the Department of Housing and Urban Development, *The Third Annual Homeless Assessment Report to Congress*, July 2008, p. 2, footnote 5, http://www.hudhre.info/documents/3rdHomelessAssessmentReport.pdf
[5] 42 U.S.C. § 11302(a).
[6] Id.

Section 420.621, F.S., defines "homeless" as an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:

- Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
- Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;
- Is living in an emergency or transitional shelter;
- Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;
- Is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or
- Is a migratory individual who qualifies as homeless because he or she is living in any of the circumstances described above.[7]

During the 2019 point in time count, 28,591 individuals who are homeless were identified in Florida.[8] This included 16,111 sheltered individuals and 12,480 unsheltered individuals.[9] Individuals in homeless households-including at least one adult and one child—comprised 7,287 of these individuals, or 25.5% of the total.[10] The 2019 point in time count represents a reduction of 1,126 individuals identified as homeless in the 2018 point in time count. Since 2015, the number of people experiencing homelessness in Florida has decreased by 20%.[11]

Federal Homeless Programs

The Homeless Assistance Grants, administered by the federal Department of Housing and Urban Development (HUD), were first authorized by Congress in 1987 as part of the Stewart B. McKinney Homeless Assistance Act.[12] There were four programs authorized and funded by Congress: the Emergency Shelter Grants program; the Supportive Housing (SHP) program; the Shelter Plus Care (S+C) program; and the Section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings (SRO) program. Funds for the Emergency Shelter Grants program were used primarily for the short-term needs of homeless persons, such as emergency shelter, while the other three programs addressed longer-term transitional and permanent housing needs.

In 2009, the HEARTH Act made a variety of changes to the federal approach to funding homeless services. The HEARTH Act changed the makeup of the four existing grants by combining the SHP, S+C, and SRO programs into one grant called the Continuum of Care (CoC) program; renaming the Emergency Shelter Grants program as the Emergency Solutions Grants (ESG) program; and creating the Rural Housing Stability Assistance program (RHS) to provide rural communities the option of competing for funds.[13]

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[7] The term does not include an individual imprisoned pursuant to state or federal law or individuals or families who are sharing housing due to cultural preferences, voluntary arrangements, or traditional networks of support. The terms include an individual who has been released from jail, prison, the juvenile justice system, the child welfare system, a mental health and developmental disability facility, a residential addiction treatment program, or a hospital, for whom no subsequent residence has been identified, and who lacks the resources and support network to obtain housing.

[8] Department of Children and Families, Council on Homelessness Annual Report 2019, p. 3, available at https://myflfamilies.com/service-programs/homelessness/docs/2019CouncilReport.pdf (last visited October 20, 2019).

[9] *Supra,* note 8 at 47.

[10] *Supra,* note 8 at 49.

[11] *Supra,* note 8 at 3.

[12] *Supra,* note 1.

[13] Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009, Pub. L. 111-22, May 20, 2009, 123 Stat. 1632, 42 U.S.C. §§ 11301-11481.

Emergency Solutions Grants Program

Funds from the ESG program are distributed by HUD to grantee states and local communities to assist those experiencing homelessness. ESG funds may be used for five program components:

- Street outreach;[14]
- Emergency shelter;[15]
- Homelessness prevention;[16]
- Rapid rehousing assistance;[17] and
- Homeless Management Information Systems and administrative activities.[18]

Recipients of ESG funds must make matching contributions in an amount equal to the recipient's fiscal year grant received.[19] Over the past three years, Florida has received a total of $41,453,435 in ESG funds from HUD, including: $12,613,662 in 2019; $12,005,522 in 2018; and $16,834,251 in 2017.[20]

Continuum of Care Program

The purpose of the HUD CoC program is to:

- Promote communitywide commitment to the goal of ending homelessness;
- Provide funding efforts by nonprofit providers, States, and local governments to quickly rehouse homeless individuals and families, while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness;
- Promote access to and effective utilization of mainstream programs by homeless individuals and families; and
- Optimize self-sufficiency among individuals and families experiencing homelessness.[21]

HUD considers a Continuum of Care or Continuum to mean a group organized to carry out certain responsibilities that is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate.[22]

The responsibilities required by HUD of a Continuum of Care include developing a plan to coordinate the implementation of a housing and service system within its geographic area that meets the needs of

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[14] 24 C.F.R. § 576.101(a) authorizes ESG funds to be used for costs of providing essential services necessary to reach out to unsheltered homeless people; connect them with emergency shelter, housing, or critical services; and provide urgent, nonfacility-based care to unsheltered homeless people who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility.

[15] 24 C.F.R. § 576.102 authorizes ESG funds to be used for costs of providing essential services to homeless families and individuals in emergency shelters, renovating buildings to be used as emergency shelter for homeless families and individuals, and operating emergency shelters.

[16] 24 C.F.R. § 576.103 authorizes ESG funds to be used to provide housing relocation and stabilization services and short- and/or medium-term rental assistance necessary to prevent an individual or family from moving into an emergency shelter.

[17] 24 C.F.R. § 576.104 authorizes ESG funds to be used to provide housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help a homeless individual or family move as quickly as possible into permanent housing and achieve stability in that housing.

[18] 24 C.F.R. § 576.107 authorize ESG funds to be used to pay the costs of contributing data to the HMIS designated by the Continuum of Care for the area; and 24 C.F.R. § 576.108 authorizes recipients to use of to 7.5 percent of its ESG grant for the payment of administrative costs related to the planning and execution of ESG activities.

[19] 24 C.F.R. § 576.201.

[20] HUD Awards and Allocations, Find Award and Allocation Amounts for Grantees by Year, Program, and State, available at https://www.hudexchange.info/grantees/allocations-awards/ (last visited October 9, 2019).

[21] 24 C.F.R. § 578.1.

[22] 24 C.F.R. § 578.3.

the homeless individuals.[23] At a minimum the system must include: outreach, engagement, and assessment; shelter, housing, and supportive services; and prevention strategies. The Continuum of Care plan must also plan for and conduct, at least biennially, a point-in-time count of homeless persons within the geographic area. Further, Continuums of Care are required to designate a single Homeless Management Information System (HMIS) for the geographic area of each Continuum and an applicant to manage the Continuum's HMIS.[24]

The bulk of funding for the Homeless Assistance Grants is awarded as competitive grants through the CoC program.[25] The CoC program differs from the ESG program in that it focuses on the longer-term housing and service needs of homeless individuals and families. Prior to the enactment of the HEARTH Act, which created the CoC program by consolidating the SHP, SRO, and S+C programs, applicants were required to submit separate applications for each of these grant programs. The new consolidated CoC grant provides funds for all permanent housing, transitional housing, supportive services, rehousing activities and homeless management information services.[26]

There are two types of permanent housing permitted by HUD that grantees may provide under the CoC program, permanent supportive housing and rapid rehousing.[27] Grantees may provide permanent housing with supportive services to individuals with disabilities and families where an adult or child has a disability. Rapid rehousing is a process targeted to assist homeless individuals and families through supportive services and short-term[28] or medium-term[29] tenant-based rental assistance.

Transitional housing is housing available for up to 24 months to help homeless individuals and families transition from homelessness to permanent housing. Grant funds may be used for acquisition, rehabilitation, new construction, leasing, rental assistance, operating costs, and supportive services.[30]

CoC programs may fund an array of supportive services for homeless individuals and families.[31] The services include case management, child care, education services, employment assistance and job training, life skills training, legal services, mental health services, outpatient health services, substance abuse treatment, transportation, and payment of moving costs and utility deposits.[32]

CoC programs may provide funding for homeless management information services in the form of a database established at the local level through which homeless service providers collect, organize, and store information about homeless clients who receive services.

Continuums of Care must design, operate, and follow a collaborative process for the development of applications and approve the submission of applications in response to a notice of funding availability published by HUD.[33] The collaborative process must include establishing priorities for funding projects in the geographic area. The Continuum must then determine if one application for funding will be submitted for all projects within the geographic area or if more than one application will be submitted for the projects within the geographic area. If more than one application will be submitted, the Continuum must designate an eligible applicant to be the collaborative applicant[34] that will collect and combine the

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[23] 24 C.F.R. § 578.7(c).
[24] 24 C.F.R. § 578.7(b).
[25] Congressional Research Service, *The HUD Homeless Assistance Grants: Programs Authorized by the HEARTH Act,* August 2017, p. 10, available at https://fas.org/sgp/crs/misc/RL33764.pdf (last visited October 8, 2019).
[26] 24 C.F.R. § 578.37(a).
[27] 24 C.F.R. § 578.37(a)(1).
[28] For a period of up to three months.
[29] For a period of up to 24 months.
[30] 24 C.F.R. § 578.37(a)(2).
[31] 42 U.S.C. §11383(a)(6). In addition to being available to individuals and families who are experiencing homelessness, supportive services are available to formerly homeless individuals and families who are living in permanent supportive housing indefinitely and those who are living in permanent housing (but not *supportive* housing) for up to six months after finding housing.
[32] 42 U.S.C. §11360(27), 24 C.F.R. §578.53 at 77 *Federal Register* 45453.
[33] 24 C.F.R. § 578.9.
[34] A collaborative applicant is the eligible applicant that has been designated by the Continuum of Care to apply for CoC funds on behalf of the continuum.

required application information from all applicants and for all projects within the geographic area that the Continuum has selected funding. In 2018, $85,425,367 in Federal funding was awarded under the CoC program to continuums of care in Florida.[35]

State Office on Homelessness

In 2001, the Florida Legislature created the State Office on Homelessness (State Office) within the Department of Children and Families (DCF) to serve as a central point of contact within state government on issues relating to homelessness.[36] The State Office is responsible for coordinating resources and programs across all levels of government, and with private providers that serve the homeless. It also manages targeted state grants to support the implementation of local homeless service continuum of care plans.[37]

Council on Homelessness

The Legislature also created the inter-agency Council on Homelessness (Council) in 2001. The 17-member council develops recommendations on how to reduce homelessness statewide and advises the State Office. The Council includes:

- The Secretary of DCF, or his or her designee;
- The Executive Director of the Department of Economic Opportunity, or his or her designee, who shall advise the Council on issues related to rural development;
- The State Surgeon General, or his or her designee;
- The Executive Director of Veterans' Affairs, or his or her designee;
- The Secretary of Corrections, or his or her designee;
- The Secretary of the Agency for Health Care Administration, or his or her designee;
- The Commissioner of Education, or his or her designee;
- The Director of CareerSource Florida, Inc., or his or her designee;
- One representative of the Florida Association of Counties;
- One representative of the Florida League of Cities;
- One representative of the Florida Supportive Housing Coalition;
- The Executive Director of the Florida Housing Finance Corporation, or his or her designee;
- One representative of the Florida Coalition for the Homeless; and
- Four members appointed by the Governor.[38]

The Council is required to provide an annual report to the Governor, the Legislature, and the Secretary of DCF summarizing the extent of homelessness in the state and the Council's recommendations for reducing homelessness in Florida.[39]

[35] *Supra,* note 8 at 45.
[36] S. 420.622(1), F.S.
[37] S. 420.622(3), F.S.
[38] S. 420.622(2), F.S.
[39] S. 420.622(9), F.S.

Coalitions and Continuums of Care

Local Coalitions for the Homeless

DCF is required to establish local coalitions to plan, network, coordinate, and monitor the delivery of services to the homeless.[40] Groups and organizations provided the opportunity to participate in such coalitions include:

- Organizations and agencies providing mental health and substance abuse services;
- County health departments and community health centers;
- Organizations and agencies providing food, shelter, or other services targeted to the homeless;
- Local law enforcement agencies;
- Regional workforce boards;
- County and municipal governments;
- Local public housing authorities;
- Local school districts
- Local organizations and agencies serving specific subgroups of the homeless population such as veterans, victims of domestic violence, persons with HIV/AIDS, runaway youth; and
- Local community-based care alliances.[41]

Continuums of Care

Section 420.621(1), F.S., defines "continuum of care" as the community components needed to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency; it includes action steps to end homelessness and prevent a return to homelessness.

A local homeless assistance continuum of care is a framework for a comprehensive and seamless array of emergency, transitional, and permanent housing, and services to address the various needs of the homeless and those at risk of homelessness.[42] The purpose of this framework is to help communities and regions envision, plan, and implement comprehensive and long-term solutions to homelessness in their own community or region.[43]

The local homeless assistance continuum of care planning effort is an ongoing process that addresses all subpopulations of the homeless. Section 420.624(7), F.S., lists elements that a continuum of care plan should include, such as outreach, intake and assessment procedures; emergency shelter; transitional housing; Rapid ReHousing; and permanent supportive housing.

Each local homeless assistance continuum of care plan must designate a lead agency that will serve as the point of contact and accountability to the State Office. The lead agency may be a local homeless coalition, municipal or county government, or other public agency or private, not-for-profit corporation.[44]

The State Office may only recognize one homeless assistance continuum of care plan and its designated lead agency for a local homeless assistance continuum of care.[45] Continuum of care catchment areas must be designated and revised as necessary by the State Office, with the input of local homeless coalitions and public or private organizations that have previously certified to HUD and that currently serve as lead agencies for a local homeless assistance continuum of care.[46] Designated

[40] S. 420.623, F.S.
[41] Id.
[42] S. 420.624(1), F.S.
[43] S. 420.624(2), F.S.
[44] S. 420.624(4), F.S.
[45] S. 420.624(6), F.S.
[46] S. 420.624(5), F.S.

catchment areas must not be overlapping, and the designations must be consistent with those made by HUD in conjunction with the awarding of federal Stewart B. McKinney Act homeless assistance funding.

Grants

Challenge Grants

In 2001, the Florida Legislature established the Challenge Grant and authorized the State Office to accept and administer moneys appropriated to it to provide Challenge Grants annually to designated lead agencies of homeless assistance continuums of care.

DCF must establish award levels for Challenge Grants specifying criteria to determine award levels and, after consultation with the Council on Homelessness, to specify the grant award levels in the notice of solicitation of grant applications.[47] Any lead agency that receives a Challenge Grant must submit reports to DCF detailing its use of the grant funds.[48]

The State Office may award grants in an amount of up to $500,000 per lead agency.[49] In order to qualify for a grant, the lead agency must develop and implement a local homeless assistance continuum of care plan for its designated area. The continuum of care plan must implement a coordinated assessment or central intake system to screen, assess, and refer persons seeking assistance to the appropriate service provider. The lead agency must also document the commitment of local government or private matching funds or in-kind support in an amount equal to the grant requested.

Preference is given to lead agencies that have demonstrated the ability of their continuum of care to provide quality services to homeless persons and the ability to leverage federal homeless-assistance funding under the Stewart B. McKinney Act with local government funding or private funding for the provision of services to the homeless. Preference is also given to lead agencies in catchment areas with the greatest need for the provision of housing and services to the homeless, relative to the population of the catchment area.[50]

Challenge grants may be used to fund any of the housing, program, or service needs included in the local homeless assistance continuum of care plan. The lead agency may allocate the grant to programs, services, or housing providers that implement the local homeless assistance continuum of care plan. The lead agency may also provide sub-grants to a local agency to implement programs or services or provide housing identified for funding in the lead agency's application to DCF. Lead agencies are limited to spending a maximum of 8% of total funding on administrative costs.[51]

Section 420.622(6), F.S., requires the State Office, in conjunction with the Council, to establish performance measures and specific objectives by which it may evaluate the performance and outcomes of lead agencies that receive grant funds. Challenge grants made through the State Office must be distributed to lead agencies based on their overall performance and their achievement of specified objectives. In evaluating the performance of the lead agencies, the State Office must base its criteria on the program objectives, goals, and priorities that were set forth by the lead agencies in their proposals for funding. Such criteria may include the number of persons or households that are no longer homeless, the rate of recidivism to homelessness, and the number of individuals who obtain gainful employment.

Section 420.622(8), F.S., requires DCF, with input from the Council, to adopt rules relating to the challenge grants.

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[47] S. 420.622(4), F.S.
[48] S. 420.622(4)(e), F.S.
[49] S. 420.622(4), F.S.
[50] S. 420.622(4)(a), F.S.
[51] S. 420.622(4)(d), F.S.

In 2019, the Legislature appropriated, and the State Office allocated $3,488,244.68 from the Local and State Government Housing Trust Fund to be awarded as challenge grants.[52]

Homeless Housing Assistance Grants

The State Office on Homelessness, with the concurrence of the Council on Homelessness, may administer money appropriated to it to provide homeless housing assistance grants annually to lead agencies for local homeless assistance continuum of care to acquire, construct, or rehabilitate transitional or permanent housing units for homeless persons. Such money shall consist of any sums that the state may appropriate, as well as money received from donations, gifts, bequests, or otherwise from any public or private source.[53]

Grants applicants must be ranked competitively, and preference must be given to applicants who leverage additional private funds and public funds, particularly federal funds designated for the acquisition, construction, or rehabilitation of transitional or permanent housing for the homeless, and who:

- Acquire, build, or rehabilitate the greatest number of units; or
- Acquire, build, or rehabilitate in catchment areas having the greatest need for housing for the homeless relative to the population of the catchment area.[54]

Funding for any particular project may not exceed $750,000. Projects are required to reserve the number of units acquired, constructed, or rehabilitated through homeless housing assistance grant funding to serve persons who are homeless at the time they assume tenancy for a minimum of 10 years.[55] The maximum amount of funds allowed to be spent on administrative costs is 5% of total funds.[56]

Section 420.622(8), F.S., requires DCF, with input from the Council, to adopt rules relating to homeless housing assistance grants.

Grants in Aid

Section 420.625, F.S., outlines the grant-in-aid program. The purpose of this program is to assist persons in their communities who have become, or are about to become, homeless, and where possible, restore the homeless to suitable living conditions and self-sufficiency as quickly as possible.[57] DCF is to develop guidelines for the development of spending plans for the evaluation and approval of spending plans, based upon such factors as:

- Demonstrated level of need for the program,
- The demonstrated ability of the local agency or agencies seeking assistance to deliver the services and to assure that identified needs will be met,
- The ability of the local agency or agencies seeking assistance to deliver a wide range of services,
- The adequacy and reasonableness of proposed budgets and planned expenditures, and the demonstrated capacity of the local agency or agencies to administer the funds sought,
- A statement from the local coalition for the homeless as to the steps to be taken to assure coordination and integration of services in the district to avoid unnecessary duplication and costs,

[52] *Supra,* note 8 at 45.
[53] S. 420.622(5), F.S.
[54] S. 420.622(5)(a), F.S.
[55] S. 420.622(5)(c), F.S.
[56] S. 420.622(5)(f), F.S.
[57] S. 420.625(2), F.S.

- Assurances by the local coalition for the homeless that alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, and local government or private agency funding have been explored, and
- The existence of an evaluation component designed to measure program outcomes and determine the overall effectiveness of the local programs for the homeless for which funding is sought.

DCF is to allocate funds to its districts, which then distribute them to local agencies based upon recommendations of the local coalitions. These allocations are to be based upon sufficient documentation of:

- The magnitude of the problem of homelessness in the district, and the demonstrated level of unmet need for services in the district for those who are homeless or are about to become homeless.
- A strong local commitment to seriously address the problem of homelessness as evidenced by coordinated programs involving preventive, emergency, and transitional services and by the existence of active local organizations committed to serving those who have become, or are about to become, homeless.
- Agreement by local government and private agencies currently serving the homeless not to reduce current expenditures for services presently provided to those who are homeless or are about to become homeless if grant assistance is provided pursuant to this section.
- Geographic distribution of district programs to ensure that such programs serve both rural and urban areas, as needed.[58]

DCF no longer has districts, having moved to a regionally-based model.[59]

Effect of the Bill:

Many of the bill's provisions align Florida's approach to homeless services with federal law. Others increase the capacity of agencies to receive grant funds and administer them.

Homelessness

The bill redefines the term "homeless" to incorporate solely the conditions defined in federal regulations:

- An individual or family who lacks a fixed, regular, and adequate nighttime address, and
- An individual or family who will imminently lose their primary nighttime residence.

State Office on Homelessness

The bill revises many of the duties specified in statute for the State Office. These changes include:

- Changing references from "coalitions for the homeless" to "continuums of care";
- Focusing on ending homelessness instead of addressing the needs of the homeless;
- Specifying that the State Office must have input from continuums of care when conducting or promoting research on the effectiveness of current programs and proposing pilot projects, which must be aimed at ending homelessness rather than improving services, as is required by existing statute,
- Requiring the State Office to use summary data from databases and charts required by HUD instead of developing its own outcome and accountability measures; and
- Requiring the State Office's technical assistance to support and strengthen continuums of care rather than establish, maintain, and expand them.

[58] S. 420.625(6), F.S.
[59] Department of Children and Families, *2020 Agency Legislative Bill Analysis,* September 16, 2019 (on file with the Health and Human Services Committee).

Council on Homelessness

HB 163 adds two new members to the Council, bringing the total to 19 members. These two members would be the Secretary of the Department of Elder Affairs or his or her designee and one representative from the Florida Housing Coalition.

The Florida Housing Coalition is a statewide, nonprofit membership organization which consults on affordable housing and related issues and advocates for policies, programs and use of funding resources that maximize the availability and improve the quality of affordable housing in Florida.[60]

The bill also encourages representatives of the Council to have had experience in the provision of services to persons experiencing homelessness.

Coalitions and Continuums of Care

HB 163 repeals s. 420.623, F.S., regarding local coalitions for the homeless, and s. 420.624, F.S., regarding local homeless assistance continuums of care.

The bill redefines "continuum of care" to be solely a group organized to carry out the responsibilities imposed under ss. 420.621-420.628, F.S., to coordinate, plan, and pursue ending homelessness in a designated catchment area. It lists possible member organizations such as nonprofit homeless providers, victim service providers, faith-based organizations, governments, and businesses. The bill removes language including action steps as an element of a continuum of care.

HB 163 specifies that the purpose of a continuum of care is to coordinate community efforts to prevent and end homelessness in its catchment area and to fulfill the responsibilities set forth in ch. 420. The bill makes the "collaborative applicant" for HUD the lead agency for state purposes and requires the State Office to align its catchment areas for continuums of care with HUD's.

The bill requires each continuum of care to create a continuum of care plan which implements an effective and efficient housing crisis response system to prevent and end homelessness in the continuum of care catchment area. Further, the bill requires each continuum of care plan to include all of the following components:

- Outreach to unsheltered individuals and families to link them with appropriate housing interventions;
- A coordinated entry system, compliant with the requirements of the federal HEARTH Act of 2009, which is designed to coordinate intake, utilize common assessment tools, prioritize households for housing interventions, and refer households to the appropriate housing intervention;
- Emergency shelter, designed to provide safe temporary shelter while the household is in the process of obtaining permanent housing;
- Supportive services, designed to maximize housing stability once the household is in permanent housing;
- Permanent supportive housing, designed to provide long-term affordable housing and support services to persons with disabilities who are moving out of homelessness;
- Rapid ReHousing, as specified in s. 420.6265, F.S.;
- Permanent housing, including links to affordable housing, subsidized housing, long-term rental assistance, housing vouchers, and mainstream private sector housing; and
- An ongoing planning mechanism to end homelessness for all subpopulations of persons experiencing homelessness.

[60] Florida Housing Coalition, *"About Us"*, http://www.flhousing.org/about/ (last visited October 20, 2019).

Each continuum of care must also promote participation by all interested individuals, acting in a nondiscriminatory manner, and must coordinate and integrate with other mainstream health, social services and employment programs for which homeless populations may be eligible.

Grants

Challenge Grants

The bill:

- Requires that services provided with grant funds must be implemented through the continuum of care's entry coordinated system;
- Increases the grant amount award that continuum of care lead agencies can receive from $500,000 to $750,000;
- Reduces the required matching funds or in-kind support provided by a continuum of care lead agency to receive a Challenge Grant to 25% from 100%;
- Increases the maximum percentage of grant funds that a continuum of care lead agency may spend on its administrative costs from 8% to 10%;
- Changes preference for funding to be for lead agencies for continuums of care that have a demonstrated ability to move households out of homelessness, instead of giving such preference to lead agencies that provide quality services and effectively leverage federal and other sources of funding and to areas with the greatest need for housing and homeless services;
- Specifies criteria that the State Office must at a minimum use when determining award of homeless housing assistance grants. These criteria consider quality of services, ability to leverage other funding, need for services, and performance in maintaining housing; and
- Removes the requirement for lead agencies to give the State Office a thorough evaluation of the grant-funded program's performance related to households that are no longer homeless, rate of recidivism, and number of persons who obtain gainful employment, and instead requires the State Office to use performance measures it establishes to evaluate the performance of lead agencies which receive state grant funds.

Grants in Aid

The bill repeals s. 420.625, F.S., regarding grants-in-aid and creates a new section, on grants-in-aid. The new section, s. 420.6227, F.S., removes the preference for targeting the new and temporary homeless. It removes as the purpose helping homeless individuals find suitable living conditions and self-sufficiency and retains as the purpose to assist individuals who are or may become homeless, and to help homeless households move to permanent housing as quickly as possible.

HB 163 allows a continuum of care to use grants-in-aid funding for any component of their continuum of care plan, with funding to be awarded on a competitive basis and granted to agencies based on the recommendations of lead agencies in accordance with their plans. The bill removes the criteria in law for the evaluation and approval of spending plans and instead allows the State Office to develop the criteria.

Rapid Re-Housing

The bill removes legislative findings on Rapid ReHousing. It requires that individuals and families being considered for Rapid ReHousing assistance be assessed and prioritized through the continuum of care's coordinated entry system. HB 163 also changes the objective of Rapid ReHousing services from the recipients' not developing a dependency on the assistance to their attaining stability and integration into the community as quickly as possible.

Housing First

HB 163 removes legislative findings on Housing First and amends statute to emphasize the permanent, stable nature of the housing provided through the Housing First approach. It removes the element of Housing First service provision involving an individual having a background check and complete rehabilitation for any addiction to substances. It also removes reference to linkages between Housing First and emergency and transitional housing systems and instead states that the links are with community-based social service and health care organizations.

Discharge Policies

HB 163 amends s. 420.626, F.S., to require hospitals and inpatient medical facilities, crisis stabilization units, residential treatment facilities, assisted living facilities, and detoxification centers to communicate with programs to whom clients or patients might be discharged to determine their capability to serve these individuals and if they will be accepted into the programs.

B. SECTION DIRECTORY:

Section 1: Amends s. 420.621, F.S., relating to definitions.
Section 2: Amends s. 420.622, F.S., relating to State Office on Homelessness; Council on Homelessness.
Section 3: Creates s. 420.6225, F.S., relating to continuum of care.
Section 4: Creates s. 420.6227, F.S., relating to grant-in-aid program.
Section 5: Repeals s. 420.623, F.S., relating to local coalitions for the homeless.
Section 6: Repeals s. 420.624, F.S., relating to local homeless assistance continuum of care.
Section 7: Repeals s. 420.625, F.S., relating to grant-in-aid program.
Section 8: Amends s. 420.626, F.S., relating to homelessness; discharge guidelines.
Section 9: Amends s. 420.6265, F.S., relating to Rapid ReHousing.
Section 10: Amends s. 420.6275, F.S., relating to Housing First.
Section 11: Amends s. 420.507, F.S., relating to powers of the corporation.
Section 12: 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:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

The bill does not contain an appropriation, or otherwise affect state expenditures; however, it alters the criteria by which programs addressing homelessness are funded and how recipients may spend grant awards. To the extent that lead agencies increase their withholding of funds for administrative purposes (from 8 percent to 10 percent), the remaining funds available for direct services may decrease, since the appropriation is limited. Similarly, the bill increases the maximum award amount from $500,000 to $750,000, the source of which is a fixed appropriation.

The bill decreases the required local matching level from 100 percent to 25 percent, which may decrease the total funding available to an individual project when considering all funding sources. Also, modifications to the qualifying criteria and approval process may influence a prospective continuum of care agency's decision to apply.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to DCF 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 homelessness; amending s. 420.621, F.S.; revising and providing definitions; amending s. 420.622, F.S.; increasing the number of members on the Council on Homelessness; revising the duties of the State Office on Homelessness; revising requirements for the state's system of homeless programs; requiring entities that receive state funding to provide summary aggregated data to the council; revising the qualifications for and amount of grant awards to continuum of care lead agencies; requiring continuum of care lead agencies to submit a report to the Department of Children and Families; increasing the minimum number of years for which projects must reserve certain units for the homeless; authorizing, rather than requiring, the Department of Children and Families to adopt certain rules; authorizing the office to administer certain money; creating s. 420.6225, F.S.; specifying the purpose of a continuum of care; requiring each continuum of care to designate a collaborative applicant; providing requirements for such applicants; authorizing such applicants to be referred to as continuum of care lead agencies; providing requirements for continuum of care catchment areas and lead agencies; requiring continuums of care

to create continuum of care plans; specifying requirements for such plans; requiring continuums of care to promote participation by all interested individuals and organizations; creating s. 420.6227, F.S.; providing legislative findings and program purpose; establishing a grant-in-aid program to help continuums of care prevent and end homelessness; providing requirements for such program; repealing s. 420.623, F.S., relating to local coalitions for the homeless; repealing s. 420.624, F.S., relating to local homeless assistance continuum of care; repealing s. 420.625, F.S., relating to a grant-in-aid program; amending s. 420.626, F.S.; revising procedures for certain facilities and institutions to implement when discharging specified persons to reduce homelessness; amending s. 420.6265, F.S.; revising the Rapid ReHousing methodology; amending s. 420.6275, F.S.; revising the Housing First methodology; amending s. 420.507, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 420.621, Florida Statutes, is amended to read:

420.621 Definitions.—As used in ss. 420.621-420.628, the term:

(1) "Continuum of care" means a group organized to carry out the responsibilities imposed under ss. 420.621-420.628 to coordinate, plan, and pursue ending homelessness in a designated catchment area. Such a group shall be composed of representatives from certain organizations, including, but not limited to, nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and organizations that serve homeless and formerly homeless persons, to the extent that these organizations are represented within the designated catchment area and are available to participate ~~the community components needed to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness~~.

(2) "Continuum of care lead agency" or "continuum of care collaborative applicant" means the organization designated by a continuum of care under s. 420.6225.

(3) ~~(2)~~ "Council on Homelessness" means the council created

in s. 420.622.

(4) ~~(3)~~ "Department" means the Department of Children and Families.

~~(4) "District" means a service district of the department, as set forth in s. 20.19.~~

(5) "Homeless~~,~~" means:

(a) An individual or family who lacks a fixed, regular, and adequate nighttime residence as defined under "homeless" in 24 C.F.R. 578.3; or

(b) An individual or family who will imminently lose their primary nighttime residence as defined under "homeless" in 24 C.F.R. 578.3.~~applied to an individual, or "individual experiencing homelessness" means an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:~~

~~(a) Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;~~

~~(b) Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;~~

~~(c) Is living in an emergency or transitional shelter;~~

~~(d) Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;~~

~~(e) Is living in a car, park, public space, abandoned~~

~~building, bus or train station, or similar setting; or~~

~~(f) Is a migratory individual who qualifies as homeless because he or she is living in circumstances described in paragraphs (a)-(e).~~

~~The terms do not refer to an individual imprisoned pursuant to state or federal law or to individuals or families who are sharing housing due to cultural preferences, voluntary arrangements, or traditional networks of support. The terms include an individual who has been released from jail, prison, the juvenile justice system, the child welfare system, a mental health and developmental disability facility, a residential addiction treatment program, or a hospital, for whom no subsequent residence has been identified, and who lacks the resources and support network to obtain housing~~.

~~(6) "Local coalition for the homeless" means a coalition established pursuant to s. 420.623.~~

~~(7) "New and temporary homeless" means individuals or families who are homeless due to societal factors.~~

(6)~~(8)~~ "State Office on Homelessness" means the state office created in s. 420.622.

Section 2. Section 420.622, Florida Statutes, is amended to read:

420.622 State Office on Homelessness; Council on Homelessness.—

(1) The State Office on Homelessness is created within the Department of Children and Families to provide interagency, council, and other related coordination on issues relating to homelessness.

(2) The Council on Homelessness is created to consist of 19 ~~17~~ representatives of public and private agencies who shall develop policy and advise the State Office on Homelessness. The council members shall be: the Secretary of Children and Families, or his or her designee; the executive director of the Department of Economic Opportunity, or his or her designee, who shall advise the council on issues related to rural development; the State Surgeon General, or his or her designee; the Executive Director of Veterans' Affairs, or his or her designee; the Secretary of Corrections, or his or her designee; the Secretary of Health Care Administration, or his or her designee; the Commissioner of Education, or his or her designee; the Director of CareerSource Florida, Inc., or his or her designee; one representative of the Florida Association of Counties; one representative of the Florida League of Cities; one representative of the Florida Supportive Housing Coalition; one representative of the Florida Housing Coalition; the Executive Director of the Florida Housing Finance Corporation, or his or her designee; one representative of the Florida Coalition for the Homeless; the Secretary of the Department of Elder Affairs, or his or her designee; and four members appointed by the

Governor. The council members shall be nonpaid volunteers and shall be reimbursed only for travel expenses. The appointed members of the council shall be appointed to staggered 2-year terms~~,~~ and are encouraged to have experience in the administration or provision of resources, services, or housing that addresses the needs of persons experiencing homelessness. The council shall meet at least four times per year. The importance of minority, gender, and geographic representation shall be considered in appointing members to the council.

(3) The State Office on Homelessness, pursuant to the policies set by the council and subject to the availability of funding, shall:

(a) Coordinate among state, local, and private agencies and providers to produce a statewide consolidated inventory for the state's entire system of homeless programs which incorporates local continuum of care plans ~~regionally developed plans~~. Such programs include, but are not limited to:

1. Programs authorized under the McKinney-Vento Homeless Assistance ~~Stewart B. McKinney Homeless Assistance~~ Act of 1987, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, 42 U.S.C. ss. 11302 ~~ss. 11371~~ et seq., and carried out under funds awarded to this state; and

2. Programs, components thereof, or activities that assist persons who are homeless or at risk for homelessness.

(b) Collect, maintain, and make available information concerning persons who are homeless ~~or at risk for homelessness~~, including summary demographics information drawn from the local continuum of care Homeless Management Information System or the annual Point-in-Time Count, and the local continuum of care Housing Inventory Chart required by the United States Department of Housing and Urban Development ~~current services and resources available, the cost and availability of services and programs, and the met and unmet needs of this population~~. All entities that receive state funding must provide summary aggregated ~~access to all~~ data ~~they maintain in summary form~~, with no individual identifying information, to assist the council in providing this information. The State Office on Homelessness, in consultation with the designated lead agencies for a ~~local homeless~~ continuum of care and with the Council on Homelessness, shall develop a process by which summary data is collected ~~the system and process of data collection~~ from all continuum of care lead agencies for the purpose of analyzing trends and assessing impacts in the ~~statewide homeless delivery~~ system for delivering services to the homeless. ~~Any statewide homelessness survey and database system must comply with all state and federal statutory and regulatory confidentiality requirements.~~

(c) Annually evaluate state and continuum of care system programs ~~local services and resources~~ and develop a consolidated plan for addressing the needs of the homeless or those at risk

for homelessness.

(d) Explore, compile, and disseminate information regarding public and private funding sources for state and local programs serving the homeless and provide technical assistance in applying for such funding.

(e) Monitor and provide recommendations for coordinating the activities and programs of continuums of care ~~local coalitions for the homeless~~ and promote the effectiveness of programs to prevent and end homelessness in the state ~~addressing the needs of the homeless~~.

(f) Provide technical assistance to facilitate efforts to support and strengthen ~~establish, maintain, and expand local homeless assistance~~ continuums of care.

(g) Develop and assist in the coordination of policies and procedures relating to the discharge or transfer from the care or custody of state-supported or state-regulated entities persons who are homeless or at risk for homelessness.

(h) Spearhead outreach efforts for maximizing access by people who are homeless or at risk for homelessness to state and federal programs and resources.

(i) Promote a federal policy agenda that is responsive to the needs of those who are homeless or at risk of homelessness ~~the homeless population~~ in this state.

(j) Review reports on continuum of care system performance measures and ~~Develop outcome and accountability measures and~~

~~promote and~~ use such measures to evaluate program effectiveness and make recommendations for improving current practices to work toward ending homelessness in this state ~~in order to best meet the needs of the homeless~~.

(k) Formulate policies and legislative proposals aimed at preventing and ending homelessness in this state ~~to address more effectively the needs of the homeless~~ and coordinate the implementation of state and federal legislative policies.

(l) Convene meetings and workshops of state and local agencies, continuums of care ~~local coalitions and programs~~, and other stakeholders for the purpose of developing and reviewing policies, services, activities, coordination, and funding of efforts to end homelessness ~~meet the needs of the homeless~~.

(m) With the input of the continuums of care, conduct or promote research on the effectiveness of current programs and propose pilot projects aimed at ending homelessness ~~improving services~~.

(n) Serve as an advocate for issues relating to homelessness.

(o) Investigate ways to improve access to participation in state funding and other programs for the prevention and reduction ~~alleviation~~ of homelessness to faith-based organizations and collaborate and coordinate with faith-based organizations.

(4) The State Office on Homelessness~~, with the concurrence~~

~~of the Council on Homelessness,~~ shall accept and administer moneys appropriated to it to provide annual "challenge grants" to lead agencies of ~~homeless assistance~~ continuums of care designated by the State Office on Homelessness under ~~pursuant to~~ s. 420.6225 ~~s. 420.624~~. The department shall establish varying levels of grant awards up to $750,000 ~~$500,000~~ per continuum of care lead agency. The department, in consultation with the Council on Homelessness, shall specify a grant award level in the notice of the solicitation of grant applications.

(a) To qualify for the grant, a continuum of care lead agency must develop and implement a local ~~homeless assistance~~ continuum of care plan for its designated catchment area. The services and housing funded through the grant must be implemented through the continuum of care's ~~care plan must implement a~~ coordinated entry ~~assessment or central intake~~ system as provided in s. 420.6225(5)(b) and must be designed to ~~screen,~~ assess~~,~~ and refer persons seeking assistance to the appropriate housing intervention and service provider. The continuum of care lead agency shall also document the commitment of local government or private organizations to provide matching funds or in-kind support in an amount equal to 25 percent of the grant requested. Expenditures of leveraged funds or resources, including third-party cash or in-kind contributions, are authorized only for eligible activities carried out in connection with a ~~committed on one~~ project in which such funds

or resources have not been used as leverage or match for any other project or program. The expenditures ~~and~~ must be certified through a written commitment.

(b) Preference must be given to those continuum of care lead agencies that have demonstrated the ability of their continuum of care to help households move out of homelessness ~~provide quality services to homeless persons and the ability to leverage federal homeless-assistance funding under the Stewart B. McKinney Act with local government funding or private funding for the provision of services to homeless persons~~.

~~(c) Preference must be given to lead agencies in catchment areas with the greatest need for the provision of housing and services to the homeless, relative to the population of the catchment area.~~

(c) ~~(d)~~ The grant may be used to fund any of the housing, program, or service needs included in the local ~~homeless assistance~~ continuum of care plan. The continuum of care lead agency may allocate the grant to programs, services, or housing providers that implement the local ~~homeless assistance~~ continuum of care plan. The continuum of care lead agency may provide subgrants to a local agency to implement programs or services or provide housing identified for funding in the continuum of care lead agency's application to the department. A continuum of care lead agency may spend a maximum of 10 ~~8~~ percent of its funding on administrative costs.

(d) ~~(c)~~ The continuum of care lead agency shall submit a final report to the department documenting the outcomes achieved by the grant-funded programs ~~grant~~ in enabling persons who are homeless to return to permanent housing, thereby ending such person's episode of homelessness.

(5) The State Office on Homelessness~~, with the concurrence of the Council on Homelessness,~~ may administer moneys given ~~appropriated~~ to it to provide homeless housing assistance grants annually to continuum of care lead agencies ~~for local homeless assistance continuum of care, as~~ recognized by the State Office on Homelessness~~,~~ to acquire, construct, or rehabilitate ~~transitional or~~ permanent housing units for homeless persons. These moneys shall consist of any sums that the state may appropriate, as well as money received from donations, gifts, bequests, or ~~otherwise from~~ any other public or private source, which are intended to acquire, construct, or rehabilitate ~~transitional or~~ permanent housing units for homeless persons.

(a) Grant applicants shall be ranked competitively based on criteria that include, but are not limited to, all of the following:

1. The ability of the continuum of care to provide quality services.

2. The ability of the continuum of care to leverage federal homeless assistance and private funding.

3. The extent of the need for providing housing and

services to individuals experiencing homelessness in a continuum of care's planning areas relative to the population of the counties served.

4. The effectiveness of the continuum of care in keeping families housed ~~Preference must be given to applicants who leverage additional private funds and public funds, particularly federal funds designated for the acquisition, construction, or rehabilitation of transitional or permanent housing for homeless persons; who acquire, build, or rehabilitate the greatest number of units; or who acquire, build, or rehabilitate in catchment areas having the greatest need for housing for the homeless relative to the population of the catchment area~~.

(b) Funding for any particular project may not exceed $750,000.

(c) Projects must reserve, for a minimum of 20 ~~10~~ years, the number of units acquired, constructed, or rehabilitated through homeless housing assistance grant funding to serve persons who are homeless at the time they assume tenancy.

(d) No more than two grants may be awarded annually in any given ~~local homeless assistance~~ continuum of care catchment area.

(e) A project may not be funded which is not included in the local ~~homeless assistance~~ continuum of care plan, as recognized by the State Office on Homelessness, for the catchment area in which the project is located.

(f) The maximum percentage of funds that the State Office on Homelessness and each applicant may spend on administrative costs is 10 ~~5~~ percent.

(6) The State Office on Homelessness, in conjunction with the Council on Homelessness, shall establish performance measures related to state funding provided through the State Office on Homelessness and use those grant-related measures to ~~and specific objectives by which it may~~ evaluate the performance and outcomes of continuum of care lead agencies that receive state grant funds. ~~Challenge Grants made through the State Office on Homelessness shall be distributed to lead agencies based on their overall performance and their achievement of specified objectives. Each lead agency for which grants are made under this section shall provide the State Office on Homelessness a thorough evaluation of the effectiveness of the program in achieving its stated purpose. In evaluating the performance of the lead agencies, the State Office on Homelessness shall base its criteria upon the program objectives, goals, and priorities that were set forth by the lead agencies in their proposals for funding. Such criteria may include, but are not limited to, the number of persons or households that are no longer homeless, the rate of recidivism to homelessness, and the number of persons who obtain gainful employment.~~

(7) The State Office on Homelessness must monitor the

challenge grants and homeless housing assistance grants to ensure proper expenditure of funds and compliance with the conditions of the applicant's contract.

(8) The Department of Children and Families, with input from the Council on Homelessness, may ~~must~~ adopt rules relating to the challenge grants and the homeless housing assistance grants and related issues consistent with the purposes of this section.

(9) The Council on Homelessness ~~council~~ shall, by June 30 of each year, provide to the Governor, the Legislature, and the Secretary of Children and Families a report summarizing the extent of homelessness in the state and the council's recommendations for ending ~~reducing~~ homelessness in this state.

(10) The State Office on Homelessness may administer moneys appropriated to it for distribution among the continuum of care lead agencies and entities funded in the 2018-2019 state fiscal year which are designated by the office as local coalitions for the homeless ~~28 local homeless continuums of care designated by the Department of Children and Families~~.

Section 3. Section 420.6225, Florida Statutes, is created to read:

420.6225 Continuum of care.—

(1) The purpose of a continuum of care, as defined in s. 420.621, is to coordinate community efforts to prevent and end homelessness in its catchment area designated as provided in

subsection (3) and to fulfill the responsibilities set forth in this chapter.

(2) Under the federal HEARTH Act of 2009, each continuum of care is required to designate a collaborative applicant that is responsible for submitting the continuum of care funding application for the designated catchment area to the United States Department of Housing and Urban Development. The designated continuum of care collaborative applicant shall serve as the point of contact for the State Office on Homelessness, is accountable for representations made in the application, and, in carrying out responsibilities under this chapter, may be referred to as the continuum of care lead agency.

(3) Continuum of care catchment areas must be designated and revised as necessary by the State Office on Homelessness and must be consistent with the continuum of care catchment areas recognized by the United States Department of Housing and Urban Development for the purposes of awarding federal homeless assistance funding for continuum of care programs.

(4) The State Office on Homelessness shall recognize only one continuum of care lead agency for each designated catchment area. Such continuum of care lead agency must be consistent with the designated continuum of care collaborative applicant recognized by the United States Department of Housing and Urban Development in the awarding of federal funds to continuums of care.

(5) Each continuum of care shall create a continuum of care plan, the purpose of which is to implement an effective and efficient housing crisis response system to prevent and end homelessness in the continuum of care catchment area. A continuum of care plan must include all of the following components:

(a) Outreach to unsheltered individuals and families to link them with appropriate housing interventions.

(b) A coordinated entry system, compliant with the requirements of the federal HEARTH Act of 2009, which is designed to coordinate intake, utilize common assessment tools, prioritize households for housing interventions, and refer households to the appropriate housing intervention.

(c) Emergency shelter, designed to provide safe temporary shelter while the household is in the process of obtaining permanent housing.

(d) Supportive services, designed to maximize housing stability once the household is in permanent housing.

(e) Permanent supportive housing, designed to provide long-term affordable housing and support services to persons with disabilities who are moving out of homelessness.

(f) Rapid ReHousing, as specified in s. 420.6265.

(g) Permanent housing, including links to affordable housing, subsidized housing, long-term rental assistance, housing vouchers, and mainstream private sector housing.

(h) An ongoing planning mechanism to end homelessness for all subpopulations of persons experiencing homelessness.

(6) Continuums of care must promote participation by all interested individuals and organizations and may not exclude individuals and organizations on the basis of race, color, national origin, sex, handicap, familial status, or religion. Faith-based organizations, local governments, and persons who have experienced homelessness are encouraged to participate. To the extent possible, these individuals and organizations must be coordinated and integrated with other mainstream health, social services, and employment programs for which homeless populations may be eligible, including, but not limited to, Medicaid, the state Children's Health Insurance Program, the Temporary Assistance for Needy Families Program, the Food Assistance Program, and services funded through the Mental Health and Substance Abuse Block Grant, the Workforce Innovation and Opportunity Act, and the welfare-to-work grant program.

Section 4. Section 420.6227, Florida Statutes, is created to read:

420.6227 Grant-in-aid program.—

(1) LEGISLATIVE FINDINGS.—The Legislature finds and declares that many services for households experiencing homelessness have been provided by local communities through voluntary private agencies and religious organizations and that those resources have not been sufficient to prevent and end

homelessness in the state. The Legislature recognizes that the level of need and types of problems associated with homelessness may vary from community to community, due to the diversity and geographic distribution of the homeless population and the resulting differing needs of particular communities.

(2) PURPOSE.—The principal purpose of the grant-in-aid program is to provide needed assistance to continuums of care to enable them to do all of the following:

(a) Assist persons in their communities who have become, or may likely become, homeless.

(b) Help homeless households move to permanent housing as quickly as possible.

(3) ESTABLISHMENT.—There is established a grant-in-aid program to help continuums of care prevent and end homelessness, which may include any aspect of the local continuum of care plan, as described in 420.6225.

(4) APPLICATION PROCEDURE.—Continuums of care that intend to apply for the grant-in-aid program must submit an application for grant-in-aid funds to the State Office on Homelessness for review.

(5) SPENDING PLANS.—The State Office on Homelessness shall develop guidelines for the development, evaluation, and approval of spending plans that are created by local continuum of care lead agencies.

(6) ALLOCATION OF GRANT FUNDS.—The State Office on

Homelessness shall administer grant-in-aid funds for continuums of care, which must be awarded on a competitive basis.

(7) DISTRIBUTION TO LOCAL AGENCIES.—The State Office on Homelessness shall distribute funds awarded under subsection (6) to local agencies to fund programs that are required by the local continuum of care plan, as described in s. 420.6225 and provided in subsection (3), based upon the recommendations of the local continuum of care lead agencies, in accordance with spending plans that are developed by the lead agencies and approved by the office. Not more than 10 percent of the total state funds awarded under a spending plan may be used by the continuum of care lead agency for staffing and administrative expenditures.

(8) LOCAL MATCHING FUNDS.—If an entity contracts with local agencies to provide services and receives financial assistance obtained under this section, the entity must provide at least 25 percent of the funding necessary for the support of project operations. In-kind contributions, including, but not limited to, materials, commodities, transportation, office space, other types of facilities, or personal services may be evaluated and counted as part or all of the required local funding, at the discretion of the State Office on Homelessness.

Section 5. Section 420.623, Florida Statutes, is repealed.

Section 6. Section 420.624, Florida Statutes, is repealed.

Section 7. Section 420.625, Florida Statutes, is repealed.

Section 8. Subsection (3) of section 420.626, Florida Statutes, is amended, and subsection (2) of that section is republished, to read:

420.626 Homelessness; discharge guidelines.—

(2) The following facilities and institutions are encouraged to develop and implement procedures designed to reduce the discharge of persons into homelessness when such persons are admitted or housed for more than 24 hours at such facilities or institutions: hospitals and inpatient medical facilities; crisis stabilization units; residential treatment facilities; assisted living facilities; and detoxification centers.

(3) The procedures should include all of the following:

(a) Development and implementation of a screening process or other mechanism for identifying persons to be discharged from the facility or institution who are at considerable risk for homelessness or face some imminent threat to health and safety upon discharge.~~;~~

(b) Development and implementation of a discharge plan addressing how identified persons will secure housing and other needed care and support upon discharge.~~;~~

(c) Communication with ~~Assessment of the capabilities of~~ the entities to whom identified persons may potentially be discharged to determine their capability to serve such persons and their acceptance of such persons into their programs, and

selection of the entity determined to be best equipped to provide or facilitate the provision of suitable care and support.~~;~~

(d) Coordination of effort and sharing of information with entities that are expected to bear the responsibility for providing care or support to identified persons upon discharge.~~;~~ ~~and~~

(e) Provision of sufficient medication, medical equipment and supplies, clothing, transportation, and other basic resources necessary to ensure ~~assure~~ that the health and well-being of identified persons are not jeopardized upon their discharge.

Section 9. Section 420.6265, Florida Statutes, is amended to read:

420.6265 Rapid ReHousing.—

~~(1) LEGISLATIVE FINDINGS AND INTENT.—~~

~~(a) The Legislature finds that Rapid ReHousing is a strategy of using temporary financial assistance and case management to quickly move an individual or family out of homelessness and into permanent housing.~~

~~(b) The Legislature also finds that public and private solutions to homelessness in the past have focused on providing individuals and families who are experiencing homelessness with emergency shelter, transitional housing, or a combination of both. While emergency shelter and transitional housing programs~~

~~may provide critical access to services for individuals and families in crisis, the programs often fail to address their long-term needs.~~

~~(c) The Legislature further finds that most households become homeless as a result of a financial crisis that prevents individuals and families from paying rent or a domestic conflict that results in one member being ejected or leaving without resources or a plan for housing.~~

~~(d) The Legislature further finds that Rapid ReHousing is an alternative approach to the current system of emergency shelter or transitional housing which tends to reduce the length of time a person is homeless and has proven to be cost effective.~~

~~(e) It is therefore the intent of the Legislature to encourage homeless continuums of care to adopt the Rapid ReHousing approach to preventing homelessness for individuals and families who do not require the intense level of supports provided in the permanent supportive housing model.~~

~~(2) RAPID REHOUSING METHODOLOGY.~~

(1)~~(a)~~ The Rapid ReHousing response to homelessness differs from traditional approaches to addressing homelessness by focusing on each individual's or family's barriers to housing. By using this approach, communities can significantly reduce the amount of time that individuals and families are homeless and prevent further episodes of homelessness.

(2)~~(b)~~ In Rapid ReHousing, when an individual or a family is identified as being homeless, the individual or family is assessed and prioritized for housing through the continuum of care's coordinated entry system, temporary assistance is provided to allow the individual or family to obtain permanent housing as quickly as possible, and necessary~~, if needed,~~ assistance is provided to allow the individual or family to retain housing.

(3)~~(c)~~ The objective of Rapid ReHousing is to provide assistance for as short a term as possible so that the individual or family receiving assistance attains stability and integration into the community as quickly as possible ~~does not develop a dependency on the assistance~~.

Section 10. Section 420.6275, Florida Statutes, is amended to read:

420.6275 Housing First.—

~~(1) LEGISLATIVE FINDINGS AND INTENT.—~~

~~(a) The Legislature finds that many communities plan to manage homelessness rather than plan to end it.~~

~~(b) The Legislature also finds that for most of the past two decades, public and private solutions to homelessness have focused on providing individuals and families who are experiencing homelessness with emergency shelter, transitional housing, or a combination of both. While emergency shelter programs may provide critical access to services for individuals~~

~~and families in crisis, they often fail to address their long-term needs.~~

~~(c) The Legislature further finds that Housing First is an alternative approach to the current system of emergency shelter or transitional housing which tends to reduce the length of time of homelessness and has proven to be cost-effective.~~

~~(d) It is therefore the intent of the Legislature to encourage homeless continuums of care to adopt the Housing First approach to ending homelessness for individuals and families.~~

~~(2) HOUSING FIRST METHODOLOGY.~~

(1)~~(a)~~ The Housing First approach to homelessness provides permanent ~~differs from traditional approaches by providing~~ housing assistance, followed by ~~case management, and~~ support services responsive to individual or family needs once ~~after~~ housing is obtained. By using this approach ~~when appropriate~~, communities can significantly reduce the amount of time that individuals and families are homeless and prevent further episodes of homelessness. Housing First emphasizes that social services provided to enhance individual and family well-being can be more effective when people are in their own home, and:

(a)~~1.~~ The housing is not time-limited.

(b)~~2.~~ The housing is not contingent on compliance with services. Instead, participants must comply with a standard lease agreement.

(c) Individuals and families ~~and~~ are provided with

individualized ~~the~~ services and support ~~that are~~ necessary to help them maintain stable housing ~~do so successfully~~.

~~3. A background check and any rehabilitation necessary to combat an addiction related to alcoholism or substance abuse has been completed by the individual for whom assistance or support services are provided.~~

(2)~~(b)~~ The Housing First approach addresses the societal causes of homelessness and advocates for the immediate return of individuals and families into housing and communities. Housing First links affordable housing with community-based social service and health care organizations ~~Housing First provides a critical link between the emergency and transitional housing system and community-based social service, educational, and health care organizations~~ and consists of four components:

(a)~~1.~~ Crisis intervention and short-term stabilization.

(b)~~2.~~ Screening, intake, and needs assessment.

(c)~~3.~~ Provision of housing resources.

(d)~~4.~~ Provision of case management.

Section 11. Paragraph (d) of subsection (22) of section 420.507, Florida Statutes, is amended to read:

420.507 Powers of the corporation.—The corporation shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of this part, including the following powers which are in addition to all other powers granted by other provisions of this part:

(22) To develop and administer the State Apartment Incentive Loan Program. In developing and administering that program, the corporation may:

(d) In counties or rural areas of counties that do not have existing units set aside for homeless persons, forgive indebtedness for loans provided to create permanent rental housing units for persons who are homeless, as defined in s. 420.621 ~~s. 420.621(5)~~, or for persons residing in time-limited transitional housing or institutions as a result of a lack of permanent, affordable housing. Such developments must be supported by a ~~local homeless assistance~~ continuum of care developed under s. 420.6225 ~~s. 420.624~~, be developed by nonprofit applicants, be small properties as defined by corporation rule, and be a project in the local housing assistance continuum of care plan recognized by the State Office on Homelessness.

Section 12. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 559 Institutional Formularies Established by Nursing Home Facilities
SPONSOR(S): Byrd
TIED BILLS: **IDEN./SIM. BILLS:** SB 1020

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

SUMMARY ANALYSIS

Nursing homes provide 24 hour a day care, case management, health monitoring, personal care, nutritional meals and special diets, physical, occupational, and speech therapy, social activities, and respite care for those who are ill or physically infirm. In providing such care, nursing homes acquire, dispense, or administer prescription medications to residents.

For most medicines, there exist several similar or alternative products which can be either generic or therapeutically equivalent brand name drugs. Therapeutic substitution is the practice of dispensing drugs that are chemically distinct from the prescribed drug, but therapeutically similar in terms of their efficacy, safety, and tolerability profiles. Therapeutic substitution is designed to achieve an improved or neutral outcome with a different drug, while reducing overall treatment costs. Currently, a pharmacist must dispense a prescription for a nursing home resident as written, unless substituting a generic or biosimilar drug. Otherwise, a pharmacist must contact the prescribing physician and request a new prescription.

HB 599 authorizes a nursing home facility to establish an institutional formulary by which a pharmacist may use therapeutic substitution without a new prescription to replace a resident's prescribed drug with a chemically different drug listed in the formulary that is expected to have the same clinical effect.

The bill requires each prescriber to opt into the institutional formulary for all the prescriber's patients entering the nursing home and allows a prescriber to opt out of the institutional formulary with regard to a specific patient, a particular drug, or a class of drugs. The bill authorizes a pharmacist to perform a therapeutic substitution in accordance with a nursing home's institutional pharmacy if the prescriber has agreed to its use.

The bill has an insignificant, negative fiscal impact on the Agency for Health Care Administration, which can be absorbed within existing resources. The bill has no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Nursing Home Facilities

Nursing homes provide 24 hour a day care, case management, health monitoring, personal care, nutritional meals and special diets, physical, occupational, and speech therapy, social activities, and respite care for those who are ill or physically infirm.[1] Nursing homes are regulated by the Agency for Health Care Administration (AHCA) under the Health Care Licensing Procedures Act (Act) in part II of chapter 408, F.S., which provides licensure requirements for all provider types regulated by AHCA, and part II of chapter 400, F.S., which includes unique provisions for nursing home licensure beyond the uniform criteria in the Act.

Resident Rights

Florida law requires nursing homes to adopt the residents' bill of rights[2], which provides the rights and responsibilities of residents, and requires nursing homes to treat such residents in accordance with its provisions.[3] Nursing homes must provide a copy of the resident's bill of rights to each resident or the resident's legal representative at or before the resident's admission to the facility.[4] The residents' bill of rights include, among other things, the right to:[5]

- Civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from staff to exercise these rights;
- Be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment; and
- Receive adequate and appropriate health care and protective and support services.

The staff of the nursing home must receive training on resident rights and also be provided a copy of the resident's rights.[6] A nursing home may be subject to administrative fines, emergency moratorium on admissions, or denial, suspension, or revocation of license if it violates a resident's rights.[7]

Nursing Home Pharmacy Services

Nursing homes must adopt procedures to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident.[8] Nursing homes must also employ the services of a state licensed consultant pharmacist to provide consultation on all

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[1] Agency for Health Care Administration, *Nursing Homes*, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/Nursing_Homes.shtml (last visited December 6, 2019).
[2] Rule 59A-4.106(1)(a)1., F.A.C.
[3] Section 400.022(1), F.S.
[4] Section 400.022(2), F.S.
[5] *Supra* note 3.
[6] Id.
[7] Section 400.022(3), F.S. The action imposed by AHCA will be dependent on the scope of the violation and the gravity of its probably effect on the residents. *See* part II of ch. 408, F.S.
[8] Rule 59A-4.112(1), F.A.C.

aspects of the provision of pharmacy services in the facility. Other duties of the consultant pharmacist include:[9]

- Establishing a system to accurately record the receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
- Ensuring that all drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Prescription drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles.[10] Nursing homes must also maintain an emergency medication kit containing a limited supply of medications in the facility for use during emergency or after-hours situations. The contents of the kit is determined by the residents' needs, in consultation with the medical director, director of nursing, and pharmacist and must be in accordance with facility policies and procedures.[11]

Pharmacies

The Florida Pharmacy Act regulates the practice of pharmacy and contains the minimum requirements for safe practice.[12] The Board of Pharmacy (board) is tasked with adopting rules to implement the provisions of the chapter and setting standards of practice within the state.[13] Any person who operates a pharmacy in Florida must have a permit from the Department of Health (DOH).

DOH issues several types of pharmacy permits, including those for community pharmacies and institutional pharmacies. A community pharmacy is a location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis;[14] generally, retail pharmacies such as CVS or Walgreens. An institutional pharmacy is a location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medicinal drugs are compounded, dispensed, stored, or sold.[15]

DOH issues four classes of permits for institutional pharmacies.[16] A Class I institutional pharmacy is a pharmacy in which all medicinal drugs are administered from individual prescription containers to the individual patient and in which medicinal drugs are not dispensed on the premises.[17] No medicinal drugs may be dispensed in a Class I Institutional pharmacy. A Special- Closed System Pharmacy Permit, Special Parenteral and Enteral Pharmacy Permit, or Community Pharmacy Permit fills and dispense individual patient prescriptions.

A Class II institutional pharmacy is a pharmacy which employs the services of a registered pharmacist who, in practicing institutional pharmacy, provides dispensing and consulting services on the premises to patients of that institution, for use on the premises of that institution.[18] A consultant pharmacist of record is responsible for establishing a written policy and procedure manual for the implementation of the drug delivery system and the requirement of Board rules.[19]

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[9] Rule 59A-4.112(2)(3)(4), F.A.C.
[10] Rule 59A-4.112(5), F.A.C.
[11] Rule 59A-4.112(10), F.A.C.
[12] Chapter 465, F.S.
[13] Sections 465.005, 465.0155, and 465.022, F.S.
[14] Sections 465.003(11)(a)1. and 465.018, F.S.
[15] Sections 465.003(11)(a)2. and 465.019, F.S.
[16] Section 465.019, F.S.
[17] Section 465.019(2)(a), F.S.
[18] Section 465.019(2)(b), F.S.
[19] Rule 64B16-28.702, F.A.C.

A modified Class II institutional pharmacy is a pharmacy in a short-term, primary care treatment center that meet all the requirements for a Class II permit, except space and equipment requirements.[20] Modified Class II Institutional pharmacies are further classified according to the type of specialized pharmaceutical delivery system utilized.[21]

A Class III institutional pharmacy is a pharmacy, including central distribution facilities affiliated with a hospital that provides the same services as a Class II institutional pharmacy, but may also dispense, distribute, compound, and fill prescriptions for medicinal drugs and prepare prepackaged drug products.[22]

Formularies

A drug formulary is a continually updated list of medications supported by the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health.[23] The purpose of a formulary is to encourage the use of safe, effective, and most affordable medication.[24] Formularies are primarily used by health care payers, such as employers and insurers, to reduce costs.

Institutional Formularies

An institutional formulary system is a method by which the medical staff evaluates, appraises, and selects those medicinal drugs or proprietary preparations, which, in the medical staff's clinical judgment, are the most useful in patient care, and which are available for dispensing by a practicing pharmacist in a Class II or Class III institutional pharmacy.[25] Under current law, a facility with a Class I or Class II institutional pharmacy that operates under a formulary system must establish policies and procedures for the development of the system in accordance with the joint standards of the American Hospital Association and American Society of Hospitals Pharmacists for the utilization of a hospital formulary system, which must be approved by medical staff.[26] Such standards include the following requirements.[27]

- An organized and representative pharmacy and therapeutics (P&T) committee or equivalent body, composed of actively participating physicians, other prescribers, pharmacists, nurses, administrators, quality improvement managers, and other health care professionals and staff who participate in the medication use process.
- Policies formulated by the P&T committee regarding evaluation, selection, diagnostic and therapeutic use, and monitoring of medications.
- Mechanisms to communicate to health care professionals, patients, and payers about all aspects of the formulary system, including changes to the formulary or policies and formulary decisions are made.

According to the joint standards of the American Hospital Association and American Society of Hospitals Pharmacists, a formulary system must also:[28]

- Evaluate the clinical use of medications (outcomes);

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[20] Section 465.019(c)(c), F.S.
[21] *Supra* note 19.
[22] Section 465.019(2)(d), F.S.
[23] American Society of Health System Pharmacists, *ASHP Statement on the Pharmacy and Therapeutics Committee and the Formulary System,* AM J HEALTH SYST PHARM, 2008, 65:2384-6, available at https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacy-and-therapeutics-committee-and-formulary-system.ashx (last visited December 5, 2019).
[24] Academy of Managed Care Pharmacy, *Formulary Management*, (Nov. 2009), available at https://amcp.org/sites/default/files/2019-03/Formulary%20Management.pdf (last visited December 5, 2019).
[25] Section 465.003(7), F.S.
[26] Section 465.019(6), F.S.
[27] *Supra* note 23.
[28] Id.

- Establish and implement policies and quality assurance activities for medication use and administration;
- Evaluate and monitor adverse drug reactions and medication errors;
- Be endorsed by medical staff based on recommendations of the P&T committee; and
- Ensure that all personnel involved in patient care are informed about the existence of the formulary system, how to access the formulary system, the procedures governing operation, any changes in those procedures, and other necessary information.

Under these standard, an evidence-based institutional formulary, the P&T committee must:[29]

- Timely revise and maintain the formulary;
- Promote the rational, clinically appropriate, safe, and cost-effective use of medications via guidelines, protocols, and other mechanisms;
- Objectively appraise, evaluate, and select medications for addition to or deletion from the formulary, on an ongoing basis;
- Select formulary items based on their relative economic, clinical, and humanistic outcomes and not solely on economic factors;
- Identify potential safety concerns for each medication considered for inclusion and ensure those concerns are addressed if the medication is added to the formulary;
- Clearly define terminology related to the formulary; and
- Evaluate coordination issues with local health care plans and other organizations' formularies.

The formulary should be published and updated regularly.[30] It should also be readily available and accessible at all times to all personnel involved in patient care and the use of medications.[31] The P&T committee should also recommend or assist in the formulation of educational programs for professional staff, patients, families, and caregivers related to medications and medication use.

Similarly, the American Medical Association (AMA), recommends that institutional formularies meet the following standards:[32]

- Have the concurrence of the organized medical staff;
- Openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
- Have policies for the development, maintenance, approval, and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
- Provide for protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drugs;
- Have enough qualified medical staff, pharmacists, and other professionals to carry out required activities;
- Include policies that state practitioners will not be penalized for prescribing non-formulary drugs that are medically necessary; and
- Be in compliance with applicable state and federal rules and statutes.

Therapeutic Substitution of Prescription Drugs

For most medicines, there exist several similar or alternative products which can be either generic or therapeutically equivalent brand-name drugs.[33] Therapeutic substitution is the practice of switching or dispensing drugs that are chemically distinct but therapeutically similar in terms of their efficacy, safety,

[29] Id.
[30] Id.
[31] Id.
[32] Id.
[33] Rachel Chu, et al, *Patient Safety and Comfort - The Challenges of Switching Medicines* (2010), p. 8, available at http://www.patients-rights.org/uploadimages/Patient_Safety_and_Comfort_The_Challenges_of_Switching.pdf (last visited December 5, 2019).

and tolerability profiles.[34] Therapeutic substitution is designed to achieve an improved or neutral outcome by using the new drug, while reducing overall treatment costs.[35]

Substitution of brand name drugs may include substituting a brand-name drug for its generic equivalent. Generic drugs are copies of brand-name drugs with the same dosage form, safety, strength, route of administration, quality, and performance characteristics.[36] Therapeutic substitution may also involve brand name products that have been deemed to have therapeutic equivalence with an originally prescribed medicine or therapy.[37] These drugs will have a different chemical composition and use a different active ingredient than the originally prescribed drug.[38]

The AMA recommends therapeutic interchange, as long as it is authorized by the prescriber and occurs in accordance with previously established and approved written guidelines or protocols within a formulary system.[39] The AMA further states that facilities that perform therapeutic interchanges must inform the prescriber in a timely manner of any substitutions and allow the prescriber to override the system when necessary, without in appropriate burden. Such facilities must also provide active surveillance mechanisms to regularly monitor both compliance with standards and clinical outcomes where substitution has occurred, and intercede when indicated.

Three states authorize therapeutic substitution in community pharmacies: Arkansas, Idaho, and Kentucky.[40] In general, the prescriber must opt-in to allow the therapeutic substitution and the pharmacist must notify the prescriber of any interchanges made.[41] These laws also requires patient notification and allow patients to refuse the substitution.[42]

Some states authorize therapeutic substitution in institutional pharmacies. For example, Idaho, authorizes therapeutic substitution in a nursing home based on a formulary developed by the Board of Pharmacy.[43] Connecticut allows a medical director of a nursing home to substitute a prescribed drug for a resident of the facility, but requires approval from the prescriber before making the substitution.[44] Wisconsin authorizes a pharmacist to make therapeutic substitutions for a nursing home patient if approved by the patient's attending physician for the patient's period of stay within the nursing facility.[45]

Pharmacist Substitution in Florida

Florida law requires pharmacists to substitute a less expensive generic medication for a prescribed brand name medication.[46] The presenter of the prescription may specifically request the brand name medication to override this requirement.[47] The prescriber may also prevent substitution by indicating the brand name medication is "medically necessary" in writing, orally, or, in the case of an electronic

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[34] Flood, J., Mihalik, C., Fleming, R., Strober, B., Zucker, D., & Burgoyne, D., "The Use of Therapeutic Interchange for Biologic Therapies," Managed Care Magazine, January 2007, p. 51. http://www.managedcaremag.com/archives/0701/0701.peer_switch.html (last visited December 5, 2019).
[35] Id.
[36] U.S. Food and Drug Administration, *Generic Drug Facts*, (last rev. June 1, 2018), available at http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/default.htm (last visited December 5, 2019).
[37] Id.
[38] *Supra* note 33.
[39] American Medical Association, "Drug Formularies and Therapeutic Interchange H-125.991," (last rev. 2010), available at https://policysearch.ama-assn.org/policyfinder/detail/Drug%20Formularies%20and%20Therapeutic%20Interchange%20H-125.991?uri=%2FAMADoc%2FHOD.xml-0-227.xml (last visited December 5, 2019),
[40] Vanderholm, T. Klepser, D., & Adams, A., "State Approaches to Therapeutic Interchange in Community Pharmacy Settings: Legislative and Regulatory Authority," J MANAG CARE SPEC PHARM, Dec. 2018, 24(12): 1260-1263, available at https://www.jmcp.org/doi/10.18553/jmcp.2018.24.12.1260 (last visited December 6, 2019).
[41] Id.
[42] Id.
[43] Rule 27.01.01, ID Admin. Code.
[44] *See* CT Public Act No. 12-30.
[45] Wis. Stat. s. 450.01.
[46] Section 465.025(2), F.S.
[47] Id.

transmission of the prescription, by making an overt act to indicate the brand name medication is "medically necessary."[48] The Board of Pharmacy and the Board of Medicine establish a formulary which lists brand name medications and generic medications they determine to be so clinically different as to be biologically and therapeutically inequivalent, which cannot be substituted.[49]

Florida law allows a pharmacist to substitute a biosimilar[50] for a prescribed biological product[51] if the biosimilar has been determined by the U.S. Food and Drug Administration to be interchangeable with the prescribed biological product and the prescriber does not express a preference against substitution in writing, orally, or electronically.[52] The ability of a pharmacist to substitute a biosimilar for a prescription biological product is permissive unlike the substitution of brand name drugs with generic drugs, which is mandatory.

For generic and biosimilar substitution, the pharmacist must notify the patient and advise the patient of the right to reject the substitution and request the prescribed brand name medication or biologic.[53]

Florida law does not specifically authorize a pharmacist to substitute a therapeutically equivalent, but chemically different, drug for a prescribed drug without the express authorization of the prescriber.

Effect of Proposed Changes

HB 599 authorizes a nursing home facility to establish an institutional formulary through which a pharmacist may use therapeutic substitution. This would allow a pharmacist to replace a resident's prescribed drug with a chemically different drug listed in the formulary that is expected to have the same clinical effect.

To implement an institutional formulary, a nursing home facility must:

- Establish a committee, which consists of the medical director, director of nursing, and a consultant pharmacist, to develop the institutional formulary, as well as written guidelines or procedures for the formulary;
- Establish methods and criteria for selecting and objectively evaluating available drugs that may be used as therapeutic substitutes;
- Establish and maintain policies and procedures for developing and maintaining an institutional formulary and for approving, disseminating, and notifying prescribers of the formulary and make such policies and procedures available to AHCA, upon request; and
- Quarterly monitor compliance with the established policies and procedures and the clinical outcomes of therapeutic substitutions.

Each prescriber must annually opt into the use of the institutional formulary, as well as any subsequent changes to the formulary. However, a prescriber who has authorized the use of the institutional formulary for his or her patients may opt out of the formulary with respect to an individual patient, drug, or class of drugs. If a prescriber does not want a therapeutic substitution for a particular prescription, the prescriber must indicate "NO THERAPEUTIC SUBSTITUTION" on the prescription. In cases in which the prescriber has opted out of the formulary, a pharmacist must dispense the drug or drugs as prescribed. The bill prohibits a nursing home facility from taking adverse action against a prescriber who refuses to agree to the use of its institutional formulary.

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[48] Id.
[49] Section 465.025(6), F.S.; *see also* Rule 64B-16.27.500, F.A.C.
[50] 42 U.S.C. s. 262 (h) defines a "biosimilar" is a biological product that is highly similar to the licensed biological product or reference product, that notwithstanding minor differences in clinically inactive components, has no clinically meaningful differences in terms of safety, purity, and potency of the product.
[51] 42 U.S.C. s. 262 (h) defines "biological product" as a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein, or analogous product, or arsphenamine or derivative of
[52] Section 465.0252(2), F.S. arsphenamine, applicable to the prevention, treatment, or cure of a disease or condition.
[53] Sections 465.025(3)(a) and 465.0252(2)(c), respectively.

The bill authorizes a pharmacist to perform a therapeutic substitution in accordance with a nursing home's institutional pharmacy if the prescriber has agreed to its use. The pharmacist may not therapeutically substitute a drug if the prescriber indicates verbally or electronically, "NO THERAPEUTIC SUBSTITUTION".

The bill does not require the nursing home facility to notify the prescriber when a substitution is made, as required in other states that authorize therapeutic substitutions. The bill also does not require that the facility notify the resident or resident's representative of a therapeutic substitution, or advise the resident or the resident's representative that the nursing home has implemented an institutional formulary. The resident's bill of rights in current law may require the nursing home facility to inform the resident of the use of an institutional formulary and substitutions planned for the resident, as the resident has the right to be informed of and participate in the planning of all medical treatment.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 400.143, F.S., relating to institutional formularies established by nursing home facilities.
Section 2: Amends s. 465.025, F.S., relating to substitution of drugs.
Section 3: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA may experience an insignificant, nonrecurring, negative fiscal impact to amend rules and survey materials to ensure nursing homes that adopt institutional formularies comply with the bill's requirements.

   The bill has no impact on the Medicaid program, which uses a preferred drug list and prior authorization protocol; the institutional formularies authorized by the bill would not apply to Medicaid patients.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Patients and nursing homes may experience cost savings if a less expensive drug is therapeutically substituted for a prescribed drug, in instances where patients and nursing homes incur drug costs. It is unclear whether private insurers using their own formularies would experience an economic impact.

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 in ss. 400.23 and 408.819, F.S., 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 institutional formularies established by nursing home facilities; creating s. 400.143, F.S.; providing definitions; authorizing a nursing home facility to establish and implement an institutional formulary; requiring a nursing home facility to establish a committee to develop an institutional formulary; providing for committee membership; providing requirements for the development and implementation of the institutional formulary; requiring a nursing home facility to maintain the written policies and procedures for the institutional formulary; requiring a nursing home facility to make available such policies and procedures to the Agency for Health Care Administration, upon request; requiring a prescriber to annually authorize the use of the institutional formulary for certain patients; requiring the prescriber to opt into any changes made to the institutional formulary; authorizing a prescriber to opt out of using the institutional formulary or to prevent a therapeutic substitution under certain circumstances; prohibiting a nursing home facility from taking adverse action against a prescriber for refusing to agree to the use of the institutional formulary; amending s. 465.025, F.S.;

authorizing a pharmacist to therapeutically substitute medicinal drugs under an institutional formulary established by a nursing home facility under certain circumstances; prohibiting a pharmacist from therapeutically substituting a medicinal drug under certain circumstances; providing an effective date.

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

Section 1. Section 400.143, Florida Statutes, is created to read:

400.143 Institutional formularies established by nursing home facilities.—

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

(a) "Institutional formulary" means a list of medicinal drugs established by a nursing home facility under this section for which a pharmacist may use a therapeutic substitution for a medicinal drug prescribed to a resident of the facility.

(b) "Medicinal drug" has the same meaning as provided in s. 465.003(8).

(c) "Prescriber" has the same meaning as provided in s. 465.025(1).

(d) "Therapeutic substitution" means the practice of replacing a nursing home facility resident's prescribed medicinal drug with another chemically different medicinal drug

that is expected to have the same clinical effect.

(2) A nursing home facility may establish and implement an institutional formulary in accordance with the requirements of this section.

(3) A nursing home facility that implements an institutional formulary under this section must:

(a) Establish a committee to develop the institutional formulary and written guidelines or procedures for such institutional formulary. The committee must consist of, at a minimum:

1. The facility's medical director.

2. The facility's director of nursing services.

3. A consultant pharmacist licensed by the Department of Health and certified under s. 465.0125.

(b) Establish methods and criteria for selecting and objectively evaluating all available pharmaceutical products that may be used as therapeutic substitutes.

(c) Establish policies and procedures for developing and maintaining the institutional formulary and for approving, disseminating, and notifying prescribers of the institutional formulary.

(d) Perform quarterly monitoring to ensure compliance with the policies and procedures established under paragraph (c) and monitor the clinical outcomes in circumstances in which a therapeutic substitution has occurred.

(4) The nursing home facility shall maintain all written policies and procedures for the institutional formulary established under this section. Each nursing home facility shall make available such policies and procedures to the agency, upon request.

(5)(a) A prescriber must annually authorize the institutional formulary for his or her patients. A prescriber must opt into any subsequent changes made to a nursing home facility's institutional formulary.

(b) A prescriber may opt out of the nursing home facility's institutional formulary with respect to a particular patient, medicinal drug, or class of medicinal drugs.

(c) A prescriber may prevent a therapeutic substitution for a specific medication order if such order is provided verbally or generated and transmitted electronically by indicating "NO THERAPEUTIC SUBSTITUTION" on the prescription.

(d) A nursing home facility may not take adverse action against a prescriber for refusing to agree to the use of the facility's institutional formulary.

Section 2. Subsection (9) is added to section 465.025, Florida Statutes, to read:

465.025 Substitution of drugs.—

(9) A pharmacist may therapeutically substitute medicinal drugs in accordance with an institutional formulary established under s. 400.143 for the resident of a nursing home facility if

the prescriber has agreed to the use of such institutional formulary. The pharmacist may not therapeutically substitute a medicinal drug pursuant to the facility's institutional formulary if the prescriber indicates verbally or electronically on the prescription "NO THERAPEUTIC SUBSTITUTION" as authorized under s. 400.143(5)(c).

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 767 Assisted Living Facilities
SPONSOR(S): Health Market Reform Subcommittee, Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 402

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

SUMMARY ANALYSIS

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator. ALFs are licensed and regulated by the Agency for Health Care Administration (AHCA) under part I of ch. 429, F.S., and part II of ch. 408, F.S., and rule 59A-36. The bill amends various provisions in Ch. 429 regulating ALFs. Specifically, the bill:

- Requires AHCA to conduct a full inspection instead of an abbreviated biennial licensure inspection to review key quality-of-care standards for a facility that has a history of class I, class II, or uncorrected class III violations resulting from complaints referred by the State Long-Term Care Ombudsman Program.
- Codifies current rule requirements to law relating to training and education of facility staff.
- Allows ALFs to admit or retain residents that require the use of assistive devices, which are defined as any device designed or adapted to help a resident perform an action, task, an activity of daily living, a transfer, prevention of a fall, or recovery from a fall.
- Allows ALFs to admit residents that require 24-hour nursing care, or residents that are receiving hospice services, if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility.
- Allows ALFs to admit residents who are bedridden if they are bedridden for no more than 7 days, or for an ALF licensed as extended congregate care, no more than 14 days.
- Allows the use of certain physical restraints in ALFs, including, full-bed rails and geriatric chairs.
- Amends the Resident Bill of Rights to allow the State Long-Term Care Ombudsman Program to provide assistance to a resident who needs to be relocated due to the closure of the facility.
- Removes the requirement for ALF staff assisting with the self-administration of medication to read the label of the medication to the resident. Instead, the bill requires staff to, in the presence of the resident, confirm the medication is correct and advise the resident of the medication name and purpose.
- Authorizes rules to address technological advances in the provision of care, safety, and security, including the use of devices, equipment and other security measures for wander management, emergency response, staff risk management, and for the general safety and security of residents, staff, and the facility.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Long-Term Care Ombudsman Program

The State Long-Term Care Ombudsman Program (LTCOP) is a statewide, volunteer-based system of local councils that act as advocates for residents of long-term care facilities.[1] Through 14 district and regional offices that together cover the entire state, volunteers identify, investigate, and resolve complaints made by, or on behalf of, residents of assisted living facilities (ALFs), nursing homes, adult family care homes, board and care facility, or any other similar residential adult care facility.[2]

In addition to investigating and resolving complaints, the LTCOP:

- Monitors, and comments on the development and implementation of federal, state, and local laws, regulations, and policies regarding health, safety, and welfare of residents in long-term care facilities;
- Provides information and referrals with regard to long-term care facilities; and
- Conducts annual assessments of long-term care facilities.[3]

A representative of the LTCOP has the right to enter an ALF unannounced to determine compliance with part I of ch. 429, F.S., part II of ch. 408, F.S., and applicable rules. Data collected by the LTCOP may be used by AHCA in investigations involving violations of regulatory standards.[4]

Assisted Living Facilities

Licensure

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[5] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[6] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[7]

ALFs are licensed and regulated by AHCA under part I of ch. 429, F.S., and part II of ch. 408, F.S., rule 59A-36, F.A.C. In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include limited nursing services,[8] limited mental health services, and extended congregate care services.[9]

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[1] Part I of ch. 400, F.S.
[2] Florida Ombudsman Program, *FY 2019 Annual Report,* available at http://www.ombudsman.myflorida.com/publications/ar/LTCOP_2019_Annual_Report.pdf (last visited January 13, 2020).
[3] Id.
[4] S. 429.34(1), F.S.
[5] S. 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[6] S. 429.02(16), F.S.
[7] S. 429.02(1), F.S.
[8] S. 429.07(3)(c), F.S. Limited nursing services include acts that may be performed by a person licensed as a nurse but are not complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints (s. 429.02(13), F.S.).
[9] S. 429.07(3)(b), F.S. Extended congregate care facilities provide services to an individual that would otherwise be ineligible for continued care in an ALF. The primary purpose is to allow a resident the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired.

Current law requires rules governing ALFs promote a safe and sanitary environment that is residential and non-institutional in design or nature.[10] Current law also requires rules set requirements for and maintenance of facilities relating to plumbing, heating, cooling, lighting, ventilation, living space and other housing conditions that are not in conflict with ch. 553, F.S., governing building construction standards. Current law also requires AHCA to develop key quality-of-care standards for ALFs with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules.[11] Rules must also address moratoriums, classification of deficiencies, the levying of penalties and the use of income from fees and fines.[12]

Some counties and municipalities require all businesses to obtain a business tax receipt, formerly known as an occupational license[13], prior to engaging in business.[14] A business tax receipt serves as evidence that a business is in compliance with all business tax regulations of the local governing authority.[15] Current law requires counties and municipalities to verify with AHCA that an ALF is licensed prior to issuing an occupational license. The term occupational license is no longer used in the Local Business Tax Act in ch. 205, F.S.[16]

Inspections, Surveys and Monitoring Visits

Current law requires AHCA to adopt rules on uniform standards and criteria to be used during standard biennial licensure inspections to determine compliance with facility standards and residents' rights. The rule requires AHCA to utilize certain core survey tasks during an inspection, including:

- Conducting a tour of the facility to observe and assess resident behavior and demeanor, adherence to facility abuse prohibition policy, adherence to facility infection control policy, and more;
- Conducting interviews with residents or their family members and staff; and
- Reviewing facility records.[17]

Current law also authorizes AHCA to use an abbreviated biennial licensure inspection that consists of key quality-of-care standards in lieu of a full inspection if the facility has a good record of past performance.[18] Current law requires a full inspection if a facility has a history of class I or class II violations, uncorrected class II violations, confirmed ombudsman complaints or confirmed licensure complaints.[19]

Section 408.813, F.S. categorizes violations into four classes according to the nature and gravity of its probable effect on residents. If an ALF is cited for a class I violation or three or more class II violations arising from separate surveys within a 60-day period or due to unrelated circumstances during the same survey, AHCA must conduct an additional licensure inspection within six months.[20]

During any calendar year in which no survey is performed, AHCA may conduct at least one monitoring visit of a facility, as necessary, to ensure compliance of a facility with a history of certain violations that

[10] S. 429.41(1), F.S.
[11] S. 429.41(5), F.S. AHCA reviews the key quality-of-care standards for compliance during an abbreviated biennial licensure inspection (s. 429.41(5), F.S.).
[12] S. 429.41(1)(f), F.S.
[13] Ch. 2006-152 Laws of Fla., amended ch. 205, F.S., to change the title from Local Occupational License Tax Act to Local Business Tax Act. The bill also changed all references of occupational license to business tax.
[14] S. 205.053, F.S.
[15] S. 205.022(2), F.S.
[16] Supra at 13.
[17] Rule 59A-36.001, F.A.C.
[18] S. 429.41(5), F.S.
[19] Id.
[20] S. 429.34(2), F.S.

threaten the health, safety, or security of residents. If warranted, AHCA will perform an inspection as a part of a complaint investigation of alleged noncompliance with the Resident Bill of Rights.[21]

Training and Education

Prior to 2019, the state had a bifurcated, two agency regulatory structure for ALFs. The Department of Elder Affairs (DOEA), was responsible for rulemaking while AHCA was responsible for enforcing the rules. In 2019, the legislature transferred rulemaking authority to AHCA to create operational efficiencies by virtue of allowing the state agency to adopt the rules that they are responsible for enforcing.[22] AHCA has since adopted rules relating to a variety of subjects, including, rules on training and education requirements for ALF administrators and staff.[23] Training and education requirements are also provided in statute. There are some differences in terminology used in the rule as compared to the statute. The training and education requirements in statute are also difficult to interpret as far as which requirements apply to administrators, and which requirements apply to other facility staff.

Current law requires all new ALF employees to complete a pre-service orientation prior to interacting with residents.[24]

Current law requires all administrators to complete a competency test to indicate successful completion of training and education requirements within 90 day of employment.[25]

Current ALF rule requires ALF staff who provide direct care to residents, other than administrators or managers, to participate in in-service training on certain topics, including, infection control, reporting adverse incidents, safe food handling practices, and emergency evacuation procedures.[26] Certificates or copies of certificates indicating completion of training requirements are required to be documented in the facility's personnel file, but the rule does not specify that the a single certificate of completion coving all required in-service training topics may be issued if the training is provided in a single training course.

Current ALF law authorizes AHCA to establish registration requirements for trainers to train ALF staff, and AHCA has already adopted such rules.[27] However, current law does not authorize AHCA to adopt rules on the revocation of a trainer's registration.

Current law authorizes AHCA to adopt rules to establish specific policies and procedures on resident elopement and resident elopement drill requirements.[28] ALF rule requires all facility staff to participate in in-service training on the facility's procedures for resident elopement within 30 days of employment.[29] ALF rule also requires the facility to document staff participation in resident elopement drills.[30]

Admission

An ALF must provide appropriate care and services to meet the needs of the residents admitted to the facility.[31] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on certain criteria.[32] Current law requires each resident to be examined by a physician or nurse practitioner within 60 days before admission to the ALF, if possible.[33] If an

[21] Id.
[22] Ch. 2019-11 Laws of Fla.
[23] Rule 59A-36.011, F.A.C.
[24] S. 429.52, F.S., and rule 59A-36.011(2), F.A.C.
[25] Id.
[26] Rule 59A-36.011(3), F.A.C.
[27] S. 429.52(12), F.S., F.S., and rule 59A-36.029, F.A.C.
[28] S. 429.41(1)(l), F.S.
[29] Rule 59A-36.011(3)(f), F.A.C.
[30] Id.
[31] For specific minimum standards, see Rule 59A-36.006, F.A.C.
[32] S. 429.26, F.S.
[33] S. 429.26(4), F.S.

examination has not been completed prior to admission, an examination must be made within 30 days after admission.[34] Current law requires the completed medical examination to be signed, but does not specify by whom. The owner or facility administrator must use the information contained in the medical examination report to determine the appropriateness of the resident's admission. If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or a health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[35]

Current law allows an ALF to retain a terminally ill resident (including a resident who requires 24-hour nursing supervision, who no longer meets the criteria for continued residency), if the following conditions are met:

- The arrangement is mutually agreeable to the resident and the facility,
- Additional care is rendered through a licensed hospice, and
- The resident is under the care of a physician who agrees that the physical needs of the resident are being met.[36]

Rule 59A-36.006, F.A.C., authorizes an ALF with a standard license, a limited nursing services license, or a limited mental health license to retain a resident who is bedridden for up to 7 days. Further, the rule authorizes an ALF with an extended congregate care license to retain a resident who is bedridden for up to 14 days.

Resident Rights and Safety

A physical restraint is a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint.[37] The term also includes any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. Current law limits the use of physical restraints by an ALF to half-bed rails as prescribed by the resident's physician with consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact.[38] Current ALF rule requires the prescribing physician to assess the need of the resident for physical restraints annually. Current law does not expressly authorize the use of geriatric chairs or full bed rails.

Current laws requires an ALF to provide notice of relocation to a resident, unless, the resident has been certified by a physician to require an emergency relocation to a facility that can provide a more skilled level of care, or, if the resident engages in a pattern of conduct that is harmful or offensive to other residents.[39] The notice of relocation must be in writing, and, must be provided at least 45 days prior to a change in residency.[40] Currently, the ALF is not required to provide notice of relocation to the resident's guardian, unless the resident has been adjudicated mentally incapacitated.

In the event an ALF decides to close its business operation, the facility must inform each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the expected time of discontinuance of the operation.[41] An ALF resident may have several agencies acting on their behalf, so it may be unclear to an ALF exactly which agency they are required to notify, and there is no statutory requirement for them to specifically notify AHCA. The notice of relocation or termination of

[34] S. 429.26(5), F.S.
[35] Rule 59A-36.006(5), F.A.C.
[36] S. 429.26(9) and (11), F.S.
[37] S. 429.02(18), F.S.
[38] S. 429.41(1)(k), F.S.
[39] S. 429.28(1)(k), F.S.
[40] Id.
[41] S. 429.31(1), F.S.

residency must be provided at least 45 days prior to a change in residency.[42] In the event a resident doesn't have anyone to represent them, the facility is responsible for referral to an appropriate social service agency for placement.[43] AHCA is required to monitor the transfer of residents to other facilities and ensure that resident's rights are being protected.[44] AHCA, in consultation with the Department of Children and Families, must specify procedures for ensuring that all residents who receive services are appropriately relocated.[45]

On October 31, 2019, the Miami Herald published an article about the closure of an ALF in Broward County describing issues faced by residents in receiving assistance with relocating to another facility.[46] According to the article, while the facility did timely notify its residents and AHCA, many residents did not receive the proper assistance with finding a new facility from the facility or state agencies.[47]

Assistance to Residents

Currently, the Resident Bill of Rights states that a resident has the right to assistance from the ALF in obtaining access to adequate and appropriate health care. Such assistance includes the management of medication, assistance in making appointments for health care services, providing transportation to health care appointments, and performing certain other health care services by appropriately licensed personnel or volunteers.

An unlicensed ALF staff member may provide assistance to a resident who is medically stable with self-administration of a routine, regularly scheduled medication that is intended to be self-administered if there is a documented request by and the written informed consent of the resident.[48] Assistance with medication includes, among other things, in the presence of the resident, reading the label, opening the container, removing the prescribed amount from the container, and closing the container.[49] Current law, does not provide that the resident may opt out of being read the label by facility staff.

Self-administered medication includes legend and over-the-counter oral dosage forms, topical dosage forms and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers. Currently, an unlicensed ALF staff member is not authorized to provide assistance to a resident with the self-administration of a transdermal patch.

Currently, unlicensed ALF staff are prohibited from assisting with the self-administration of medications, ordered by a physician, that have prescriptive authority to be given "as needed", unless, at the request of a competent resident, the order is written with specific parameters that remove independent judgement on the part of the unlicensed person.[50]

Current law requires ALFs to notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment.[51] If an underlying condition is determined to exist, ALF must arrange, with the appropriate health care provider, the necessary care and services to treat the condition.[52]

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[42] S. 429.28(1)(k), F.S.
[43] S. 429.31(1), F.S.
[44] S. 429.31(2), F.S.
[45] Id.
[46] Jack Brook, *Retirement Home Had Bad Bed Bugs. It's Closing, but Could Residents Wind Up Somewhere Worse,* Miami Herald, Oct. 31, 2019, available at https://www.miamiherald.com/news/local/article235871067.html (last visited January 4, 2020).
[47] Id. "AHCA spokesman said in a statement to the Miami Herald that AHCA had been properly notified by owners about the closure, but more than a week after the ALF handed out its notice to residents, word had not reached a key state monitor tasked with protecting residents' rights." "Broward's district ombudsman manager said she was not aware of the facility closing until contacted by a Miami Herald reporter."
[48] S. 429.256(2), F.S.
[49] S. 429.256(3)(b), F.S.
[50] S. 429.256(4)(g), F.S.
[51] S. 429.26(7), F.S.
[52] Id.

Adverse Incident Reporting Requirements

When an ALF has reason to believe that an adverse incident has occurred, current law requires them to submit a preliminary report to AHCA by electronic mail, facsimile, or United States mail, within one business day after the occurrence of an adverse incident.[53] The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. After submission of the preliminary report, if the event is still considered an adverse incident by the facility, the facility must submit a full report to AHCA by electronic mail, facsimile, or United States mail, within 15 days, which must include the results of the facility's investigation into the adverse incident.[54]

However, if, after submission of a preliminary report, the facility determines that the event was not an adverse incident, the facility is responsible for withdrawing the preliminary report. If a facility fails to withdraw a preliminary report, AHCA has no way of knowing that the event was determined not to be an adverse incident, so they still expect the facility to timely file a full report. A facility that fails to withdraw a preliminary report and later fails to timely file a full report will be subject to a citation from AHCA for failure to timely file a final report.

According to AHCA, based on ALF adverse incident reports submitted since June 27, 2017, AHCA has initiated 60 investigations on ALFs that forgot to withdraw preliminary reports prior to the deadline for final reports.[55]

Currently, AHCA is not required to remind the facility that an adverse incident report is due. However, AHCA does send an automated email one day prior to the deadline for the final report.[56]

Emergency Management Plan

Pursuant to s. 429.41, F.S., each ALF must prepare a written comprehensive emergency management plan that must address the following:

- Provision for all hazards;
- Provision for the care of residents remaining in the facility during an emergency, including, emergency power, supplies, and equipment;
- Provision for the care of additional residents who may be evacuated to the facility during an emergency;
- Identification of residents with Alzheimer's disease or related disorders, and residents with mobility limitations who may need specialized assistance;
- Identification of and coordination with the local emergency management agency;
- Arrangement for post-disaster activities, including, responding to family inquiries, transportation, and obtaining medical intervention for residents; and
- Identification of staff responsible for implementing each part of the plan.[57]

The comprehensive emergency management plan is subject to review and approval by the county emergency management agency. The county emergency management agency is required to ensure that volunteer organizations and other agencies are given the opportunity to review the plan, including DOH, AHCA, and the Division of Emergency Management.[58]

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[53] S. 429.23(3), F.S.
[54] S. 429.23(4), F.S.
[55] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 767, December 16, 2019 (on file with Health Market Reform Subcommittee staff).
[56] Id.
[57] Rule 59A-36.019, F.A.C.
[58] S. 429.41(1)(b), F.S.

New ALFs, and facilities whose ownership has been transferred, must submit an emergency management plan to the local emergency management agency within 30 days of obtaining a license.[59]

Uniform Fire Safety Standards

Section 633.206, F.S., authorizes the State Fire Marshal to establish uniform fire safety standards for ALFs, of which the State Fire Marshal is the final administrative interpreting authority. The State Fire Marshal is authorized to inspect an ALF at any reasonable hour if there is reasonable cause to believe that a violation of the fire safety code may exist.[60] Pursuant to rules adopted by the State Fire Marshal, the uniform fire safety standards applicable to ALFs in Florida are the standards of the National Fire Protection Association (NFPA) for life safety in the NFPA 101, Life Safety Code.[61]

The uniform fire safety standards for ALFs in Florida, adopted and enforced by the State Fire Marshal, allow the use of locking devices in ALFs.[62] Locking devices can be used in ALFs to separate certain residents by the level of care they are receiving.[63] For example, a locking device can be used to keep residents in a memory care unit separate from the general population of the facility. Locking devices may also be used for delayed egress on facility exit doors. For example, when someone pushes the horizontal crash bar of the locked door, a local buzzer will sound, and the door will automatically open within 15 seconds. Currently, AHCA does not have statutory authority to adopt rules on the use of locking devices in ALFs.

As of January 3, 2020, there were 3,080 licensed ALFs.[64]

Effect of the Bill

Licensure

The bill authorizes AHCA to adopt rules to cultivate technological advances in the provision of care, safety, and security, including the use of devices, equipment and other security measures for wander management, emergency response, staff risk management, and for the general safety and security of residents, staff, and the facility.

As a condition of licensure, ALFs must be inspected by the local county health department for food safety and environmental sanitation requirements, the local authority having jurisdiction over fire and life safety matters, as well as by AHCA. The bill moves portions of current law, which will result in no practical or measured effect. Specifically, the bill moves current law that:

- Authorizes AHCA to adopt rules relating to a safe and decent living environment and the sanitary condition of facilities that are not in conflict with the requirements in ch. 553, F.S., s. 381.006, F.S., s. 381.0072, F.S., or s. 633.206, F.S.[65]
- Requires the rules to clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are not duplicative; and
- Authorizes AHCA to collect fees for food service inspections conducted by county health departments and transfer the fees to the Department of Health.

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[59] Id.
[60] S. 633.216, F.S.
[61] Rule 69A-40.028, F.A.C.
[62] NFPA 101, *Life Safety Code,* 2018 Edition.
[63] Greene, L, *Following the Code-Code Changes are an Important Part of Access Control or Egress,* Security Today, April 1, 2016, available at https://securitytoday.com/Articles/2016/04/01/Following-the-Code.aspx (last visited January 19, 2020).
[64] AGENCY FOR HEALTH CARE ADMINISTRATION, *Facility/Provider Search Results – Assisted Living Facilities,* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited January 4, 2020).
[65] Ch. 553, F.S., contains Building Construction Standards, s. 381.006, F.S., contains the Environmental Health Program administered by the Department of Health, s. 381.0072, F.S., contains food service protection requirements enforced by the Department of Health, and s. 633.206, F.S., contains the uniform fire safety standards.

The bill authorizes AHCA to adopt rules relating to furnishings for resident bedrooms or sleeping areas, linens, and other housing conditions relating to hazards, to promote the health, safety, and welfare of residents suitable to the size of the structure. AHCA has already adopted rules on all of these topics, so this will have no practical effect.

The bill removes the authority for rules that set standards for plumbing, heating, cooling, lighting, ventilation, living space and other housing conditions because references to the Florida Building Code were removed from ALF rules in 2010.[66] The bill removes the authority for rules that address the use of income from fees and fines because it is duplicative of a provision in s. 408.818, F.S. The bill removes the requirement that key quality-of-care standards be developed with input from the ombudsman and representatives of provider groups as the rulemaking process already allows for public participation.

The bill makes a conforming change to the prohibition on a county or municipality issuing an occupational license to a facility prior to determining whether the facility is licensed as an ALF by replacing the term "occupational license" with "business tax receipt". Counties and municipalities issue business tax receipts, not occupational licenses, to persons or entities that have complied with laws governing business taxes in ch. 205, F.S. Business taxes are fees charged by a county or municipality for the privilege of engaging in any business, profession, or occupation within its jurisdiction.[67]

Inspections, Surveys and Monitoring Visits

Current law requires AHCA to adopt rules on uniform standards and criteria to be used during inspections to determine compliance with facility standards and residents' rights. The bill removes this rulemaking authority. As a result, AHCA will be able to repeal the core survey inspection tasks contained in rule 59A-36.001, F.A.C. In effect, AHCA will not be confined to surveying for compliance with such a defined level of specificity. Instead, AHCA will be able to inspect facilities for a broad array of issues. The bill also requires inspections to be used to determine compliance with part I of ch. 429, F.S., in its entirety, instead of using them to determine only general compliance with facility standards and residents' rights.

The bill requires AHCA to conduct a full inspection instead of an abbreviated biennial licensure inspection to review key quality-of-care standards for a facility that has a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program.

Training and Education

Currently, there are some differences in terminology used in the training and education requirements in rule as compared to the statute. The training and education requirements in statute are also difficult to interpret as far as which requirements apply to administrators, and which requirements apply to other facility staff. The bill amends the training and education requirements for ALF administrators and staff to provide consistency between ALF statutes and rules, and to clearly illustrate which requirements apply to administrators and which requirements apply to other facility staff.

Current ALF law authorizes AHCA to establish registration requirements for trainers to train ALF staff, and AHCA has already adopted such rules. However, current law does not authorize AHCA to adopt rules on the revocation of a trainer's registration. The bill authorizes AHCA to adopt rules to establish a process for revocation of a trainer's registration.

The bill codifies to law an ALF rule to law that requires ALF staff who provide direct care to residents to participate in in-service training, which will have no practical effect because it is already required in rule.

[66] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 767, December 16, 2019 (on file with Health Market Reform Subcommittee staff).
[67] S. 205.022, F.S.

However, the bill also provides that the topics covered during the pre-service orientation are not required to be repeated during in-service training. This provision is not currently in ALF rule, so ALF staff who provide direct care to residents will no longer have to repeat topics in in-service training that they have already learned in pre-service orientation. The bill allows a single certificate of completion that covers all required in-service training topics to be issued to a participating staff member if the training is provided in a single training session.

The bill authorizes AHCA to contract with another entity to administer the core competency test. AHCA has a contract with the MacDonald Research Institute to administer the test.[68]

The bill codifies in statute a current rule requirement that staff involved with the management of medications and assisting with the self-administration of medications must complete a minimum of 2 hours of continuing education on providing assistance with self-administration of medication and safe medication practices.

Current law authorizes AHCA to adopt rules to establish specific policies and procedures on resident elopement and resident elopement drill requirements.[69] The bill requires AHCA to adopt rules on resident elopement drill requirements. AHCA has already adopted such rules, so this requirement will have no effect. The bill codifies ALF rule requirement to law that requires administrators and direct care staff to review the facility's procedures on resident elopement, and requires the facility to document staff participation in resident elopement drills. This will have no effect because these requirements are already in rule.

Admission

The bill allows an ALF to admit or retain the following residents:

- Residents that receive a health care service or treatment designed to be provided within a private residential setting if all requirements for providing the service or treatment are met by the ALF or a third party; and
- Residents that require the use of assistive devices, which the bill defines as any device designed or adapted to help a resident perform an action, task, an activity of daily living, a transfer, prevention of a fall, or recovery from a fall.

The bill allows an ALF to admit a resident that requires 24-hour nursing care, or a resident that is receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. Current law only allows ALFs to retain such residents, rather than admit them.

The bill codifies a current ALF rule to law that allows an ALF to admit a bedridden resident if the resident is bedridden for no more than 7 days, or for an ALF licensed as extended congregate care, no more than 14 days. Currently, ALF statutes only allow ALFs to retain such residents, rather than admit them. This will have no practical effect because it is just codifying a current ALF rule to law.

Current law requires each resident to be examined by a physician or nurse practitioner within 60 days before admission to the ALF, if possible. If an examination has not been completed prior to admission, an examination must be made within 30 days after admission. The bill removes the "if possible" language from current law to explicitly require a resident to undergo a medical examination within 60 days before admission or within 30 days after admission. The bill provides that the medical examination form must be signed only by the practitioner, and may only be used to record the practitioner's direct

[68] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 767, December 16, 2019 (on file with Health Market Reform Subcommittee staff).
[69] S. 429.41(1)(l), F.S.

observation of the patient at the time of examination and must include the patient's medical history. The form must only be used as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility.

Resident Rights and Safety

Current law limits the use of physical restraints by an ALF to half-bed rails as prescribed by the resident's physician with consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The bill authorizes the use of full-bed rails, geriatric chairs, and any device the resident chooses to use and is able to remove or avoid independently, as prescribed by the resident's physician, and with consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Current ALF rule requires the prescribing physician to assess the need of the resident for physical restraints annually, but does not specify requirements for care planning or staff monitoring. The bill authorizes AHCA to adopt rules to specify requirements for care planning and staff monitoring.

Current law requires an ALF to provide notification of a non-emergency relocation to a resident's legal guardian, but only for a resident who has been adjudicated mentally incapacitated. The bill requires an ALF to provide notice of a non-emergency relocation for any resident. The bill also requires the notice of relocation or termination to state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program.

The bill amends s. 429.31, F.S., to provide relocation assistance to a resident of an ALF whose residency is being terminated due to closure of the facility. Specifically, the bill requires the notice of relocation or termination to state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. The bill requires an ALF to notify AHCA of its plans to discontinue facility operation. Further, the bill requires AHCA, upon receiving notice of a facility's voluntary or involuntary termination, to immediately inform the State Long-Term Care Ombudsman Program so they can provide assistance with relocation to the resident.

Assistance to Residents

The bill removes the requirement that an ALF make arrangements with a health care provider for services to treat an underlying condition that contributes to a resident's dementia or cognitive impairment. Instead, the bill requires ALFs to assist in making appointments for the necessary care and services to treat the condition, and to notify the resident's representative or designee in of the need for health care services. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility must arrange with the appropriate health care provider for the necessary care and services to treat the condition.

The bill removes the requirement for ALF staff assisting with the self-administration of medication to read the label of the medication to the resident. Instead, the bill requires staff to, in the presence of the resident, confirm the medication is correct and advise the resident of the medication name and purpose. The bill also provides the resident with the ability to opt out of being orally advised of the medication name and dosage by signing a waiver. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.

Currently, an unlicensed ALF staff member is not authorized to provide assistance to a resident with the self-administration of a transdermal patch. The bill adds transdermal patches to the list of medications to be considered self-administered medications.

Currently, unlicensed ALF staff are prohibited from assisting with the self-administration of medications, ordered by a physician, that have prescriptive authority to be given "as needed", unless, at the request of a competent resident, the order is written with specific parameters that remove independent judgement on the part of the unlicensed person. The bill allows unlicensed staff to assist with the self-administration of medication, under the same circumstances, but requires the resident requesting assistance to be aware of their need for the medication and understand the purpose for taking it, instead of requiring them to be competent.

Adverse Incident Reporting Requirements

The bill amends s. 429.23, F.S., to require ALFs to submit the adverse incident preliminary report and final report through AHCA's online portal, or by electronic mail if the portal is offline, instead of by facsimile or United States Mail. The bill also adds language to prevent an ALF from being fined for failing to submit a final report until three days after AHCA notifies the ALF that the final report is due if the incident is determined to, in fact, not be an adverse incident.

Emergency Management Plan

The bill codifies a current rule in law that requires new ALFs and facilities who have a change of ownership to submit a comprehensive emergency management plan to the county emergency management agency within 30 days of receiving a license. In addition, it removes current law that requires county emergency management agencies to give volunteer organizations an opportunity to review the plan.

Uniform Fire Safety Standards

The bill also authorizes AHCA to adopt rules on locking devices, which AHCA is currently not statutorily permitted to do. The uniform fire safety standards for ALFs in Florida, adopted and enforced by the State Fire Marshal, allow the use of locking devices in ALFs. Locking devices can be used in ALFs to separate certain residents by the level of care they are receiving. For example, a locking device can be used to keep residents in a memory care unit separate from the general population of the facility. Locking devices may also be used for delayed egress on facility exit doors. For example, when someone pushes the horizontal crash bar of the locked door, a local buzzer will sound, and the door will automatically open within 15 seconds. In effect, the bill allows AHCA to monitor the use of locking devices in ALFs in accordance with the rules they see appropriate to draft. However, such rules must not be in conflict with or duplicative of the uniform fire safety standards.

The bill also moves current law requirements for fire safety standards from the section governing rulemaking to a newly created section of law because the State Fire Marshal is responsible for adopting rules to enforce the Uniform Fire Safety Standards not AHCA. This will have no practical or measurable effect.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 429.02, F.S., relating to definitions.
Section 2: Amends s. 429.07, F.S., relating to license required; fee.
Section 3: Amends s. 429.11, F.S., relating to initial application for license; provisional license.
Section 4: Amends s. 429.176, F.S., relating to notice of change of administrator.
Section 5: Amends s. 429.23, F.S., relating to internal risk management and quality assurance program; adverse incidents and reporting requirements.
Section 6: Amends s. 429.255, F.S., relating to use of personnel; emergency care.
Section 7: Amends s. 429.256, F.S., relating to assistance with self-administration of medication.

Section 8: Amends s. 429.26, F.S., relating to appropriateness of placements; examinations of residents.
Section 9: Amends s. 429.28, F.S., relating to resident bill of rights.
Section 10: Amends s. 429.31, F.S., relating to closing of facility; notice; penalty.
Section 11: Amends s. 429.41, F.S., relating to rules establishing standards.
Section 12: Creates s. 429.435, F.S., relating to uniform firesafety standards.
Section 13: Amends s. 429.52, F.S., relating to staff training and educational programs; core educational requirement.
Section 14: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 15, 2020, the Health Market Reform Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires facility inspections and surveys to determine compliance with part I of ch. 429, F.S., which includes all ALF statutes, instead of determining compliance with only s. 429.28, F.S., and
- Deletes AHCA rule-making authority for uniform standards and criteria used to determine compliance with facility standards and residents' rights.

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

A bill to be entitled

An act relating to assisted living facilities; amending s. 429.02, F.S.; providing and revising definitions; amending s. 429.07, F.S.; providing that an assisted living facility licensed to provide extended congregate care services or limited nursing services must maintain a written progress report on each person receiving services from the facility's staff; conforming a cross-reference; amending s. 429.11, F.S.; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; amending s. 429.176, F.S.; requiring an owner of a facility to provide certain documentation to the Agency for Health Care Administration regarding a new administrator; amending s. 429.23, F.S.; authorizing a facility to send certain reports regarding adverse incidents through the agency's online portal; requiring the agency to send reminders by electronic mail to certain facility contacts regarding submission deadlines for such reports within a specified timeframe; amending s. 429.255, F.S.; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing cardiopulmonary

resuscitation or use of an automated external defibrillator; amending s. 429.256, F.S.; revising the types of medications that may be self-administered; revising provisions relating to assistance with the self-administration of such medications; requiring a person assisting with a resident's self-administration of medication to confirm that the medication is intended for that resident and to orally advise the resident of the medication name and dosage; authorizing a resident to opt out of such advisement through a signed waiver; revising provisions relating to certain medications that are not self-administered with assistance; amending s. 429.26, F.S.; including medical examinations within criteria used for admission to an assisted living facility; providing specified criteria for determinations of appropriateness for admission to and continued residency in an assisted living facility; authorizing such facility to admit certain individuals under certain conditions; defining the term "bedridden"; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility; requiring that such examination be recorded on a form; providing that such form may be used only to record a practitioner's

direct observations of the patient at the time of the examination; providing that such form is not a guarantee of a resident's admission to, continued residency in, or delivery of services at the facility; revising provisions relating to the placement of residents by the Department of Children and Families; requiring a facility to notify a resident's representative or designee of the need for health care services and to assist in making appointments for such care and services under certain circumstances; requiring the facility to arrange with an appropriate health care provider for the care and services needed to treat a resident under certain circumstances; removing provisions relating to the retention of certain residents in a facility; amending s. 429.28, F.S.; providing requirements for a notice of relocation or termination of residency from a facility; revising provisions requiring the agency to conduct a licensure survey to determine whether a facility has complied with certain standards and residents' rights; removing a requirement that the agency adopt certain rules; amending s. 429.31, F.S.; revising notice requirements for facilities that are terminating operations; requiring the agency to inform the State Long-Term Ombudsman Program immediately upon

notice of a facility's termination of operations; amending s. 429.41, F.S.; revising legislative intent; removing provisions to conform to changes made by the act; requiring county emergency management agencies, rather than local emergency management agencies, to review and approve or disapprove of a facility's comprehensive emergency management plan; requiring a facility to submit a comprehensive emergency management plan to the county emergency management agency within a specified timeframe after its licensure; revising the criteria under which a facility must be fully inspected; revising standards for the care of residents provided by a facility; prohibiting the use of Posey restraints in facilities; authorizing other physical restraints to be used under certain conditions and in accordance with certain rules; requiring the agency to establish resident elopement drill requirements; requiring that elopement drills include a review of a facility's procedures addressing elopement; requiring a facility to document participation in such drills; revising provisions requiring the agency to adopt by rule key quality-of-care standards; creating s. 429.435, F.S.; providing uniform firesafety standards for assisted living facilities; amending s. 429.52, F.S.; revising certain

provisions relating to facility staff training and educational requirements; requiring the agency, in conjunction with providers, to establish core training requirements for facility administrators; revising the training and continuing education requirements for facility staff who assist residents with the self-administration of medications; revising provisions relating to the training responsibilities of the agency; requiring the agency to contract with another entity to administer a certain competency test; requiring the agency to adopt a curriculum outline with learning objectives to be used by core trainers; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsections (7) through (27) of section 429.02, Florida Statutes, are renumbered as subsections (8) through (28), respectively, present subsections (11) and (18) are amended, and a new subsection (7) is added to that section, to read:

429.02 Definitions.—When used in this part, the term:

(7) "Assistive device" means any device designed or adapted to help a resident perform an action, a task, an

activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or recliner lift that a resident is able to operate independently.

(12) ~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (18) which ~~(17) that~~ may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services that ~~which~~ may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(19) ~~(18)~~ "Physical restraint" means a device that ~~which~~ physically limits, restricts, or deprives an individual of movement or mobility, including~~, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include~~ any device that is ~~which was~~ not specifically manufactured as a restraint but is ~~which has been~~ altered, arranged, or otherwise used for that ~~this~~ purpose. The term does ~~shall~~ not include any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury.

Section 2. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services, directly or through contract, beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care services may also admit an

individual who exceeds the admission criteria for a facility with a standard license, if he or she is determined appropriate for admission to the extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. This designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Each existing facility that qualifies to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved

by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

The agency may deny or revoke a facility's extended congregate care license for not meeting the criteria for an extended congregate care license as provided in this subparagraph.

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. The licensee shall notify the agency, in writing, when it has admitted at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with the requirements of an extended congregate care license. A licensee with a provisional extended congregate care license which ~~that~~ demonstrates compliance with all the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to

sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living facility requirements during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a followup visit.

3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least

24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

4. A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5. A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(5) ~~s. 429.26(4)~~ and the facility must develop a preliminary service plan for the individual.

7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s.

429.28(1)(k).

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This designation may be made at the time of initial licensure or licensure renewal, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies to provide limited nursing services must have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services <u>from the facility's staff</u>. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the

agency shall visit the facility at least annually to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive the required yearly monitoring visit for a facility that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 3. Subsection (7) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

(7) A county or municipality may not issue a business tax receipt ~~an occupational license~~ that is being obtained for the purpose of operating a facility regulated under this part without first ascertaining that the applicant has been licensed to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing business tax receipts ~~occupational licenses~~ sufficient instruction for making such determinations.

Section 4. Section 429.176, Florida Statutes, is amended to read:

429.176 Notice of change of administrator.—If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 5. Subsections (3), (4), and (5) of section 429.23, Florida Statutes, are amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, ~~facsimile, or United States mail,~~ a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, ~~facsimile, or United States mail,~~ a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident ~~Each facility shall report monthly to the agency any liability claim filed against it. The report~~

~~must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part~~.

Section 6. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order <u>not</u> to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

Section 7. Subsection (2), paragraph (b) of subsection

(3), and paragraphs (e), (f), and (g) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

(3) Assistance with self-administration of medication includes:

(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage ~~reading the label~~,

opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.

(4) Assistance with self-administration does not include:

(e) The use of irrigations or debriding agents used in the treatment of a skin condition.

(f) Assisting with rectal, urethral, or vaginal preparations.

(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and ~~at~~ the ~~request of a competent~~ resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.

Section 8. Section 429.26, Florida Statutes, is amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must ~~shall~~ be based upon an evaluation ~~assessment~~ of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:

(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

(b) A facility may admit or retain a resident who requires the use of assistive devices.

(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the

facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident.

(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:

a. Move, turn, or reposition without total physical assistance;

b. Transfer to a chair or wheelchair without total physical assistance; or

c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.

2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.

3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or

designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) ~~(2)~~ A physician, physician assistant, or advanced practice registered nurse ~~practitioner~~ who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests ~~interest~~ in the facility.

(4) ~~(3)~~ Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(5) ~~(4)~~ ~~If possible,~~ Each resident must ~~shall~~ have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse ~~practitioner~~ within 60 days before admission to the facility or

within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The ~~signed and completed~~ medical examination form, signed only by the practitioner, must ~~report shall~~ be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or ~~and~~ continued residency ~~stay~~ in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes ~~report shall become~~ a permanent part of the facility's record of the resident ~~at the facility~~ and must ~~shall~~ be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and

s. 429.07(3)(b)6.

~~(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.~~

(6) Any resident accepted in a facility and placed by ~~the department or~~ the Department of Children and Families must ~~shall~~ have been examined by medical personnel within 30 days before placement in the facility. The examination must ~~shall~~ include an assessment of the appropriateness of placement in a facility. The findings of this examination must ~~shall~~ be recorded on the examination form provided by the agency. The completed form must ~~shall~~ accompany the resident and ~~shall~~ be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social

worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that ~~providing~~ it was completed within 90 days prior to admission to the facility. The ~~applicable~~ Department of Children and Families shall provide to the facility administrator any information about the resident which ~~that~~ would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The ~~applicable~~ Department of Children and Families shall advise and assist the facility administrator when ~~where~~ the special needs of residents who are recipients of optional state supplementation require such assistance.

(7) The facility shall ~~must~~ notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification

must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making appointments for ~~shall arrange, with the appropriate health care provider,~~ the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.

(8) The Department of Children and Families may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Families; or a representative of the State Long-Term Care Ombudsman Program who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings must ~~shall~~ be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

~~(9) A terminally ill resident who no longer meets the~~

~~criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.~~

(9)~~(10)~~ Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

~~(11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, shall be retained in a facility licensed under this part.~~

Section 9. Paragraph (k) of subsection (1) and subsection (3) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the

Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must ~~shall~~ be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(3)(a) The agency shall conduct a survey to determine whether the facility is complying with this part ~~general compliance with facility standards and compliance with residents' rights~~ as a prerequisite to initial licensure or licensure renewal. ~~The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance~~

~~with facility standards and compliance with residents' rights.~~

(b) In order to determine whether the facility is adequately protecting residents' rights, the licensure renewal ~~biennial~~ survey must ~~shall~~ include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

Section 10. Subsections (1) and (2) of section 429.31, Florida Statutes, are amended to read:

429.31 Closing of facility; notice; penalty.—

(1) In addition to the requirements of part II of chapter 408, the facility shall inform, in writing, the agency and each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the fact and the proposed time of discontinuance of operation, following the notification requirements provided in s. 429.28(1)(k). In the event a resident has no person to represent him or her, the facility shall be responsible for referral to an appropriate social service agency for placement.

(2) Immediately upon the notice by the agency of the voluntary or involuntary termination of such operation, the agency shall inform the State Long-Term Care Ombudsman Program and monitor the transfer of residents to other facilities and ensure that residents' rights are being protected. The agency, in consultation with the Department of Children and Families,

shall specify procedures for ensuring that all residents who receive services are appropriately relocated.

Section 11. Subsections (1), (2), and (5) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote ~~ensure~~ a safe and sanitary environment that is residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. ~~Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency may adopt rules to administer part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents,~~ The

agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules~~,~~ ~~policies, and procedures~~ to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for ~~and~~ maintenance and the sanitary condition of facilities, not in conflict with, or duplicative of, the requirements in chapter 553, s. 381.006, s. 381.0072, or s. 633.206, relating to a safe and decent living environment, including furnishings for resident bedrooms or sleeping areas, locking devices, linens ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and other housing conditions relating to hazards, which will promote ~~ensure~~ the health, safety, and welfare ~~comfort~~ of residents suitable to the size of the structure. The rules must clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by county health departments and may transfer such fees to the Department of Health.

~~1. Firesafety evacuation capability determination. An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.~~

~~2. Firesafety requirements.~~

~~a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in~~

~~determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.~~

~~b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.~~

~~c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.~~

~~d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or~~

~~seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code must thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.~~

~~3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.~~

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the agency after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan is subject to review and approval by the <u>county</u> ~~local~~ emergency

management agency. During its review, the county ~~local~~ emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. ~~Also, appropriate volunteer organizations must be given the opportunity to review the plan.~~ The county ~~local~~ emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. A facility must submit a comprehensive emergency management plan to the county emergency management agency within 30 days after issuance of a license.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

~~(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the~~

~~Department of Health.~~

(d) ~~(e)~~ License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(e) ~~(f)~~ Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties~~, and use of income from fees and fines~~.

(f) ~~(g)~~ The enforcement of the resident bill of rights specified in s. 429.28.

(g) ~~(h)~~ The care ~~and maintenance~~ of residents provided by the facility, which must include~~, but is not limited to~~:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements ~~arrangement~~ for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary ~~nutritional~~ needs of residents;

7. Resident records; ~~and~~

8. Internal risk management and quality assurance.

(h) ~~(i)~~ Facilities holding a limited nursing, extended

congregate care, or limited mental health license.

(i) ~~(j)~~ The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(j) ~~(k)~~ The use of physical or chemical restraints. The use of Posey restraints is prohibited. Other physical restraints may be used in accordance with agency rules when ordered ~~is limited to half-bed rails as prescribed and documented~~ by the resident's physician and consented to by ~~with the consent of~~ the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(k) ~~(l)~~ The establishment of specific resident elopement drill requirements and policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident

elopement drills each year. All administrators and direct care staff shall participate in the drills, which must include a review of the facility's procedures to address resident elopement. Facilities shall document participation in the drills.

(2) In adopting any rules pursuant to this part, the agency shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to this section may not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. If a continuing care facility licensed under chapter 651 or a retirement community offering multiple levels of care licenses a building or part of a building designated for independent living for assisted living, staffing requirements established in rule apply only to residents who receive personal, limited nursing, or extended congregate care services under this part. Such facilities shall retain a log listing the names and unit number for residents receiving these services. The log must be available to surveyors upon request. ~~Except for uniform firesafety standards,~~ The agency shall adopt by rule separate and distinct standards for

facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds must be appropriate for a noninstitutional residential environment; however, the structure may not be more than two stories in height and all persons who cannot exit the facility unassisted in an emergency must reside on the first floor. The agency may make other distinctions among types of facilities as necessary to enforce this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the agency relative to the physical characteristics of facilities and the types of care offered.

(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations; ~~,~~ uncorrected class III violations; or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program~~, confirmed ombudsman council complaints, or confirmed licensure complaints~~ within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency shall adopt by rule ~~develop~~

the key quality-of-care standards ~~with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules~~.

Section 12. Section 429.435, Florida Statutes, is created to read:

429.435 Uniform firesafety standards.—Uniform firesafety standards for assisted living facilities, which are residential board and care occupancies, shall be established by the State Fire Marshal pursuant to s. 633.206.

(1) EVACUATION CAPABILITY.—A firesafety evacuation capability determination shall be conducted within 6 months after the date of initial licensure of an assisted living facility, if required.

(2) FIRESAFETY REQUIREMENTS.—

(a) The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, must be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

(b) A local government or a utility may charge fees that do not exceed the actual costs incurred by the local government or the utility for the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.

(c) All licensed facilities must have an annual fire

inspection conducted by the local fire marshal or authority having jurisdiction.

(d) An assisted living facility that was issued a building permit or certificate of occupancy before July 1, 2016, at its option and after notifying the authority having jurisdiction, may remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. A facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy was issued before July 1, 2016, which undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or which seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code, shall thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206 and the Florida Fire Prevention Code in effect for assisted living facilities as adopted by the State Fire Marshal.

Section 13. Section 429.52, Florida Statutes, is amended to read:

429.52 Staff training and educational requirements ~~programs; core educational requirement~~.—

(1) ~~Effective October 1, 2015,~~ Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage ~~completion~~ of the core competency test ~~training and educational requirements~~. The required core competency test ~~training and education~~ must cover at least the following topics:

(a) State law and rules relating to assisted living

facilities.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related disorders.

(4) A ~~new~~ facility administrator must complete the required core training ~~and education~~, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.

(5) Administrators are required to participate in

continuing education for a minimum of 12 contact hours every 2 years.

(6) Staff ~~involved with the management of medications and~~ assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or~~,~~ a licensed pharmacist before providing assistance~~, or agency staff~~. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this ~~additional~~ training.

(7) ~~Other~~ Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule ~~of the agency~~. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

(8) If the agency determines that there are problems in a facility which could be reduced through specific staff training ~~or education~~ beyond that already required under this section, the agency may require~~,~~ and provide, or cause to be provided, the training ~~or education~~ of any personal care staff in the facility.

(9) The agency shall adopt rules related to these training

and education requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop and administer the competency test. The agency shall adopt a curriculum outline with learning objectives to be used by core trainers~~, which shall be used~~ as the minimum core training content requirements. The agency shall consult with representatives of stakeholder associations and agencies in the development of the curriculum outline.

(10) The core training required by this section ~~other than the preservice orientation~~ must be conducted by persons registered with the agency as having the requisite experience and credentials to conduct the training. A person seeking to register as a core trainer must provide the agency with proof of completion of the ~~minimum~~ core training ~~education~~ requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5).

(11) A person seeking to register as a core trainer also must ~~also~~:

(a) Provide proof of completion of a 4-year degree from an accredited college or university and must have worked in a management position in an assisted living facility for 3 years after being core certified;

(b) Have worked in a management position in an assisted living facility for 5 years after being core certified and have

1 year of teaching experience as an educator or staff trainer for persons who work in assisted living facilities or other long-term care settings;

(c) Have been previously employed as a core trainer for the agency or department; or

(d) Meet other qualification criteria as defined in rule, which the agency is authorized to adopt.

(12) The agency shall adopt rules to establish core trainer registration and removal requirements.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 833 Program of All-Inclusive Care for the Elderly
SPONSOR(S): Rommel
TIED BILLS: **IDEN./SIM. BILLS:** SB 916

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

SUMMARY ANALYSIS

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated health benefits program authorized by the federal Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system funded by a combination of federal Medicare and state Medicaid financing. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

In Florida, the PACE is operated cooperatively by the Department of Elderly Affairs (DOEA) and the Agency for Health Care Administration (AHCA). AHCA and DOEA have operated the program using authority granted by the federal government.

HB 833 codifies the PACE in Florida law and sets specific parameters on program services and participating organizations. The bill directs AHCA, in consultation with DOEA, to review and consider program applications submitted by entities seeking to become PACE organizations.

The bill also requires PACE organizations to meet specific quality and performance standards, as outlined by the federal Centers for Medicare and Medicaid Services. AHCA is charged with monitoring the reporting requirements assigned to PACE organizations.

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

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid serves approximately 3.8 million people in Florida, with over half of those being children and adolescents 19 years of age or younger. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services or CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies. To qualify for nursing home care under Medicaid, both an individual's income and assets must not exceed certain thresholds.

In Florida, the Medicaid program is administered by the AHCA. AHCA delegates certain functions to other state agencies, including the Department of Children, Families and Elder Affairs (DCF), the Agency for Persons with Disabilities (APD), and the DOEA. AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services. DCF is responsible for determining financial eligibility for Medicaid recipients.

Program of All-Inclusive Care for the Elderly (PACE)

The PACE is a capitated health benefits program authorized by the federal Balanced Budget Act of 1997[1] that features a comprehensive service delivery system funded by a combination of federal Medicare and state Medicaid financing.[2] The PACE is an optional Medicaid benefit, but operates as a three-way agreement between the federal government, a state agency, and a PACE organization.[3] In Florida, the PACE is a Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which supports Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[4]

The PACE provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly. PACE was created as a way to provide clients, family, caregivers and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community.[5] The purpose of a PACE program is to provide comprehensive health care services that are designed to:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize dignity of and respect for older adults;
- Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.[6]

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[1] Pub. L. 105-33.
[2] Services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.
[3] Department of Health and Human Services, Centers for Medicare and Medicaid Services, CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual (issued 6-9-2011), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last accessed January 10, 2020).
[4] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (Jan. 14, 2014), available at http://ahca.myflorida.com/docs/PACE_Evaluation_2014.pdf (last accessed January 10, 2020).
[5] Supra note 3.
[6] Supra note 4.

In Florida, the PACE is operated cooperatively by the Department of Elderly Affairs (DOEA) and the Agency for Healthcare Administration (AHCA). DOEA is the operating entity and oversees the participating PACE organizations, while AHCA is formally responsible for maintaining the PACE agreement with the federal government. DOEA, AHCA, and the federal Centers for Medicare and Medicaid Services (CMS) must approve any application for new PACE agreements, as well as any expansion of current PACE organizations.[7]

PACE Organizations

A PACE organization is a not-for-profit, for-profit private or public entity that is primarily engaged in providing PACE services. For-profit entities operating PACE organizations do so under demonstration authority. The following characteristics also apply to a PACE organization. It must:

- Have a governing body or a designated person functioning as a governing body that includes participant representation.
- Be able to provide the complete service package regardless of frequency or duration of services.
- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals.
- Have a defined service area.
- Have safeguards against conflict of interest.
- Have demonstrated fiscal soundness.
- Have a formal participant bill of rights.
- Have a process to address grievances and appeals.[8]

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.[9]

Eligibility and Benefits

Under federal program rules, PACE participants must:

- Be age 55 or older.
- Reside in the PACE organization's service area.
- Be certified as eligible for nursing home care by their state and be able to live safely in a community setting at the time of enrollment.

Eligible beneficiaries who choose to enroll in PACE agree to forgo their usual sources of care and receive all their services through the PACE organization. PACE provides participants all the care and services covered by Medicare and Medicaid, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. There are no limitations or condition as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

Under the PACE, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. The benefit package for all PACE participants includes:

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[7] Id.
[8] Id.
[9] Id.

- Primary Care;
- Hospital Care;
- Medical Specialty Services;
- Prescription Drugs (including Medicare Part D drugs);
- Nursing Home Services;
- Nursing Services;
- Personal Care Services;
- Emergency Services;
- Home Care;
- Physical Therapy;
- Occupational Therapy;
- Adult Day Health Care;
- Recreational Therapy;
- Meals;
- Dental Care;
- Nutritional Counseling;
- Social Services;
- Laboratory/X-Ray;
- Social Work Counseling;
- End of Life Care and Transportation.

In most cases, the comprehensive service package permits participants to continue living at home rather than be institutionalized.[10]

Quality of Care

Each PACE organization is responsible for identifying areas in which to improve service delivery and patient care as well as developing and implementing plans of action to improve or maintain quality of care. Such activities are documented in the PACE organization's Quality Assessment and Performance Improvement (QAPI) plan. The QAPI plan must demonstrate improved performance in regard to five areas:

- Utilization of services in the PACE organization, especially in key services.
- Participant and caregiver satisfaction with services.
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period.
- Effectiveness and safety of direct and contracted services delivered to participants.
- Outcomes in the organization's non-clinical areas.[11]

Florida PACE Project

The Florida PACE project provides alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. Florida's first PACE organization was located in Miami-Dade County and began serving enrollees in February 2003 with a total of150 slots. Since then, the Legislature has approved additional slots either as part of the GAA or general law. Currently, PACE organizations with funded slots exist in these Florida counties: Baker, Broward, Charlotte, Clay, Collier, Desoto, Duval, Lee, Miami-Dade, Palm Beach, Pinellas, Manatee, Martin, Nassau, Sarasota, and St. John's.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed

[10] Id.
[11] Supra note 5.

Care program (SMMC).[12] Participation by PACE in SMMC is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC managed care plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act (GAA).[13]

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. Providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that neither provider is competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the center, staffing for key positions, and signed provider network contracts, the AHCA certifies to federal CMS that the PACE site is ready. At that time, CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

Funding

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through the state's General Appropriations Act (GAA).[14] The 2019-2020 GAA provided just under $67 million in PACE program funding to PACE organizations around the state.[15] The following table includes allocation and enrollment information outlined in the 2019-2020 GAA.

Current PACE Programs[16]				
PACE Organization		Enrollment		
Service Area	Organization	Authorized Slots	Funded Slots	Enrollment (Dec. 2019)
Broward	Florida PACE	150	125	147
Charlotte	Hope Select PACE	150	150	99
Collier	Hope Select PACE	120	120	82
Duval	Northeast PACE Partners	100	100	0
Lee	Hope Select PACE	380	380	285
Martin	Morse PACE	75	75	0
Miami-Dade	Florida PACE	809	809	780
Orange	Cornerstone PACE	150	150	0
Palm Beach	Morse PACE	656	656	617
Pinellas	Suncoast Neighborly PACE	325	325	325
Statewide Totals		**2,915**	**2,890**	**2,335**

[12] Chapter 2011-135, s. 24, L.O.F., repeals s. 430.707, F.S., effective Oct. 1, 2013.
[13] Section 409.981(4), F.S.
[14] Chapter 2013-40, L.O.F.
[15] Chapter 2019-115, L.O.F.
[16] E-mail correspondence from Brian Clark, Budget Chief for the House Health Care Appropriations Subcommittee. January 10, 2020 (on file with staff of the Health Market Reform Subcommittee).

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government.

Effect of Proposed Changes

HB 833 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE). The program is not currently outlined in statute and has been operationalized through the annual appropriations process.

Program Parameters

The bill authorizes the AHCA, in consultation with the DOEA, to approve organizations who have submitted the required application and data to CMS as PACE organizations pursuant to 42 U.S.C. s. 1395eee (2019). Applications, as required by CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must also be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must do the following:

- Provide evidence that the applicant can meet all of the federal regulations and requirements established by CMS by the proposed implementation date.
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve.
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date.
- Show evidence of regulatory compliance and meet market studies requirements, if applicant is an existing PACE organization which seeks to expand to an additional service area.
- Implement program within 12 months after date of initial state approval if granted authorization as a prospective PACE organization or such approval is void.

Quality of Care

The bill requires that all PACE organizations meet specific quality and performance standards, as established by CMS. The bill designates AHCA as the state agency responsible for oversight of PACE organizations with regard to data reporting requirements.

Because the bill codifies current practices, it has no substantive effect on the PACE program.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 430.84, F.S.; relating to Program of All-Inclusive Care for the Elderly.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. While AHCA may approve PACE organizations under the bill, approval does not create new PACE enrollment slots or expenditures. The Legislature will continue to make program scope and funding decisions through the appropriations process.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Current law appears to provide AHCA with sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Program of All-Inclusive Care for the Elderly; creating s. 430.84, F.S.; providing definitions; authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve entities applying to deliver PACE services in the state; requiring notice of applications in the Florida Administrative Register; providing specified application requirements for such prospective PACE organizations; requiring existing PACE organizations to meet specified requirements under certain circumstances; requiring prospective PACE organizations to submit a complete application to the agency and the Centers for Medicare and Medicaid Services within a specified period; requiring that PACE organizations meet certain federal quality and performance standards; requiring the agency to oversee and monitor the PACE program and organizations; providing that a PACE organization is exempt from certain requirements; providing an effective date.

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

Section 1. Section 430.84, Florida Statutes, is created to

read:

430.84 Program of All-Inclusive Care for the Elderly.—

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Applicant" means an entity that has filed an application with the agency for consideration as a Program of All-Inclusive Care for the Elderly (PACE) organization.

(c) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(d) "Department" means the Department of Elderly Affairs.

(e) "PACE organization" means an entity under contract with the agency to deliver PACE services.

(f) "Participant" means an individual receiving services from a PACE organization who has been determined by the department to need the level of care required under the state Medicaid plan for coverage of nursing facility services.

(2) PROGRAM CREATION.—The agency, in consultation with the department, may approve entities that have submitted applications required by the CMS to the agency for review and consideration which contain the data and information required in subsection (3) to provide benefits pursuant to the PACE program as established in 42 U.S.C. s. 1395eee and in accordance with the requirements set forth in this section.

(3) PACE ORGANIZATION SELECTION.—The agency, in consultation with the department, shall, on a continuous basis, review and consider applications required by the CMS for PACE that have been submitted to the agency by entities seeking initial, state approval to become PACE organizations. Notice of such applications shall be published in the Florida Administrative Register.

(a) A prospective PACE organization shall submit application documents to the agency before requesting program funding. Application documents submitted to and reviewed by the agency, in consultation with the department, must include all of the following:

1. Evidence that the applicant has the ability to meet all of the applicable federal regulations and requirements, established by the CMS, for participation as a PACE organization by the proposed implementation date.

2. Market studies, including an estimate of the number of potential participants and the geographic service area in which the applicant proposes to serve.

3. A business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

(b) Each applicant must propose to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be

authorized to provide services within any unique and defined geographic service area.

(c) An existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the agency or Legislature, shall meet the requirements set forth in paragraphs (a) and (b).

(d) Any prospective PACE organization that is granted initial, state approval by the agency, in consultation with the department, shall submit its complete federal PACE application, in accordance with the application process and guidelines established by the CMS, to the agency and the CMS within 12 months after the date of initial, state approval, or such approval is void.

(4) ACCOUNTABILITY.—All PACE organizations must meet specific quality and performance standards established by the CMS for the PACE program. The agency shall oversee and monitor the PACE program and organizations based upon data and reports periodically submitted by PACE organizations to the agency and the CMS. A PACE organization is exempt from the requirements of chapter 641.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 945 Children's Mental Health
SPONSOR(S): Children, Families & Seniors Subcommittee, Silvers
TIED BILLS: **IDEN./SIM. BILLS:** SB 1440

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Overall, depressive episodes and serious thoughts of suicide are increasing among Florida's children. This may contribute to the over 36,000 involuntary examinations that were initiated under the Baker Act for individuals under the age of 18 between July 1, 2017 and June 30, 2018. Additionally, 22.61% of minors who had involuntary examinations had multiple such examinations in FY 2017-2018, ranging from 2 to 19 instances. The Department of Children and Families (DCF) identified 21 minors who had more than 10 involuntary examinations in FY 2017-2018 with a combined total of 285 initiations.

HB 945 creates a coordinated system of care, the development of which is facilitated by each behavioral health managing entity (ME), which integrates services provided through providers funded by the state's child-serving systems, as well as other systems for which children and adolescents would qualify, and facilitates access by children and adolescents to needed mental health treatment and services at any point of entry.

The bill includes crisis response services provided through mobile response teams (MRT) in the array of services available to children and adolescents who are members of certain target populations and specifies the elements of that service.

The bill revises the required provisions of the plans required for school district funding under the Mental Health Assistance allocation, such as to require a memorandum of understanding with the local managing entity and policies and procedures for referrals for other household members to services available through other delivery systems and payors under certain circumstances. It requires the development and use of a model protocol regarding use of MRTs in schools.

The bill requires DCF and the Agency for Health Care Administration (AHCA) to identify children and adolescents who are the highest users of crisis stabilization services, collaboratively take action to meet the behavioral health needs of such children and submit a joint quarterly report during Fiscal Years 2020-2021 and 2021-2022 to the Legislature. The bill also requires DCF and AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of such services and submit a joint report to the Governor and Legislature.

The bill requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

The bill has an insignificant fiscal impact on state government, which can be absorbed within existing resources, and an indeterminate fiscal impact on local governments. See fiscal comments section.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Mental Health and Mental Illness

Mental health and mental illness are not synonymous. Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[1]

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.[2] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, causing distress and problems getting through the day.[3] The most commonly diagnosed mental disorders in children are attention deficit hyperactivity disorder (ADHD), behavior problems, anxiety, and depression.[4] In 2016-2017, 21% of parents responding to a survey reported that a doctor has told them their child has autism, developmental delays, depression or anxiety, attention deficit disorder/ADHD, or behavioral/conduct problems.[5]

The most recently published data from the National Survey on Drug Use and Health shows 12.5% of children in Florida age 12 to 17 experienced a major depressive episode.[6] Approximately 37.7% of those children received depression care.[7] The Florida Department of Health's 2019 Youth Risk Behavior Survey of Florida's public high school students shows 33.7% experienced periods of persistent feelings of sadness and hopelessness, 15.6% seriously considered attempting suicide and 7.9% attempted suicide.[8] Seventy-six children between the ages of 2 to 17 died by suicide in Florida in 2018.[9]

Mental Health Services in Florida

The Department of Children and Families administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

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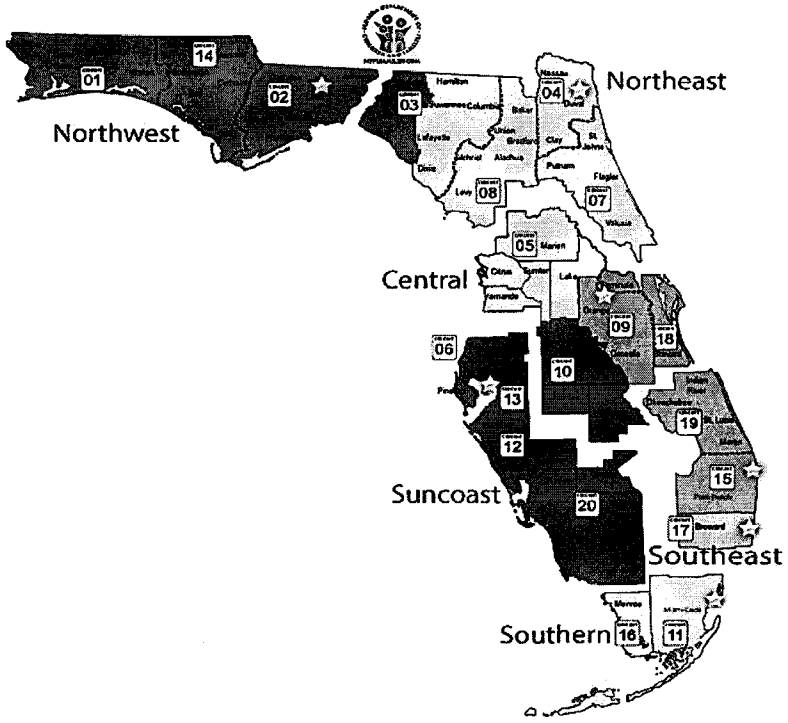
[1] Centers for Disease Control and Prevention, *Learn About Mental Health*, https://www.cdc.gov/mentalhealth/learn/ (last visited Jan. 6, 2020).
[2] Id.
[3] Centers for Disease Control and Prevention, *Data and Statistics on Children's Mental Health*, https://www.cdc.gov/childrensmentalhealth/data.html (last visited Jan. 6, 2020).
[4] Id.
[5] The Annie E. Casey Foundation Kids Count Data Center, *Children who have one or more emotional, behavioral, or developmental conditions in Florida*, (April 2019) https://datacenter.kidscount.org/data#FL/2/0/char/0 (last visited Jan. 13, 2020).
[6] Substance Abuse and Mental Health Services Administration, *Behavioral Health Barometer, Florida, Volume 5*, (2019), https://store.samhsa.gov/system/files/florida-bh-barometervolume5-sma19-baro-17-us.pdf (last visited Jan. 6, 2020).
[7] Id.
[8] Florida Department of Health, *2019 Florida Risk Behavior Survey Report*, (2019), http://www.floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/index.html (last visited Jan. 6, 2020).
[9] Florida Department of Health FLHealthCHARTS, *Suicide Deaths*, http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116 (last visited Jan. 13, 2020).

Behavioral Health Managing Entities

In 2001, the Legislature authorized DCF to implement behavioral health managing entities as the management structure for the delivery of local mental health and substance abuse services.[10] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.[11] Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.[12]
DCF contracts with seven MEs - Big Bend Community Based Care (blue), Lutheran Services Florida (yellow), Central Florida Cares Health System (orange), Central Florida Behavioral Health Network, Inc. (red), Southeast Florida Behavioral Health (pink), Broward Behavioral Health Network, Inc. (purple), and South Florida Behavioral Health Network, Inc. (beige) that in turn contract with local service providers[13] for the delivery of mental health and substance abuse services:[14]



[10] Ch. 2001-191, Laws of Fla.
[11] Ch. 2008-243, Laws of Fla.
[12] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[13] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[14] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited Jan. 6, 2020).

In FY 2018-2019, the network service providers under contract with the MEs served 339,093 individuals:[15]

Table 1: FY 2018-19 Individuals Served by Managing Entities

ME	Total Served (unduplicated)	Adults Community Mental Health	Children Community Mental Health	Adults Community Substance Abuse	Children Community Substance Abuse
BBCBC	37,874	22,074	7,248	9,493	2,608
BBHC	25,630	14,084	2,560	9,177	2,004
CFBHN	116, 557	71,225	17,564	31,031	8,349
CFCHS	31,586	14,714	2,254	14,523	4,058
LSF	52,707	32,312	5,081	17,261	2,913
SEFBHN	30,390	16,170	5,661	7,542	2,837
SFBHN	44,349	26,811	7,099	8,767	3,749

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[16] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[17] A community or region provides a coordinated system of care for those suffering from mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.[18] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.[19] DCF must use performance-based contracts to award grants.[20]

There are several essential elements which make up a coordinated system of care, including:[21]

- Community interventions, 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;

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[15] Department of Children and Families, *Substance Abuse and Mental Health Triennial Plan Update for Fiscal Year,* (Dec. 6, 2019) https://www.myflfamilies.com/service-programs/samh/publications/docs/SAMH%20Services%20Plan%202018%20Update.pdf (last visited Jan. 14, 2020).
[16] S. 394.9082(5)(d), F.S.
[17] S. 394.4573(1)(c), F.S.
[18] S. 394.4573(3), F.S.. The Legislature has not funded system improvement grants.
[19] Id.
[20] Id.
[21] S. 394.4573(2), F.S.

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;
- 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.

A coordinated system of care must include, but is not limited to, the following array of services:
- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

DCF must define the priority populations which would benefit from receiving care coordination. Statute includes considerations for DCF in defining these to include:
- The number and duration of involuntary admissions within a specified time,
- The degree of involvement with the criminal justice system and the risk to public safety posed by the individual,
- Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455,
- The degree of utilization of behavioral health services, and
- Whether the individual is a parent or caregiver who is involved with the child welfare system.[22]

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[23] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[24]

[22] S. 394.9082(3)(c), F.S.
[23] S. 394.9082(5)(b), F.S.
[24] S. 394.75(3), F.S.

Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[25] The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[26]

Involuntary Examination and Receiving Facilities

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[27] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:[28]

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[29] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[30] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[31]

Crisis Stabilization Units (CSUs) are specialized public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[32] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[33] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[34] Individuals often enter the public mental health system through CSUs.[35] For this reason, crisis services are a part of the comprehensive,

[25] Ss. 394.451-394.47892, F.S.
[26] S. 394.459, F.S.
[27] Ss. 394.4625 and 394.463, F.S.
[28] S. 394.463(1), F.S.
[29] S. 394.455(39), F.S. This term does not include a county jail.
[30] S. 394.455(37), F.S
[31] Rule 65E-5.400(2), F.A.C.
[32] S. 394.875(1)(a), F.S.
[33] Id
[34] Id.
[35] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), available at https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited Jan 6, 2020).

integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.[36]

As of September 2019, there are 122 Baker Act receiving facilities in this state, including 54 public receiving facilities and 68 private receiving facilities.[37] Of the 54 public receiving facilities, 40 are CSU's.[38]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[39] During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.[40] If the patient is a minor, the examination must be initiated within 12 hours.[41]

Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen:[42]

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

[36] Id. Sections 394.65-394.9085, F.S.
[37] Department of Children and Families, *Designated Baker Act Receiving Facilities*, (Sept. 9, 2019), https://www.myflfamilies.com/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Faciliites.pdf (last visited Jan. 6, 2020). Hospitals can also be designated as public receiving facilities.
[38] Id.
[39] S. 394.463(2)(g), F.S.
[40] S. 394.463(2)(f), F.S.
[41] S. 394.463(2)(g), F.S.
[42] S. 394.463(2)(g), F.S.

Involuntary Examinations Fiscal Year 2001-2002 through Fiscal Year 2017-2018[43]

Fiscal Year	All Ages			Minors (< 18)		
	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000
2017-2018	205,781	N/A	1,005	36,078	N/A	1,186
2016-2017	199,944	2.92%	992	32,763	10.12%	1,092
2015-2016	194,354	5.88%	981	32,475	11.09%	1,097
2014-2015	187,999	9.46%	964	32,650	10.50%	1,102
2013-2014	177,006	16.26%	919	30,355	18.85%	1,030
2012-2013	163,850	25.59%	859	26,808	34.58%	914
2011-2012	154,655	33.06%	818	24,836	45.26%	848
2010-2011	145,290	41.63%	773	21,752	65.86%	743
2009-2010	141,284	45.65%	754	21,128	70.76%	702
2008-2009	133,644	53.98%	711	20,258	78.09%	664
2007-2008	127,983	60.79%	685	19,705	83.09%	643
2006-2007	120,082	71.37%	661	19,238	87.54%	652
2005-2006	118,722	73.33%	668	19,019	89.69%	651
2004-2005	114,700	79.41%	660	19,065	89.24%	664
2003-2004	107,705	91.06%	634	18,286	97.30%	648
2002-2003	103,079	99.63%	620	16,845	114.18%	606
2001-2002	95,574	115.31%	586	14,997	140.57%	547

Report on Involuntary Examinations of Minors

In 2017, the Legislature created a task force within DCF[44] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[45]

- Analyzing data on the initiation of involuntary examinations of minors;
- Researching the root causes of and trends in such involuntary examinations;
- Identifying and evaluating options for expediting the examination process; and
- Identifying recommendations for encouraging alternatives to or eliminating inappropriate initiations of such examinations.

The task force found that specific causes of increases in involuntary examinations of children are unknown. Possible factors cited in the task force report include:[46]

- Increase in mental health concerns:
  - In 2017, 31.5% of high school students experienced periods of persistent feelings of sadness or hopelessness within the past year, an increase from 2007 (28.5%).
  - In 2017, 17.2% of high school students seriously considered attempting suicide in the past year, increasing from 14.5% in 2007.
- Social stressors such as parental substance use, poverty and economic insecurity, mass shootings, and social media and cyber bullying.
- Lack of availability of mental health services, due to wait lists for services, limitations on coverage or approval, lack of funding for prevention and diversion, and shortage of psychiatrists and other mental health professionals.

[43] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, 2019,* (Nov. 2019), p. 25, https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 4, 2020).
[44] Ch. 2017-151, Laws of Florida.
[45] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2017), https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 4, 2020).
[46] Id.

    - Among children ages 12-17 in Florida, approximately 13.0% experienced a major depressive episode in the past year. Only about 33% of children experiencing a major depressive episode in the past year receive treatment.
- Emphasis on diversion and treatment, such as through increased Youth Mental Health First Aid, Crisis Intervention Team, and similar training on recognition of issues and appropriate referral; use of alternatives to expulsion or referral to law enforcement agencies.

As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[47] As part of the report (2019 report), DCF was required to:

- Analyze data on the initiation of involuntary examinations of minors;
- Identify any patterns or trends and cases in which involuntary examinations are repeatedly initiated on the same child;
- Study root causes for such patterns, trends, or repeated involuntary examinations; and
- Make recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations.

Multiple Involuntary Examinations

The 2019 report revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.

The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.[48] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children.[49] Children have a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%).[50] Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018, ranging from 2 to 19.[51] DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 initiations.[52] DCF's review of medical records found:[53]

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88%);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most had Medicaid health insurance;
- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;
- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

[47] Ch. 2019-134, Laws of Florida.
[48] *Supra,* note 43.
[49] Id. at 2.
[50] Id.
[51] Id.
[52] Id.
[53] Id.

Recommendations

Among the 2017 task force report recommendations were to:[54]

- Amend statute to increase the number of days that the receiving facility has to submit required forms to DCF to capture additional data;
- Expedite involuntary exams by expanding the list of mental health professionals who can conduct the clinical exam to include physician assistants, psychiatric advanced registered nurse practitioners, licensed clinical social workers, licensed mental health counselors, and licensed marriage and family therapist;
- Increase funding for mobile crisis teams;
- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis;
- Expand access to outpatient crisis intervention services and treatment especially for children under 13;
- Create the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties to enhance their systems of care serving these children;
- Encourage school districts to adopt a standardized suicide risk assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination;
- Revise statutes to include school psychologists licensed under Chapter 490 to the list of mental health professionals who are qualified to initiate a Baker Act;
- Require Youth Mental Health First Aid and/or CIT training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools;
- Require AHCA to post quarterly Medicaid health plans' EPSDT compliance reports on its website; and
- Supporting Baker Act training and technical assistance by funding a position in DCF to train and provide technical assistance to providers, clinicians, and other professionals who are responsible for implementing the Baker Act.

Several of these recommendations have been implemented through statutory change or legislative appropriations.

The 2019 report recommended:[55]

- Increasing care coordination for minors with multiple involuntary examinations;
- Utilizing the wraparound care coordination approach for children with complex behavioral health needs and multi-system involvement to ensure one point of accountability and individualized care planning;
- Utilizing existing local review teams;
- Revising administrative rules to gather more information about actions taken after the initiation of exams, require electronic submission of forms, and improve care coordination and discharge planning;
- Funding an additional FTE at DCF to provide technical assistance; and
- Ensuring that parents receive information about mobile crisis response teams and other community resources and supports upon child's discharge.

<u>Mental Health Services for Students</u>

The Florida Department of Education (DOE), through the Bureau of Exceptional Education and Student Services and the Office of Safe Schools, promotes a system of support, policies, and practices that focus on prevention and early intervention to improve student mental health and school safety. Florida law requires instructional personnel to teach comprehensive health education that addresses concepts

[54] *Supra*, note 45.
[55] *Supra* note 43, at 17-18.

of mental and emotional health as well as substance use and abuse.[56] Student Services personnel, which includes school psychologists, school social workers, and school counselors, are classified as instructional personnel responsible for advising students regarding personal and social adjustments, and provide direct and indirect services at the district and school level.[57]

State funding for school districts' mental health services is provided primarily by legislative appropriations, the majority of which is distributed through an allocation through the Florida Education Finance Program (FEFP) to each district. In addition to the basic amount for current operations for the FEFP, the Legislature may appropriate categorical funding for specified programs, activities or purposes.[58] Each district school board must include the amount of categorical funds as a part of the district annual financial report to DOE, and DOE must submit a report to the Legislature that identifies by district and by categorical fund the amount transferred and the specific academic classroom activity for which the funds were spent.[59]

The law allows district school boards and state agencies administering children's mental health funds to form a multiagency network to provide support for students with severe emotional disturbance.[60] The program goals for each component of the multiagency network are to:

- Enable students with severe emotional disturbance to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living;
- Develop individual programs for students with severe emotional disturbance, including necessary educational, residential, and mental health treatment services;
- Provide programs and services as close as possible to the student's home in the least restrictive manner consistent with the student's needs; and
- Integrate a wide range of services necessary to support students with severe emotional disturbances and their families.[61]

DOE awards grants to district school boards for statewide planning and development of the multiagency Network for Students with Emotional or Behavioral Disabilities.[62] SEDNET is a network of 19 regional projects that are composed of major child-serving agencies, community-based service providers, and students and their families. Local school districts serve as fiscal agents for each local regional project.[63] SEDNET focuses on developing interagency collaboration and sustaining partnerships among professionals and families in the education, mental health, substance abuse, child welfare, and juvenile justice systems serving children and youth with and at risk of emotional and behavioral disabilities.[64]

Mental Health Assistance Allocation

Established in FY 2018-2019 in SB 7026, responding to the Parkland shooting, the mental health assistance allocation within the FEFP provides funds for school-based mental health programs as annually provided in the General Appropriations Act (GAA). The allocation provides each school district at least $100,000, with the remaining balance allocated based on each district's proportionate share of the state's total unweighted FTE student enrollment. Eligible charter schools are also entitled to a proportionate share of district funding.

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[56] S. 1003.42(2)(n), F.S.
[57] S. 1012.01(2)(b), F.S.
[58] S. 1012.01(6), F.S.
[59] Id.
[60] See s. 1006.04(1)(a), F.S.
[61] S. 1006.04(1)(b), F.S.
[62] S. 1006.04(2), F.S.
[63] Fiscal agents include the Brevard, Broward, Miami-Dade, Duval, Escambia, Hamilton, Highlands, Hillsborough, Lee, Leon, Marion, Orange, Palm Beach, Pinellas, Polk, Putnam, St. Lucie, Sarasota, and Washington school districts. Florida Department of Education, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, at p. 11, http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf (last visited Jan. 6, 2020).
[64] Florida Department of Education, Bureau of Exceptional Education and Student Services, *BEESS Discretionary Projects*, January 2017, *available at* http://www.fldoe.org/core/fileparse.php/7567/urlt/projectslisting.pdf (last visited Jan. 6, 2020).

At least 90 percent of a school district's allocation must be expended on:

- The provision of mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and students at high risk of such diagnoses; and
- The coordination of such services with a student's primary care provider and with other mental health providers involved in the student's care.

In order to receive allocation funds, a school district must develop and submit a detailed plan outlining the local program and planned expenditures to the district school board for approval. In addition, a charter school must annually develop and submit a detailed plan outlining the local program and planned expenditures of the funds in the plan to its governing body for approval. Once the plan is approved by the governing body, it must be provided to its school district for submission to the Commissioner of Education.

The Marjory Stoneman Douglas High School Public Safety Commission

The incident of mass violence at Marjory Stoneman Douglas High School in Parkland, Florida was preceded by multiple, repeated interactions between the shooter and law enforcement agencies, social services agencies, and schools, over many years. This history was characterized by a lack of communication and coordination, preventing these many entities from understanding the whole problem and taking action to prevent the mass violence incident.

In response to this problem, the Legislature created the Marjory Stoneman Douglas High School Public Safety Commission (Commission)[65] within the Florida Department of Law Enforcement (FDLE).[66] The Commission is composed of 16 voting members and four nonvoting members.[67] The Governor appoints five voting members to the Commission, including the chair; and President of the Senate and Speaker of the House of Representatives each appoint five voting members to the Commission. The Commissioner of FDLE serves as a member of the commission. The Secretary of DCF, the Secretary of DJJ, the Secretary of the Agency for Health Care Administration (AHCA) and the Commissioner of Education serve as ex officio, non-voting members of the Commission.

The Commission was tasked with investigating system failures in the Marjory Stoneman Douglas High School shooting and to develop recommendations for system improvements. Regarding children's behavioral health, the commission stated "serious consideration should be given to how children transition from child services into adult behavioral services, and Florida needs a better safety net for high-risk children."[68] The commission also expressed concern about uncoordinated care for children receiving services from multiple providers. It found that Florida's mental health system, specifically the Baker Act System, needs better discharge planning, master case management, and care coordination, and that no adequate or effective system exists for tracking or flagging high recidivist Baker Acts.[69]

Among the commission's recommendations are that:[70]

- The Legislature should require school districts to engage community health providers that receive state funding to participate in the coordination of student treatment plans.
- Programs such as Community Action Treatment teams should be enhanced and expanded,

[65] Commission is defined in s. 20.03, F.S. as a body created by specific statutory enactment within a department, the office of the Governor, or the Executive Office of the Governor and exercising limited quasi-legislative or quasi-judicial powers, or both, independently of the head of the department or the Governor.
[66] Ch. 2018-3, Laws of Florida.
[67] All members of the Commission must serve without compensation, but will be reimbursed for their per diem and travel expenses pursuant to s. 112.061, F.S.
[68] Marjory Stoneman Douglas High School Public Safety Commission, *Report Submitted to the Governor, Speaker of the House of Representatives, and Senate President* (Jan. 2, 2019) http://www.fdle.state.fl.us/MSDHS/CommissionReport.pdf (last visited Jan. 13, 2020).
[69] Id.
[70] Id.

where necessary, to provide better continuity of behavioral health services to close the gap when high-risk children transition into adulthood.
- The Legislature should require DCF, DJJ and AHCA to develop an alert system to identify those individuals who are repeatedly Baker Acted. The responsible entity must develop a course of action to address why the person is repeatedly Baker Acted.

Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors at any hour of the day.[71] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[72] All too frequently, law enforcement or EMTs are called to respond to mental health crises and they often lack the training and experience to effectively handle the situation.[73] Mobile response teams can be beneficial in such instances.

Mobile response teams provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.[74] Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent.[75] Response teams are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[76] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring.[77] It can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.[78]

SB 7026 (2018) funded additional mobile response teams to serve areas of the state that were not being served by such teams at a total of $18.3 million. There are 40 MRTs serving all 67 counties in Florida, targeting services to individuals under the age of 25.[79] Recent MRT monthly reports showed an 80% statewide average of diverting individuals from involuntary examination.[80]

DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:[81]
- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;

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[71] Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4, https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf (last visited Jan. 3, 2020).
[72] Id.
[73] Id.
[74] Id. at 2
[75] Supra note 71.
[76] Id.
[77] Supra note 71, at 7.
[78] Id.
[79] Supra note 48.
[80] Id.
[81] Supra note 71, at 2-3.

- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by AHCA and financed by federal and state funds.

The Florida Medicaid program covers approximately 3.8 million low-income individuals.[82]

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[83]

The MMA program provides acute health care services through managed care plans contracted with AHCA in the 11 regions across the state. Coverage includes preventative care, acute care, behavioral health services, therapeutics, pharmacy, and transportation services.[84] Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and

[82] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report,* December 2019, https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Jan. 16, 2020).
[83] S. 409.964, F.S.
[84] Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program,* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf (last visited Jan. 16, 2020).

- Children in a prescribed pediatric extended care center.[85]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

The long-term care program provides coverage for individuals age 65 or older, or age 18 or older with a disability, who require nursing facility level of care or hospital level of care.[86] Long-term care coverage includes nursing facility care, assisted living, and home and community based services.[87]

Current law requires each managed care plan to have an accurate and complete online database of the providers in their networks, including information about their credentials, licensure, hours of operation, and location.[88]

Effect of Proposed Changes

Coordinated System of Care

HB 945 requires collaboration and planning between child-serving systems and other stakeholders to create a coordinated system of behavioral health care, facilitated by each managing entity, focused on services for children. The coordinated system of care is to integrate services provided through providers funded by the state's child-serving systems, as well as other systems for which children and adolescents would qualify, and facilitates access by children and adolescents to needed mental health treatment and services at any point of entry.

Within current resources, the ME and collaborating organizations must create integrated service delivery approaches that allow parents and caregivers to obtain services and support by making referrals to specialized treatment providers, should it be necessary, with follow up to ensure services are received. Each coordinated system of care for children and adolescents must be documented by the ME and collaborating organizations through a memorandum of understanding (MOU) or other binding arrangements.

Plans are required to be completed by the managing entity and submitted to DCF by July 1, 2021. The entities involved in the planning process must implement the coordinated system of care specified in each plan by July 1, 2022. The ME and collaborating organizations are required to review and update the plans, as necessary, at least once every three years after implementation. The ME is responsible for identifying any gaps in the arrays of services available under each plan and include that information in its annual needs assessment submitted to DCF.

The ME is required to lead the planning process, which includes input from at a minimum:
- Children and adolescents with behavioral health needs and their families;
- Behavioral health service providers;
- Law enforcement agencies;
- School districts or superintendents;
- SEDNET;
- DCF;
- Representatives of the child welfare and juvenile justice systems;

[85] S. 409.972, F.S.
[86] Supra note 84.
[87] Id.
[88] S. 409.967(2)(c)1., F.S.

- Representatives of early learning coalitions;
- Representatives of Medicaid managed medical assistance plans; and
- Representatives of AHCA, APD, DJJ, and other community partners.

Organizations that receive state funding must participate in the planning process if requested by the managing entity.

When developing the plan, the ME and collaborating entities must take the geographical distribution of the population, needs, and resources into consideration and create separate plans on an individual county or multi-county basis in order to maximize collaboration and communication at the local level. The plan must integrate with the local plan for a designated receiving system.

Care Coordination

When defining the priority populations that will benefit from receiving care coordination, the bill requires DCF to also consider whether the individual is an adolescent who requires assistance in transitioning to services provided in the adult system of care.

Mobile Response Teams

The bill includes crisis response services provided through mobile response teams in the array of services available to children and adolescents who are members of certain target populations. It requires DCF to contract with MEs for MRTs to provide onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25 who:

- Have an emotional disturbance;
- Are experiencing an acute mental or emotional crisis;
- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function normally within their environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

At a minimum, the MRT must:

- Respond to new requests for services within 60 minutes;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family and enable them to deescalate and respond to behavioral health challenges through evidence-based practices;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Whenever possible, engage the child, adolescent, or young adult and their family as active participants in all phases of the treatment process;
- Develop a care plan for the child, adolescent, or young adult;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure a process for informed consent and confidentiality compliance measures is in place;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the ME and other key entities providing services and supports to the child, adolescent, or young adult and their family.

At a minimum, when procuring a MRT, the managing entity must:

- Collaborate with local sheriff's offices and public schools in the planning, development, evaluation and selection processes;
- Require that services be made available 24 hours per day, 7 days per week, with a response time of 60 minutes;

- Require that the provider establish response protocols with local law enforcement agencies, CBC lead agencies, the child welfare system, and the DJJ;
- Require access to board-certified or board-eligible psychiatrists or psychiatric nurse practitioners; and
- Require MRTs to refer children, adolescents, or young adults and their families to an array of crisis response services that address their individual needs as necessary to address an immediate crisis event.

The bill requires the ME to promote the use of available crisis intervention services by requiring contracted providers to provide contact information for MRTs to parents and caregivers of children, adolescents, and young adults between the ages of 18 and 25, who receive safety-net behavioral health services.

The bill amends the preservice training requirements for licensure as a foster parent to include information about and contact information for the local MRT as a means for addressing a behavioral health crisis or preventing placement disruption. It also requires CBC lead agencies to provide contact information for the local MRT to all individuals providing care for dependent children.

Mental Health Services for Students

The bill requires the Louis de la Parte Institute within the University of South Florida to develop a model response protocol by August 1, 2020, for schools to use MRTs. When developing the protocol the institute must, at a minimum, consult with:

- School districts that effectively use mobile response teams and those districts that use mobile response teams less often;
- Local law enforcement agencies;
- DCF;
- Managing entities; and
- Mobile response team providers.

Mental Health Assistance Allocation

The bill revises the requirements for plans that must be submitted by school districts in order to receive mental health assistance allocation funding to include an interagency agreement or MOU with the ME that facilitates referrals of students to community-based services and coordinates care for students served by school-based and community-based providers. The agreement or MOU must address the sharing of records and information, as provided by law, to coordinate care and increase access to appropriate services.

The plans for funding must also include policies and procedures, including contracts with service providers, which will ensure that:

- Parents are provided information about behavioral health services available through the students' school or local providers, including MRTs. The bill allows schools to meet this requirement by providing information about and website addresses for web-based directories or guides of local services as long as they are easily navigable and provide contact information for local providers;
- School districts use MRTs to the extent available and carry out the model response protocol; and
- Referrals to behavioral health services through other delivery systems or payors are available to individuals or students living in the same house as a student who is receiving services, if those services appear to be needed or would contribute to the improved well-being of the student who is receiving services.

Reporting Requirements

DCF and AHCA

The Department of Children and Families and the Agency for Health Care Administration are required to identify children and adolescents who are the highest users of crisis stabilization services, collaboratively take action to meet the behavioral health needs of such children, and submit a joint quarterly report to the Legislature in FY 2020-2021 through FY 2021-2022 on the actions taken by both agencies to better serve these children and adolescents.

The bill also requires DCF and AHCA to assess the quality of care provided in CSUs to children and adolescents who are high utilizers of such services. DCF and AHCA must:

- Review the current standards of care for settings applicable to licensure under chapters 394 and 408, Florida Statutes, and designation under s. 394.461, F.S.;
- Compare these standards to other states' and relevant national standards; and
- Make recommendations for improvements to standards.

At a minimum, the assessment and recommendations must address efforts by each CSU facility to:

- Gather and assess information regarding each child or adolescent;
- Coordinate with other providers treating the child or adolescent; and
- Create discharge plans that comprehensively and effectively address the needs of the child or adolescent in order to avoid or reduce his or her future use of CSU services.

DCF and AHCA must jointly submit a report of their findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2020.

Managing Entities

The bill requires managing entities to list and describe any gaps in the arrays of services for children or adolescents and recommendations for addressing such gaps in its annual needs assessment submitted to DCF.

Managed Care Plans

The bill requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 394.493, F.S., relating to target populations for child and adolescent mental health services funded through the department.
Section 2: Amends s. 394.495, F.S., relating to child and adolescent mental health systems of care; programs and services.
Section 3: Creates s. 394.4955, F.S., relating to coordinated system of care; child and adolescent mental health treatment and support.
Section 4: Amends s. 394.9082, F.S., relating to behavioral health managing entities.
Section 5: Amends s. 409.175, F.S., relating to licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.
Section 6: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 7: Amends s. 409.988, F.S., relating to lead agency duties; general provisions.
Section 8: Amends s. 985.601, F.S., relating to administering the juvenile justice continuum.

Section 9: Amends s. 1003.02, F.S., relating to district school board operation and control of public K-12 education within the school district.
Section 10: Amends s. 1004.44, F.S., relating to Louis de la Parte Florida Mental Health Institute.
Section 11: Amends s. 1006.04, F.S., relating to educational multiagency services for students with severe emotional disturbance.
Section 12: Amends s. 1011.62, F.S., relating to funds for operation of schools.
Section 13: Requires AHCA and DCF to submit a joint report to the Governor and Legislature.
Section 14: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires DCF to collaborate with AHCA to assess the quality of care provided to children and adolescents who are high utilizers of crisis stabilization services. The agencies will be required to submit quarterly reports of their findings and recommendations through June 2022. Both agencies indicate there will be an increased workload associated with these requirements and that additional personnel resources will be needed to perform the collaborative analysis and subsequent reports. The reporting requirement is through Fiscal Year 2021-2022, and a review of DCF and AHCA's other personnel services (OPS) base budget shows a sufficient balance to cover two years.

   The bill requires AHCA to test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems. AHCA has sufficient contracted services base budget to perform this requirement.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   School districts may incur expenses related to establishing policies and procedures to carry out the model response protocol, participating in the planning process for promoting a coordinated system of care for children and adolescents, and developing an interagency agreement or MOU with the managing entity. The impact cannot be determined at this time, but is likely insignificant and can be absorbed within each district's mental health assistance allocation.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Managing entities may experience an increase in workload within the scope of their current responsibilities associated with the proposed changes in HB 945, the extent of which cannot be determined but is likely insignificant.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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 requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems. The bill was reported the bill favorably as a committee substitute.

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

A bill to be entitled

An act relating to children's mental health; amending s. 394.493, F.S.; requiring the Department of Children and Families and the Agency for Health Care Administration to identify certain children and adolescents who use crisis stabilization services during specified fiscal years; requiring the department and agency to collaboratively meet the behavioral health needs of such children and adolescents and submit a quarterly report to the Legislature; amending s. 394.495, F.S.; including crisis response services provided through mobile response teams in the array of services available to children and adolescents; requiring the department to contract with managing entities for mobile response teams to provide certain services to certain children, adolescents, and young adults; providing requirements for such mobile response teams; providing requirements for managing entities when procuring mobile response teams; creating s. 394.4955, F.S.; requiring managing entities to develop a plan promoting the development of a coordinated system of care for certain services; providing requirements for the planning process; requiring each managing entity to submit such plan by a specified date; requiring the entities involved in

the planning process to implement such plan by a specified date; requiring that such plan be reviewed and updated periodically; amending s. 394.9082, F.S.; revising the duties of the department relating to priority populations that will benefit from care coordination; requiring that a managing entity's behavioral health care needs assessment include certain information regarding gaps in certain services; requiring a managing entity to promote the use of available crisis intervention services; amending s. 409.175, F.S.; revising requirements relating to preservice training for foster parents; amending s. 409.967, F.S.; requiring the Agency for Health Care Administration to conduct, or contract for, the testing of provider network databases maintained by Medicaid managed care plans for specified purposes; amending s. 409.988, F.S.; revising the duties of a lead agency relating to individuals providing care for dependent children; amending s. 985.601, F.S.; requiring the Department of Juvenile Justice to participate in the planning process for promoting a coordinated system of care for children and adolescents; amending s. 1003.02, F.S.; requiring each district school board to participate in the planning process for promoting a coordinated

system of care; amending s. 1004.44, F.S.; requiring the Louis de la Parte Florida Mental Health Institute to develop, in consultation with other entities, a model response protocol for schools; amending s. 1006.04, F.S.; requiring the educational multiagency network to participate in the planning process for promoting a coordinated system of care; amending s. 1011.62, F.S.; revising the elements of a plan required for school district funding under the mental health assistance allocation; requiring the Department of Children and Families and Agency for Health Care Administration to assess the quality of care provided in crisis stabilization units to certain children and adolescents; requiring the department and agency to review current standards of care for certain settings and make recommendations; requiring the department and agency to jointly submit a report to the Governor and Legislature by a specified date; providing an effective date.

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

Section 1. Subsection (4) is added to section 394.493, Florida Statutes, to read:

394.493 Target populations for child and adolescent mental

health services funded through the department.—

(4) Beginning with fiscal year 2020-2021 through fiscal year 2021-2022, the department and the Agency for Health Care Administration shall identify children and adolescents who are the highest utilizers of crisis stabilization services. The department and agency shall collaboratively take appropriate action within available resources to meet the behavioral health needs of such children and adolescents more effectively, and shall jointly submit to the Legislature a quarterly report listing the actions taken by both agencies to better serve such children and adolescents.

Section 2. Paragraph (q) is added to subsection (4) of section 394.495, Florida Statutes, and subsection (7) is added to that section, to read:

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

(4) The array of services may include, but is not limited to:

(q) Crisis response services provided through mobile response teams.

(7)(a) The department shall contract with managing entities for mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25, inclusive, who:

1. Have an emotional disturbance;

2. Are experiencing an acute mental or emotional crisis;

3. Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function typically within the family, living situation, or community environment; or

4. Are served by the child welfare system and are experiencing or are at high risk of placement instability.

(b) A mobile response team shall, at a minimum:

1. Respond to new requests for services within 60 minutes after such requests are made.

2. Respond to a crisis in the location where the crisis is occurring.

3. Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family.

4. Provide evidence-based practices to children, adolescents, young adults, and families to enable them to independently and effectively deescalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises.

5. Provide screening, standardized assessments, early identification, and referrals to community services.

6. Engage the child, adolescent, or young adult and his or her family as active participants in every phase of the

treatment process whenever possible.

7. Develop a care plan for the child, adolescent, or young adult.

8. Provide care coordination by facilitating the transition to ongoing services.

9. Ensure there is a process in place for informed consent and confidentiality compliance measures.

10. Promote information sharing and the use of innovative technology.

11. Coordinate with the managing entity within the service location and other key entities providing services and supports to the child, adolescent, or young adult and his or her family, including, but not limited to, the child, adolescent, or young adult's school, the local educational multiagency network for severely emotionally disturbed students under s. 1006.04, the child welfare system, and the juvenile justice system.

(c) When procuring mobile response teams, the managing entity must, at a minimum:

1. Collaborate with local sheriff's offices and public schools in the planning, development, evaluation, and selection processes.

2. Require that services be made available 24 hours per day, 7 days per week, with onsite response time to the location of the referred crisis within 60 minutes after the request for services is made.

3. Require the provider to establish response protocols with local law enforcement agencies, local community-based care lead agencies as defined in s. 409.986(3), the child welfare system, and the Department of Juvenile Justice. The response protocol with a school district shall be consistent with the model response protocol developed under s. 1004.44.

4. Require access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner.

5. Require mobile response teams to refer children, adolescents, or young adults and their families to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services as necessary to address the immediate crisis event.

Section 3. Section 394.4955, Florida Statutes, is created to read:

394.4955 Coordinated system of care; child and adolescent mental health treatment and support.—

(1) Pursuant to s. 394.9082(5)(d), each managing entity shall develop a plan that promotes the development and effective implementation of a coordinated system of care which integrates services provided through providers funded by the state's child-serving systems and facilitates access by children and adolescents, as resources permit, to needed mental health treatment and services at any point of entry regardless of the

time of year, intensity, or complexity of the need, and other systems with which such children and adolescents are involved, as well as treatment and services available through other systems for which they would qualify.

(2)(a) The managing entity shall lead a planning process that includes, but is not limited to, children and adolescents with behavioral health needs and their families; behavioral health service providers; law enforcement agencies; school districts or superintendents; the multiagency network for students with emotional or behavioral disabilities; the department; and representatives of the child welfare and juvenile justice systems, early learning coalitions, the Agency for Health Care Administration, Medicaid managed medical assistance plans, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and other community partners. An organization receiving state funding must participate in the planning process if requested by the managing entity.

(b) The managing entity and collaborating organizations shall take into consideration the geographical distribution of the population, needs, and resources, and create separate plans on an individual county or multi-county basis, as needed, to maximize collaboration and communication at the local level.

(c) To the extent permitted by available resources, the coordinated system of care shall include the array of services listed in s. 394.495.

(d) Each plan shall integrate with the local plan developed under s. 394.4573.

(3) By July 1, 2021, the managing entity shall complete the plans developed under this section and submit them to the department. By July 1, 2022, the entities involved in the planning process shall implement the coordinated system of care specified in each plan. The managing entity and collaborating organizations shall review and update the plans, as necessary, at least every 3 years thereafter.

(4) The managing entity and collaborating organizations shall create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and support by making referrals to specialized treatment providers, if necessary, with follow up to ensure services are received.

(5) The managing entity and collaborating organizations shall document each coordinated system of care for children and adolescents through written memoranda of understanding or other binding arrangements.

(6) The managing entity shall identify gaps in the arrays of services for children and adolescents listed in s. 394.495 available under each plan and include relevant information in its annual needs assessment required by s. 394.9082.

Section 4. Paragraph (c) of subsection (3) and paragraphs (b) and (d) of subsection (5) of section 394.9082, Florida

Statutes, are amended, and paragraph (t) is added to subsection (5) of that section, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(c) Define the priority populations that will benefit from receiving care coordination. In defining such populations, the department shall take into account the availability of resources and consider:

1. The number and duration of involuntary admissions within a specified time.

2. The degree of involvement with the criminal justice system and the risk to public safety posed by the individual.

3. Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455.

4. The degree of utilization of behavioral health services.

5. Whether the individual is a parent or caregiver who is involved with the child welfare system.

6. Whether the individual is an adolescent, as defined in s. 394.492, who requires assistance in transitioning to services provided in the adult system of care.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(b) Conduct a community behavioral health care needs assessment every 3 years in the geographic area served by the

managing entity which identifies needs by subregion. The process for conducting the needs assessment shall include an opportunity for public participation. The assessment shall include, at a minimum, the information the department needs for its annual report to the Governor and Legislature pursuant to s. 394.4573. The assessment shall also include a list and descriptions of any gaps in the arrays of services for children or adolescents identified pursuant to s. 394.4955 and recommendations for addressing such gaps. The managing entity shall provide the needs assessment to the department.

(d) Promote the development and effective implementation of a coordinated system of care pursuant to ss. 394.4573 and 394.495 ~~s. 394.4573~~.

(t) Promote the use of available crisis intervention services by requiring contracted providers to provide contact information for mobile response teams established under s. 394.495 to parents and caregivers of children, adolescents, and young adults between ages 18 and 25, inclusive, who receive safety-net behavioral health services.

Section 5. Paragraph (b) of subsection (14) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(14)

(b) As a condition of licensure, foster parents shall successfully complete preservice training. The preservice training shall be uniform statewide and shall include, but not be limited to, such areas as:

1. Orientation regarding agency purpose, objectives, resources, policies, and services;

2. Role of the foster parent as a treatment team member;

3. Transition of a child into and out of foster care, including issues of separation, loss, and attachment;

4. Management of difficult child behavior that can be intensified by placement, by prior abuse or neglect, and by prior placement disruptions;

5. Prevention of placement disruptions;

6. Care of children at various developmental levels, including appropriate discipline; ~~and~~

7. Effects of foster parenting on the family of the foster parent; and

8. Information about and contact information for the local mobile response team as a means for addressing a behavioral health crisis or preventing placement disruption.

Section 6. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care

program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the

availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 7. Paragraph (f) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(f) Shall ensure that all individuals providing care for dependent children receive:

1. Appropriate training and meet the minimum employment

standards established by the department.

2. Contact information for the local mobile response team established under s. 394.495.

Section 8. Subsection (4) of section 985.601, Florida Statutes, is amended to read:

985.601 Administering the juvenile justice continuum.—

(4) The department shall maintain continuing cooperation with the Department of Education, the Department of Children and Families, the Department of Economic Opportunity, and the Department of Corrections for the purpose of participating in agreements with respect to dropout prevention and the reduction of suspensions, expulsions, and truancy; increased access to and participation in high school equivalency diploma, vocational, and alternative education programs; and employment training and placement assistance. The cooperative agreements between the departments shall include an interdepartmental plan to cooperate in accomplishing the reduction of inappropriate transfers of children into the adult criminal justice and correctional systems. As part of its continuing cooperation, the department shall participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 9. Subsection (5) is added to section 1003.02, Florida Statutes, to read:

1003.02 District school board operation and control of

public K-12 education within the school district.—As provided in part II of chapter 1001, district school boards are constitutionally and statutorily charged with the operation and control of public K-12 education within their school district. The district school boards must establish, organize, and operate their public K-12 schools and educational programs, employees, and facilities. Their responsibilities include staff development, public K-12 school student education including education for exceptional students and students in juvenile justice programs, special programs, adult education programs, and career education programs. Additionally, district school boards must:

(5) Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 10. Subsection (4) of section 1004.44, Florida Statutes, is renumbered as subsection (5), and a new subsection (4) is added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(4) By August 1, 2020, the institute shall develop a model response protocol for schools to use mobile response teams established under s. 394.495. In developing the protocol, the institute shall, at a minimum, consult with school districts

that effectively use such teams, school districts that use such teams less often, local law enforcement agencies, the Department of Children and Families, managing entities as defined in s. 394.9082(2), and mobile response team providers.

Section 11. Paragraph (c) of subsection (1) of section 1006.04, Florida Statutes, is amended to read:

1006.04 Educational multiagency services for students with severe emotional disturbance.—

(1)

(c) The multiagency network shall:

1. Support and represent the needs of students in each school district in joint planning with fiscal agents of children's mental health funds, including the expansion of school-based mental health services, transition services, and integrated education and treatment programs.

2. Improve coordination of services for children with or at risk of emotional or behavioral disabilities and their families by assisting multi-agency collaborative initiatives to identify critical issues and barriers of mutual concern and develop local response systems that increase home and school connections and family engagement.

3. Increase parent and youth involvement and development with local systems of care.

4. Facilitate student and family access to effective services and programs for students with and at risk of emotional

or behavioral disabilities that include necessary educational, residential, and mental health treatment services, enabling these students to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living.

5. Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 12. Paragraph (b) of subsection (16) of section 1011.62, Florida Statutes, is amended to read:

1011.62 Funds for operation of schools.—If the annual allocation from the Florida Education Finance Program to each district for operation of schools is not determined in the annual appropriations act or the substantive bill implementing the annual appropriations act, it shall be determined as follows:

(16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental health assistance allocation is created to provide funding to assist school districts in establishing or expanding school-based mental health care; train educators and other school staff in detecting and responding to mental health issues; and connect children, youth, and families who may experience behavioral health issues with appropriate services. These funds shall be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district shall

receive a minimum of $100,000, with the remaining balance allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment. Charter schools that submit a plan separate from the school district are entitled to a proportionate share of district funding. The allocated funds may not supplant funds that are provided for this purpose from other operating funds and may not be used to increase salaries or provide bonuses. School districts are encouraged to maximize third-party health insurance benefits and Medicaid claiming for services, where appropriate.

(b) The plans required under paragraph (a) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plans must include the following elements:

1. Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff in order to better align with nationally recommended ratio models. These

providers include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals. The plan also must identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students, which may include the review and revision of district staffing resource allocations based on school or student mental health assistance needs.

2. An interagency agreement or memorandum of understanding with the managing entity, as defined in s. 394.9082(2), that facilitates referrals of students to community-based services and coordinates care for students served by school-based and community-based providers. Such agreement or memorandum of understanding must address the sharing of records and information as authorized under s. 1006.07(7)(d) to coordinate care and increase access to appropriate services.

3.~~2.~~ Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided

on or off the school campus and may be supplemented by telehealth.

4.~~3.~~ Policies and procedures, including contracts with service providers, which will ensure that:

a. Parents of students are provided information about behavioral health services available through the students' school or local community-based behavioral health services providers, including, but not limited to, the mobile response team as established in s. 394.495 serving their area. A school may meet this requirement by providing information about and internet addresses for web-based directories or guides of local behavioral health services as long as such directories or guides are easily navigated and understood by individuals unfamiliar with behavioral health delivery systems or services and include specific contact information for local behavioral health providers.

b. School districts use the services of the mobile response teams to the extent that such services are available. Each school district shall establish policies and procedures to carry out the model response protocol developed under s. 1004.44.

c. Students who are referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns and ensure that the assessment of students at risk for mental health

disorders occurs within 15 days of referral. School-based mental health services must be initiated within 15 days after identification and assessment, and support by community-based mental health service providers for students who are referred for community-based mental health services must be initiated within 30 days after the school or district makes a referral.

d. Referrals to behavioral health services available through other delivery systems or payors for which a student or individuals living in the household of a student receiving services under this subsection may qualify, if such services appear to be needed or enhancements in those individuals' behavioral health would contribute to the improved well-being of the student.

5.~~4.~~ Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems, depression, anxiety disorders, suicidal tendencies, or substance use disorders.

6.~~5.~~ Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders, to improve the provision of early intervention services, and to assist students in dealing with trauma and violence.

Section 13. The Department of Children and Families and the Agency for Health Care Administration shall assess the quality of care provided in crisis stabilization units to

children and adolescents who are high utilizers of crisis stabilization services. The department and agency shall review current standards of care for such settings applicable to licensure under chapters 394 and 408, Florida Statutes, and designation under s. 394.461, Florida Statutes; compare the standards to other states' standards and relevant national standards; and make recommendations for improvements to such standards. The assessment and recommendations shall address, at a minimum, efforts by each facility to gather and assess information regarding each child or adolescent, to coordinate with other providers treating the child or adolescent, and to create discharge plans that comprehensively and effectively address the needs of the child or adolescent to avoid or reduce his or her future use of crisis stabilization services. The department and agency shall jointly submit a report of their findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2020.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1183 Home Medical Equipment Providers
SPONSOR(S): Maggard
TIED BILLS: **IDEN./SIM. BILLS:** SB 1742

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

SUMMARY ANALYSIS

Home medical equipment providers are licensed and regulated by the Agency for Health Care Administration (AHCA) under part VII of ch. 400, F.S. The licensure requirements for home medical equipment providers apply to any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services. Certain individuals and entities are exempt from the licensure requirements, including, for example, hospitals, nursing homes, hospices and pharmacies. Licensed health care practitioners who utilize home medical equipment in the course of their practice but do not sell or rent home medical equipment to their patients are also exempt from licensure.

Electrostimulation medical equipment can be used to treat a number of medical symptoms and conditions. Electrical stimulators can provide direct, alternating, and pulsed waveforms of energy to the human body through electrodes that may be implanted in the skin or used on the surface of the skin. Such devices may be used to exercise muscles, demonstrate a muscular response to stimulation of a nerve, relieve pain, relieve incontinence, and provide test measurements.

The bill amends s. 400.93, F.S., to exempt physicians licensed under chapters 458 and 459, F.S., and chiropractors licensed under ch. 460, F.S., who sell or rent electrostimulation medical equipment to their patients in the course of their practice from licensure as a home medical equipment provider.

The bill will have an insignificant negative fiscal impact on AHCA.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Home Medical Equipment Providers

Home medical equipment providers are licensed and regulated by the Agency for Health Care Administration (AHCA), under part VII of ch. 400, F.S., and Chapter 59A-25, F.A.C. A home medical equipment license is required for any person or entity that:

- Holds itself out to the public as providing home medical equipment[1] and services;[2]
- Accepts physician orders for home medical equipment and services; or
- Provides home medical equipment that typically requires home medical services.[3]

Section 400.931, F.S., requires any person or entity applying for a home medical equipment provider license to submit certain information to AHCA with the application, including:

- A report of the medical equipment and services that will be provided, and whether the equipment will be provided directly or by contract;
- A list of the persons and entities with whom the applicant contracts;
- Documentation of accreditation, or an application for accreditation, from an accrediting organization recognized by AHCA;
- Proof of liability insurance; and
- An application fee of $300 and an inspection fee of $400[4].

Section 400.934, F.S., requires home medical equipment providers to comply with minimum standards of operation relating to topics such as services, training and personnel, and emergency standards.

A home medical equipment provider must offer and provide home medical equipment and services, as necessary, to consumers who purchase or rent any equipment that requires such services, and must provide at least one category of equipment directly from their own inventory.[5] A home medical equipment provider is required to respond to orders for other equipment from either their own inventory or from the inventory of other contracted companies and must maintain and repair, either directly or through contract, items rented to consumers.[6]

Home medical equipment providers are required to maintain trained personnel to coordinate orders and scheduling of equipment and service deliveries and must ensure that their delivery personnel are

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[1] Defined in s. 400.925, F.S., as any product as defined by the federal Food and Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits or any product reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes oxygen and related respiratory equipment; manual, motorized, or customized wheelchairs and related seating and positioning; motorized scooters; personal transfer systems; and specialty beds, for use by a person with a medical need. Home medical equipment does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner.

[2] Defined in s. 400.925, F.S., as equipment management and consumer instruction, including selection, delivery, set-up, and maintenance of equipment, and other related services for the use of home medical equipment in the customer's regular or temporary place of residence.

[3] S. 400.93(1) and (2), F.S.

[4] S. 400.933, F.S.; Provides that the home medical equipment provider is exempt from the inspection fee if a survey or inspection has been conducted by an accrediting organization.

[5] S. 400.934(1) and (2), F.S.

[6] S. 400.934(3) and (11), F.S.

appropriately trained.[7] Home medical equipment providers are required to ensure that all personnel have the necessary training and background screening.[8]

A home medical equipment provider must comply with certain emergency standards, including:

- Ensuring that patients are aware of service hours and emergency service procedures;
- Maintaining a safe premises;[9]
- Preparing and maintaining a comprehensive emergency management plan that must be updated annually and provide for continuing home medical equipment services for life-supporting or life-sustaining equipment during an emergency;[10] and
- Maintaining a prioritized list of patients who need continued services during an emergency.[11]

Home medical equipment providers are also required to maintain a record for each patient that includes the equipment and services provided, which must contain:

- Any physician's order or certificate of medical necessity;
- Signed and dated delivery slips;
- Notes reflecting all services, maintenance performed, and equipment exchanges;
- The date on which rental equipment was retrieved; and
- Any other appropriate information.[12]

Licensed home medical equipment providers are subject to periodic inspections, including biennial licensure inspections, inspections directed by the federal Centers for Medicare and Medicaid Services, and licensure complaint investigations.[13] Currently there are 1,167 licensed home medical equipment providers in Florida.[14]

Certain individuals and entities are considered exempt from licensure, including:

- Providers operated by the Department of Health (DOH) or the federal government;
- Nursing homes;
- Assisted living facilities;
- Home health agencies;
- Hospices;
- Intermediate care facilities;
- Homes for special services;
- Transitional living facilities;
- Hospitals;
- Ambulatory surgical centers;
- Manufacturers and wholesale distributors that do not sell directly to the consumer; and
- Pharmacies.[15]

Licensed health care practitioners are also exempt from licensure, but only if they do not sell or rent home medical equipment to their patients.

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[7] S. 400.934(4) and (5), F.S.
[8] S. 400.934(16), F.S.
[9] S. 400.934(6), F.S.
[10] S. 400.934(20)(a), F.S.
[11] S. 400.934(21), F.S.
[12] S. 400.94, F.S.
[13] S. 400.932, F.S.
[14] AHCA , Florida Health Finder, *Facility/Provider Search, Home Medical Equipment Providers*, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (search conducted January 24, 2020).
[15] S. 400.93(5), F.S.

Electrostimulation Medical Equipment

Neuromuscular electrical stimulation (NMES) devices can be used to stimulate the muscle of a patient with muscle atrophy. They can also be used to enhance functional activity in neurologically impaired patients, which is commonly known as functional electrical stimulation (FES). There are two types of NMES: transcutaneous (surface) and percutaneous (partially implanted systems).[16]

Transcutaneous Electrical Nerve Stimulation (TENS) involves placing four electrodes on the skin, which passes a current through the skin to stimulate the appropriate muscles. TENS devices can be used for physical therapy in partially paralyzed patients. For example, a TENS device can be used to enhance flexibility of the foot of a partially paralyzed stroke patient to improve the patient's gate.[17] In addition to eliciting contraction of skeletal muscles TENS devices have been used in a variety of other applications, such as to contract the heart muscle (cardiac pacemakers), alleviate pain (TENS units), improve bladder control, control epileptic seizures, prevent progress of scoliosis, improve blood circulation, control respiration, and stimulate the auditory nerve and visual cortex.[18]

A percutaneous device is implanted into the body with leads and parts of the device remaining outside the body. Percutaneous leads require surgery and have been designed as either intramuscular electrodes that are embedded into the fibers of the muscle or epimysial electrodes that lay on the surface of the muscle.[19]

Effect of the Bill

The bill amends s. 400.93, F.S., to exempt physicians licensed under Chapters 458 and 459, F.S., and chiropractors licensed under ch. 460, F.S., who sell or rent electrostimulation medical equipment to their patients in the course of their practice from home medical equipment provider licensure requirements.[20] The bill permits physicians and chiropractors to sell or rent this type of home medical equipment directly to their patients without incurring a fee for licensure or licensure renewal. The bill maintains the limited exemption for other types of practitioners, who may not sell or rent such equipment without a home medical equipment provider license.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.93, F.S., relating to licensure required; exemptions; unlawful acts; penalties.
Section 2: Provides an effective date of July 1, 2020.

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[16] Jeffrey Shuren, MD, JD, Federal Centers for Medicare & Medicaid Services, *Decision Memo for Neuromuscular Electrical Stimulation for Spinal Cord Injury (CAG-00153R),* available at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=55&TAId=5&NCDId=244&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=STI&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAQAAA& (last viewed January 24, 2020).
[17] 21 C.F.R., s. 882.5810.
[18] Sigmedics, Inc., Rehabilitation Technology for the Neurologically Impaired, *FAQ What is Functional Neuromuscular Stimulation,* available at https://www.sigmedics.com/faq (last viewed January 24, 2020).
[19] Supra FN 16.
[20] In 2015, the Florida Legislature passed HB 1305, which was identical to this bill, however, the bill was vetoed by Governor Scott before it became law. In a letter from former Governor Rick Scott to former Secretary of State Kenneth Detzner, Governor Scott explained his decision to repeal the bill as follows, "while I agree with the Legislature's attempt to deregulate and remove burdensome regulations, carve outs add additional levels of complexity to regulatory requirements while allowing outdated regulations to remain on the books. Carve outs also present an unfair advantage to certain entities competing within the same industry." Available at https://www.flgov.com/wp-content/uploads/2015/06/Transmittal-Letter-6.10.15-HB-1305.pdf (last viewed January 24, 2020).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA may experience a decrease in revenues resulting from a reduction in the number of physicians and chiropractors paying licensure fees to sell or rent electrostimulation medical equipment directly to their patients. The exact amount is uncertain but is not expected to be significant.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed physicians and chiropractors who sell or rent electrostimulation medical equipment to their patients will not have to pay licensure and licensure renewal fees.

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:

No additional rule-making is necessary 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 home medical equipment providers; amending s. 400.93, F.S.; exempting allopathic, osteopathic, and chiropractic physicians who sell or rent electrostimulation medical equipment and supplies from licensure requirements under certain circumstances; providing an effective date.

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

Section 1. Paragraph (l) is added to subsection (5) of section 400.93, Florida Statutes, to read:

400.93 Licensure required; exemptions; unlawful acts; penalties.—

(5) The following are exempt from home medical equipment provider licensure, unless they have a separate company, corporation, or division that is in the business of providing home medical equipment and services for sale or rent to consumers at their regular or temporary place of residence pursuant to the provisions of this part:

(l) Physicians licensed under chapter 458, chapter 459, or chapter 460 for the sale or rental of electrostimulation medical equipment and electrostimulation medical equipment supplies to their patients in the course of their practice.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1273 Dentistry and Dental Hygiene
SPONSOR(S): Buchanan
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures. A dental hygienist provides education, preventive and delegated therapeutic dental services.

Currently, all applicants for licensure as a dentist or dental hygienist must pass a practical examination developed by the American Board of Dental Examiners, Inc. (ADEX), in addition to meeting other qualifications. The ADEX examination must be graded by Florida-licensed practitioners.

HB 1273 authorizes the Board of Dentistry to accept passing scores on the examinations produced by the Western Regional Examining Board (WREB) for licensure as a dentist or dental hygienist, in addition to the ADEX examinations it currently accepts. The bill requires the WREB examination to be graded by Florida-licensed practitioners.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Dentistry

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act.[1] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[2] A dental hygienist provides education, preventive and delegated therapeutic dental services.[3]

Dental Licensure

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

- The National Board of Dental Examiners dental examiner (NBDE);
- A written examination on Florida laws and rules regulating the practice of dentistry; and
- A practical examination, which is the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., and graded by a Florida-licensed dentist employed by DOH for such purpose.[4]

To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.

Dental Hygiene Licensure

Any person wishing to be licensed as a dental hygienist must apply to DOH and meet the following qualifications:[5]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[6] and
- Obtain a passing score on the:
    - Dental Hygiene National Board Examination;
    - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by DOH for such purpose; and
    - A written examination on Florida laws and rules regulating the practice of dental hygiene.

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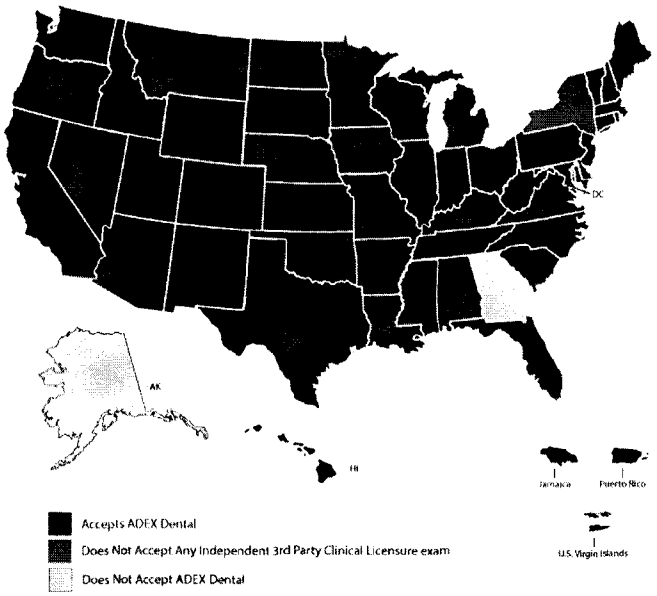
[1] Section 466.004, F.S.
[2] Section 466.003(3), F.S.
[3] Section 466.003(4)-(5), F.S.
[4] A passing score is valid for 365 days after the date the official examination results are published. A passing score on an examination obtained in another jurisdiction must be completed on or after October 1, 2011.
[5] Section 466.007, F.S.
[6] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma, which must be reviewed and approved by the Board of Dentistry.

A dental hygienist may also apply to be certified to administer local anesthesia under the direct supervision of a non-sedated, adult patient if the dental hygienist completes an accredited course of 30 hours of didactic training and 30 hours of clinical training and is certified in basic or advanced cardiac life support.[7]

American Board of Dental Examiners

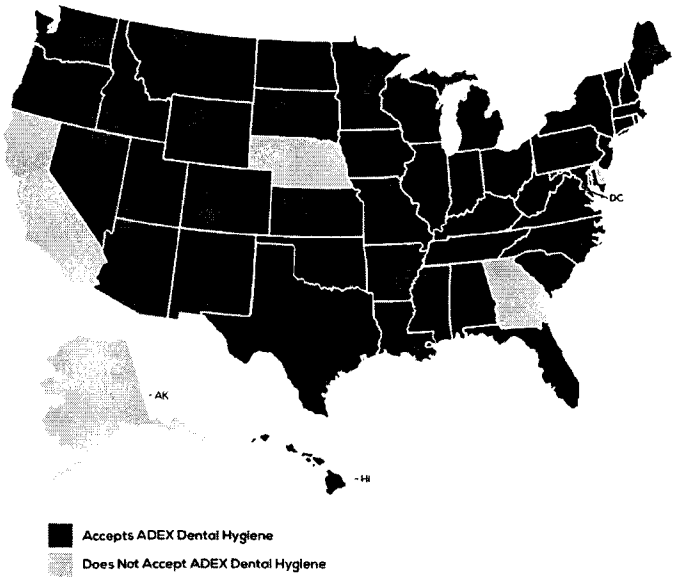
The American Board of Dental Examiners (ADEX) is a consortium of state and regional dental boards that provides for the ongoing development of uniform national dental and dental hygiene licensure examinations.[8] ADEX was created in 2003, with representatives from four regional testing agencies and 12 states. At the time ADEX was created, there were 16 different dental and dental hygiene examinations.[9]

The Commission on Dental Competency Assessment (CDCA), formerly known as the Northeast Regional Board, and the Council of Interstate Testing Agencies (CITA) administers the ADEX dental licensure examination to graduates of accredited dental schools and students about to enter their senior year at an accredited dental school.[10] The ADEX dental examination consists of three portions: a computer-based examination, simulated clinical examinations, and clinical examinations on live patients.[11] Florida law requires a Florida-licensed dentist to grade the examination.[12] The ADEX examination is widely accepted for dental licensure.[13]



[7] Section 466.017(5), F.S.
[8] American Board of Dental Examiners, Inc., *About ADEX*, available at https://adexexams.org/about-adex/ (last visited January 23, 2020).
[9] Id.
[10] Commission on Dental Competency Assessments, *Registration and DSE OSCE Manual: 2020 ADEX Dental Examination Series*, available at https://www.cdcaexams.org/documents/manuals/Dental_DSE_OSCE2020.pdf (last visited January 23, 2020).The cost of the ADEX dental examinations is $2,295; however, additional fees may be assessed, such as a facility or score report fee. The fee is reduced for partial exams and retakes. *See* Commission on Dental Competency Assessments, *Dental (ADEX) Exam*, available at https://www.cdcaexams.org/dental-exams/ (last visited January 23, 2020).
[11] Id at p. 4. The simulated clinical examinations assesses skills related to endodontics and fixed prosthodontics. The clinical examinations on live patients assesses skills related to restorative and periodontal procedures.
[12] Section 466.006(4), F.S.
[13] Commission on Dental Competency Assessments, *ADEX Acceptance Map*, available at https://www.cdcaexams.org/adex-acceptance-map/ (last visited January 23, 2020).

As with the dental examination, CDCA and CITA administer the ADEX dental hygiene examination.[14] The ADEX dental hygiene examination consists of two portions: a computer-simulated examination and a clinical examination on live patients.[15] Florida law requires a Florida-licensed dentist or dental hygienist to grade the examination.[16] The ADEX examination is widely accepted for dental hygiene licensure.[17]



Florida only accepts the ADEX examinations and the Legislature found, when specifying the ADEX examination for use in dental licensure, that the ADEX examinations, in both structure and functions, consistently meet generally accepted testing standards and that it adequately and reliably measures an applicant's ability to practice dentistry.[18] DOH contracts with the CDCA to administer the ADEX examinations, as well as the jurisprudence examinations.[19] In Fiscal Year 2018-2019, 840 dentists and 812 dental hygienists applied to the take the ADEX examinations.[20]

Western Regional Examining Board

The Western Regional Examining Board (WREB) was created in 1976 when Utah and Oregon made an arrangement to have a simultaneous dental licensure examination.[21] WREB offered its first dental hygiene examination in 1979.[22]

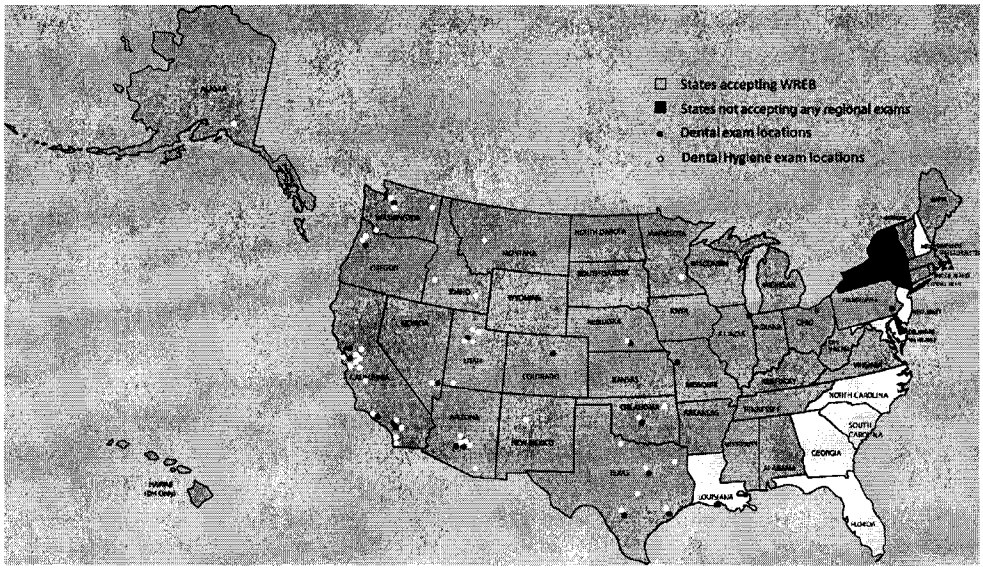
The WREB dental examination consists of three sections: operative, endodontics, and comprehensive treatment planning.[23] The operative section is performed on a live patient and the candidate must

[14] Commission on Dental Competency Assessments, *Candidate Registration and CSCE OSCE Manual: 2020 ADEX Dental Hygiene Examination*, available at https://www.cdcaexams.org/documents/manuals/Dental_Hygiene_Candidate_Registration2020.pdf (last visited January 23, 2020). The cost of the ADEX dental hygiene examinations is $995; however, additional fees may be assessed, such as a facility or score report fee.
[15] Id.
[16] Section 466.007(4), F.S.
[17] *Supra* note 13.
[18] Section 466.006(1)(a), F.S.
[19] Department of Health, *2020 Agency Legislative Bill Analysis for HB 1273,* (Jan. 21, 2020), on file with the Health Quality Subcommittee.
[20] Id.
[21] Western Regional Examining Board, *About Us*, available at https://wreb.org/about-us/ (last visited January 23, 2020). The members of the Western Regional Examining Board include Utah, Oregon, Arizona, Idaho, Alaska, New Mexico, Texas, Oklahoma, Washington, Wyoming, California, Missouri, Kansas, North Dakota, Illinois, Nevada, and Kentucky. West Virginia is an affiliate.
[22] Id.
[23] Western Regional Examining Board, *2020 WREB Exam Procedures*, available at https://wreb.org/Candidates/Dental/dentalPDFs/1_2020_WREB_Exam_Procedures.pdf (last visited January 23, 2020). The WREB

complete up to two restorative procedures. The endodontics section is simulated and the comprehensive treatment planning section is a computer-based written examination. A periodontal examination, which is performed on a live patient, and a prosthodontics examination, which is a simulated examination, are available for candidates in those states that require the examinations.[24]

The WREB dental hygiene examination assesses the candidates on patient qualification, extraoral and intraoral evaluation, calculus detection and removal, tissue management, periodontal assessment, and professional judgment.[25]

The Western Regional Examining Board's licensure examinations are widely accepted for licensure.[26]



The WREB does not administer a state-specific jurisprudence examination. Florida does not accept the WREB dentist or dental hygiene examinations for licensure.

Effect of Proposed Changes

HB 1273 authorizes the Board of Dentistry to accept passing scores on the examinations produced by the Western Regional Examining Board for licensure as a dentist or dental hygienist, in addition to the ADEX examinations it currently accepts. The bill requires the WREB examination to be graded by Florida-licensed practitioners.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 466.006, F.S., relating to examination of dentists.
Section 2: Amends s. 466.007, F.S., relating to examination of dental hygienists.
Section 3: Provides an effective date of July 1, 2020.

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dental examination costs $2,560 plus an additional school use fee that varies by site. *See* Western Regional Examining Board, *2020 Dental Exam Fees*, available at https://wreb.org/dental-candidates/2019-dental-exam-fees/ (last visited January 23, 2020).
[24] Id. Florida requires a prosthodontics examination for licensure.
[25] Western Regional Examining Board, *2020 Dental Hygiene Examination Candidate Guide*, available at https://wreb.org/Candidates/Hygiene/hygienePDFs/2020_DH_Forms/2020_WREB_Candidate_Guide_HYG_v11012019.pdf (last visited January 23, 2020). The WREB dental hygiene examination costs $1,175 plus a school use fee, which varies by site. *See* Western Regional Examining Board, *Dental Hygiene, Local Anesthesia, and Restorative Exam Fees*, available at https://wreb.org/hygiene-candidates/2018-hygiene-exam-fees/ (last visited January 23, 2020).
[26] *Supra* note 21.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will experience an insignificant increase in workload associated with providing input into the test development and administration process for the WREB examinations, which current resources can absorb.[27] DOH will incur insignificant costs related to modifying applications, rulemaking, updating Board websites, facilitating electronic submission of WREB examination scores, and updating the LEIDS licensure system, which current resources can absorb.[28]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[27] *Supra* note 19.
[28] None.

A bill to be entitled

An act relating to dentistry and dental hygiene; amending ss. 466.006 and 466.007, F.S.; authorizing the use of certain examinations produced by the Western Regional Examining Board to measure an applicant's ability to practice the profession of dentistry or dental hygiene; providing an effective date.

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

Section 1. Subsection (1), paragraph (b) of subsection (4), paragraph (a) of subsection (5), and paragraph (a) of subsection (6) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(1)(a) It is the intent of the Legislature to reduce the costs associated with an independent state-developed practical or clinical examination to measure an applicant's ability to practice the profession of dentistry and to use the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., or the Western Regional Examining Board (WREB) Dental Examination in lieu of an independent state-developed practical or clinical examination. The Legislature finds that the American Dental Licensing Examination and the

WREB Dental Examination, in both their ~~its~~ structure and function, consistently meet ~~meets~~ generally accepted testing standards and have ~~has~~ been found, as they are ~~it is~~ currently organized and operating, to adequately and reliably measure an applicant's ability to practice the profession of dentistry.

(b) Any person desiring to be licensed as a dentist shall apply to the department to take the licensure examinations and shall verify the information required on the application by oath. The application shall include two recent photographs. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee set by the board, which shall not exceed $425 plus the actual per-applicant ~~per applicant~~ cost to the department for purchase of some or all of the examination from the American Board of Dental Examiners, the WREB, or a ~~its~~ successor entity, if any, provided the board finds the successor entity's clinical examination complies with ~~the provisions of~~ this section. The examination fee may be refundable if the applicant is found ineligible to take the examinations.

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

(b)1. A practical or clinical examination, which shall be the American Dental Licensing Examination produced by the

American Board of Dental Examiners, Inc., the WREB Dental Examination, or an examination produced by a ~~its~~ successor entity, if any, that is administered in this state and graded by dentists licensed in this state and employed by the department for just such purpose, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners or the Western Regional Examining Board as the board deems appropriate by rule to ensure ~~assure~~ that the standards established herein are maintained organizationally. A passing score on the American Dental Licensing Examination or the WREB Dental Examination administered in this state and graded by dentists who are licensed in this state is valid for 365 days after the date the official examination results are published.

2.a. As an alternative to the requirements of subparagraph 1., an applicant may submit scores from an American Dental Licensing Examination or a WREB Dental Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results shall be recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination or the WREB Dental Examination administered out-of-state shall be

the same as the passing score for the American Dental Licensing Examination or the WREB Dental Examination administered in this state and graded by dentists who are licensed in this state. The examination results are valid for 365 days after the date the official examination results are published. The applicant must have completed the examination after October 1, 2011.

b. This subparagraph may not be given retroactive application.

3. If the date of an applicant's passing American Dental Licensing Examination or passing WREB Dental Examination scores from an examination previously administered in a jurisdiction other than this state under subparagraph 2. is older than 365 days, then such scores shall nevertheless be recognized as valid for the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

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

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

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States

Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation;

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

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

e.(I) In the 5 years immediately preceding the date of application for licensure in this state, the applicant must

submit proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, or, if the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant must submit proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

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

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

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

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

(III) The board shall develop rules to determine what type

of proof of full-time practice is required and to recoup the cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

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

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

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

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

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

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

h. The applicant must successfully pass a written examination on the laws and rules of this state regulating the practice of dentistry and must successfully pass the computer-based diagnostic skills examination; and

i. The applicant must submit documentation that he or she has successfully completed the National Board of Dental Examiners dental examination.

(5)(a) The practical examination required under subsection (4) shall be the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., the WREB Dental Examination, or an examination developed by a ~~its~~ successor entity, if any, provided the board finds that the successor entity's clinical examination complies with ~~the provisions of~~ this section, and shall include, at a minimum:

1. A comprehensive diagnostic skills examination covering the full scope of dentistry and an examination on applied clinical diagnosis and treatment planning in dentistry for dental candidates;

2. Two restorations on a live patient or patients. The board by rule shall determine the class of such restorations;

3. A demonstration of periodontal skills on a live

patient;

4. A demonstration of prosthetics and restorative skills in complete and partial dentures and crowns and bridges and the utilization of practical methods of evaluation, specifically including the evaluation by the candidate of completed laboratory products such as, but not limited to, crowns and inlays filled to prepared model teeth;

5. A demonstration of restorative skills on a mannequin which requires the candidate to complete procedures performed in preparation for a cast restoration;

6. A demonstration of endodontic skills; and

7. A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an applicant fails to pass the diagnostic skills examination in three attempts, the applicant shall not be eligible for reexamination unless she or he completes additional educational requirements established by the board.

The department shall require a mandatory standardization exercise for all examiners before ~~prior to~~ each practical or clinical examination and shall retain for employment only those dentists who have substantially adhered to the standard of grading established at such exercise.

(6)(a) It is the finding of the Legislature that absent a threat to the health, safety, and welfare of the public, the relocation of applicants to practice dentistry within the geographic boundaries of this state, who are lawfully and currently practicing dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, based on their scores from the American Dental Licensing Examination or the WREB Dental Examination administered in a state other than this state, is substantially related to achieving the important state interest of improving access to dental care for underserved citizens of this state and furthering the economic development goals of the state. Therefore, in order to maintain valid active licensure in this state, all applicants for licensure who are relocating to this state based on scores from the American Dental Licensing Examination or the WREB Dental Examination administered in a state other than this state must actually engage in the full-time practice of dentistry inside the geographic boundaries of this state within 1 year after ~~of~~ receiving such licensure in this state. The Legislature finds that, if such applicants do not actually engage in the full-time practice of dentistry within the geographic boundaries of this state within 1 year of receiving such a license in this state, access to dental care for the public will not significantly increase, patients' continuity of care will not be attained, and the economic

development goals of the state will not be significantly met.

Section 2. Paragraph (b) of subsection (4) and subsections (5) and (6) of section 466.007, Florida Statutes, are amended to read:

466.007 Examination of dental hygienists.—

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

(b) A practical or clinical examination approved by the board. The examination shall be the Dental Hygiene Examination produced by the American Board of Dental Examiners (ADEX), Inc., the Western Regional Examining Board (WREB) Dental Hygiene Examination, ~~(ADEX)~~ or an examination produced by a ~~its~~ successor entity, if any, if the board finds that the successor entity's clinical examination meets or exceeds the provisions of this section. The board shall approve the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination if the board has attained and continues to maintain representation on the ADEX House of Representatives, the ADEX Dental Hygiene Examination Development Committee, and such other ADEX Dental Hygiene or WREB Dental Hygiene committees as the board deems appropriate through rulemaking to ensure that the standards established in this section are maintained organizationally. The ADEX Dental Hygiene Examination, the WREB Dental Hygiene Examination, or an ~~the~~ examination produced by a ~~its~~ successor

entity is a comprehensive examination in which an applicant must demonstrate skills within the dental hygiene scope of practice on a live patient and any other components that the board deems necessary for the applicant to successfully demonstrate competency for the purpose of licensure. The ADEX Dental Hygiene Examination, the WREB Dental Hygiene Examination, or an ~~the~~ examination produced by a ~~the~~ successor entity and administered in this state shall be graded by licensed dentists and dental hygienists ~~licensed in this state~~ who are employed by the department for this purpose.

(5) Effective July 1, 2012, an applicant who has completed the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination in a jurisdiction other than this state and who has obtained a passing score may practice dental hygiene in this state if the applicant:

(a) Has successfully completed the National Board Dental Hygiene Examination at any time before the date of application;

(b) Has been certified by the American Dental Association Joint Commission on National Dental Examinations at any time before the date of application, as specified by state law;

(c) Has successfully completed a written examination on the laws and rules of this state regulating the practice of dental hygiene;

(d) Has not been disciplined by a board, except for citation offenses or minor violations; and

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

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

(b) If an applicant fails to pass the ADEX Dental Hygiene Examination or the WREB Dental Hygiene Examination in three attempts, the applicant is not eligible to retake the examination unless the applicant completes additional education requirements as specified by the board.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1341 Massage Therapy
SPONSOR(S): Goff-Marcil
TIED BILLS: **IDEN./SIM. BILLS:** SB 390

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	15 Y, 0 N	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke BM	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Massage practice is the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy, or any electrical or mechanical device, or the application of a chemical or herbal preparation to the human body. The Board of Massage Therapy (Board), within the Department of Health (DOH), regulates massage practice in this state.

HB 1341 expands the scope of practice for massage therapy by allowing massage therapists to apply over-the-counter topical agents or a topical agent prescribed by a health care practitioner in accordance with board rules. The bill also authorizes a massage therapist to assess a patient for massage therapy treatment.

Currently, there are two paths to licensure as a massage therapist: completion of a board-approved education program or completion of an apprenticeship. The bill eliminates a massage apprenticeship as a path to licensure. However, the bill grandfathers those individuals who have been issued a license as a massage apprentice before July 1, 2020, so they are still eligible for licensure if the apprenticeship is completed before July 1, 2022.

Currently, DOH is statutorily required to administer a licensure examination. The bill authorizes the Board of Massage Therapy to designate a national examination for licensure and repeals provisions requiring DOH to administer a licensure examination.

The bill changes the term "massage" to "massage therapy" throughout statutes to standardize terminology.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Massage Therapy

Massage practice is the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy, or any electrical or mechanical device, or the application of a chemical or herbal preparation to the human body.[1] Massage is therapeutic and a massage therapist must know anatomy and physiology and understand the relationship between the structure and function of the tissues being treated and the total function of the body.[2]

Chapter 480, F.S., entitled the "Massage Practice Act" governs the practice of massage therapy in Florida. The Board of Massage Therapy (Board), within the Department of Health (DOH), regulates massage practice, including massage therapists and massage establishments.[3]

Massage Therapist Licensure

A massage therapist is a person who administers massage for compensation.[4] To qualify for licensure as a massage therapist, an applicant must:[5]

- Be at least 18 years of age or have received a high school diploma or graduate equivalency diploma;
- Complete a course of study at a Board-approved massage school or apprentice program;
- Pass an examination administered by DOH; and
- Pass a background screening.

Although the statute requires that the licensure examination must be issued by DOH, the Board of Massage Therapy has approved the following licensure examinations:[6]

- 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
- National Board for Colon Hydrotherapy Examination for colonic irrigation.

In the 2017-2018 fiscal year, 3,380 individuals were granted licensure as massage therapists, 13 of which qualified for licensure by completing an approved massage apprenticeship program.[7] Massage therapy education has become more formalized and massage therapists are trained in licensed

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[1] Section 480.033(3), F.S.
[2] Section 480.032, F.S.
[3] Section 480.035, F.S.
[4] Section 480.033(4), F.S.
[5] Section 480.041, F.S. DOH must deny an application if the applicant has been convicted or found guilty of, or entered a plea of nolo contedere to a crime related to prostitution or a felony offense related to certain other crimes.
[6] In r. 64B27-25.001(3), F.A.C.,
[7] Department of Health, *2020 Agency Legislative Analysis for HB 713*, (Nov. 19, 2019), on file with the Health Quality Subcommittee. HB 713 has substantively similar provisions.

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.[8]

Massage Schools

A person seeking licensure as a massage therapist may complete a course of study at a Board-approved massage school. The Board requires the course of study to be at least 500 classroom hours, completed at a rate of no more than six hours per day and no more than 30 classroom hours per calendar week.[9] Classroom education must include:[10]

- 150 hours of anatomy and physiology;
- 100 hours of basic massage theory and history;
- 125 hours of clinical practicum;
- 76 hours of allied modalities;
- 15 hours of business;
- 15 hours of theory and practice of hydrotherapy;
- 10 hours of Florida laws and rules;
- 4 hours of professional ethics;
- 3 hours of HIV/AIDS education; and
- 2 hours of medical errors.

A massage therapy student may also complete a course of study in colonic training in addition to the training above. Such course of study must include a minimum of 100 classroom hours, consisting of 50 hours in theory, anatomy, physiology, pathology of the colon and digestive system and principles of colon hygiene, 45 hours of clinical practicum that includes 20 treatments, and five hours in sterilization techniques.[11]

Massage Apprenticeship Programs

Currently, a person seeking licensure as a massage therapist may complete a massage apprenticeship in lieu of attending massage school. A massage apprenticeship training must be completed at a qualified establishment[12] and must be completed within 12 months, in four quarters.[13] A massage therapist must complete training of no more than 500 hours per quarter. The training must include:[14]

- 300 hours of anatomy;
- 300 hours of physiology;
- 20 basic massage theory and history;
- 50 hours of theory and practice of hydrotherapy;
- 25 hours of Florida laws and rules;
- 50 hours of allied modalities;
- 700 hours of clinical practicum; and
- 3 hours of HIV/AIDS instruction.

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[8] Department of Health, *2019 Agency Legislative Analysis for HB 7031*, on file with the Health Quality Subcommittee.
[9] Rule 64B7-32.003, F.A.C.
[10] Id.
[11] Rule 64B7-32.005, F.A.C.
[12] A "qualified establishment" is one that meets the requirements for licensure, complies with board rules for massage establishments, and is equipped with massage tables, linens and linen storage areas, hydrotherapy equipment, textbooks and teaching materials. If the apprenticeship include colonic irrigation, the establishment must also have colonic irrigation equipment, sterilization equipment if non-disposable colonic attachments are use, and textbooks and teaching materials on colonic irrigation. *See* r. 64B7-29.001(6), F.A.C.
[13] Rule 64B7-29.003, F.A.C.
[14] Id.

The massage apprentice must complete 100 hours of anatomy, 100 hours of physiology, and 15 hours of Florida laws and rules regulating the practice of massage therapy during the first quarter of the apprenticeship.[15]

Colonic Irrigation Apprenticeship Programs

A massage therapist, a massage apprentice, or a student in a board-approved massage therapy school may study colonic irrigation[16] under the direct supervision of a sponsor.[17] The sponsor must be licensed to practice massage, authorized to practice colonic irrigation, and have practiced colonic irrigation for at least three years.[18] The apprenticeship must be completed within 12 months of commencement[19] and must consist of a minimum of 100 hours of training, including 45 hours of clinical practicum with a minimum of 20 treatments given.[20] Few schools in Florida offer a colonic irrigation program so apprenticeships are the primary method of training. There are 21 individuals certified to complete an apprenticeship in colonic irrigation.[21]

Effect of Proposed Changes

HB 1341 expands the scope of practice for massage therapy by allowing massage therapists to apply over-the-counter topical agents or a topical agent prescribed by a health care practitioner in accordance with board rules. The bill also authorizes a massage therapist to assess a patient for massage therapy treatment.

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, 2022.

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

The bill changes the term "massage" to "massage therapy" throughout statutes to standardize terminology, including revising the title of ch. 480, F.S., from "Massage Practice" to "Massage Therapy Practice."

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

B. SECTION DIRECTORY:

Section 1: Changes the title of ch. 490, F.S., from "Massage Practice" to "Massage Therapy Practice."
Section 2: Amends s. 480.031, F.S., relating to short title.
Section 3: Amends s. 480.032, F.S., relating to purpose.
Section 4: Amends s. 480.033, F.S., relating to definitions.
Section 5: Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure; endorsement.
Section 6: Repeals s. 480.042, F.S., relating to examinations.

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[15] Id.
[16] Colonic irrigation is a method of hydrotherapy used to cleanse the colon with the aid of a mechanical device and water (s. 480.033(6), F.S.).
[17] Rule 64B7-29.001, F.A.C.
[18] Id.
[19] Rule 64B7-29.007, F.A.C.
[20] Rule 64B7-25.001, F.A.C.
[21] *Supra* note 7.

Section 7: Amends s. 477.013, F.S., relating to definitions.
Section 8: Amends s. 477.1035, F.S., relating to exemptions.
Section 9: Amends s. 480.034, F.S., relating to exemptions.
Section 10: Amends s. 480.035, F.S., relating to Board of Massage Therapy.
Section 11: Amends s. 480.043, F.S., relating to massage establishments; requisites; licensure; inspection; human trafficking awareness training and policies.
Section 12: Amends s. 480.046, F.S., relating to grounds for disciplinary action by the board.
Section 13: Amends s. 480.0465, F.S., relating to advertisement.
Section 14: Amends s. 480.047, F.S., relating to penalties.
Section 15: Amends s. 480.052, F.S., relating to power of county or municipality to regulate massage.
Section 16: Amends s. 480.0535, F.S., relating to documents required while working in a massage establishment.
Section 17: Amends s. 627.6407, F.S., relating to massage.
Section 18: Amends s. 627.6619, F.S., relating to massage.
Section 19: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.
Section 20: Amends s. 641.31, F.S., relating to health maintenance contracts.
Section 21: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will incur insignificant costs related to adopting rules to expand the scope of practice for massage therapy and repealing rules on massage apprenticeships. Current resources can absorb these costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to massage therapy; renaming ch. 480, F.S., as "Massage Therapy Practice"; amending s. 480.031, F.S.; conforming a provision to changes made by the act; amending s. 480.032, F.S.; revising the purpose of ch. 480, F.S.; amending s. 480.033, F.S.; revising terms and definitions; amending s. 480.041, F.S.; revising requirements for licensure as a massage therapist; conforming provisions to changes made by the act; providing applicability for persons who were issued a license as a massage apprentice before a specified date; repealing s. 480.042, F.S., relating to examinations; amending ss. 477.013, 477.0135, 480.034, 480.035, 480.043, 480.046, 480.0465, 480.047, 480.052, 480.0535, 627.6407, 627.6619, 627.736, and 641.31 F.S.; conforming provisions to changes made by the act; making technical changes; providing an effective date.

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

Section 1. Chapter 480, Florida Statutes, entitled "Massage Practice," is renamed "Massage Therapy Practice."

Section 2. Section 480.031, Florida Statutes, is amended to read:

480.031 Short title.—This act ~~shall be known and~~ may be cited as the "Massage Therapy Practice Act."

Section 3. Section 480.032, Florida Statutes, is amended to read:

480.032 Purpose.—The Legislature recognizes that the practice of massage therapy is potentially dangerous to the public in that massage therapists must have a knowledge of anatomy and physiology and an understanding of the relationship between the structure and the function of the tissues being treated and the total function of the body. Massage therapy is a therapeutic health care practice, and regulations are necessary to protect the public from unqualified practitioners. It is therefore deemed necessary in the interest of public health, safety, and welfare to regulate the practice of massage therapy in this state; however, restrictions shall be imposed to the extent necessary to protect the public from significant and discernible danger to health and yet not in such a manner which will unreasonably affect the competitive market. Further, consumer protection for both health and economic matters shall be afforded the public through legal remedies provided for in this act.

Section 4. Subsections (3), (4), (5), (7), and (9) of section 480.033, Florida Statutes, are amended to read:

480.033 Definitions.—As used in this act:

(3) "Massage therapy" means the manipulation of the soft

tissues of the human body with the hand, foot, knee, arm, or elbow, regardless of whether ~~or not~~ such manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation, an over-the-counter topical agent, or a topical agent prescribed by a health care practitioner applied in accordance with board rule.

(4) "Massage therapist" means a person licensed as required by this act, who administers massage therapy for compensation and assesses or evaluates persons for massage therapy treatment.

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

(7) "Establishment" or "massage establishment" means a site or premises, or portion thereof, wherein a massage therapist practices massage therapy.

(9) "Board-approved massage therapy school" means a facility that meets minimum standards for training and curriculum as determined by rule of the board and that is licensed by the Department of Education pursuant to chapter 1005 or the equivalent licensing authority of another state or is within the public school system of this state or a college or university that is eligible to participate in the William L. Boyd, IV, Effective Access to Student Education Grant Program.

Section 5. Subsections (1), (2), and (4) of section 480.041, Florida Statutes, are amended, and subsection (8) is added to that section, to read:

480.041 Massage therapists; qualifications; licensure; endorsement.—

(1) Any person is qualified for licensure as a massage therapist under this act who:

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

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

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

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

(4) Upon an applicant's passing the examination and paying the initial licensure fee, the department shall issue to the applicant a license, valid until the next scheduled renewal date, to practice massage therapy.

(8) A person issued a license as a massage apprentice before July 1, 2020, may continue that apprenticeship and perform massage therapy as authorized under that license until its expiration. After completing his or her apprenticeship and before July 1, 2022, a massage apprentice may apply to the board for full licensure and the board must grant the application if the applicant meets all other applicable licensure requirements.

Section 6. Section 480.042, Florida Statutes, is repealed.

Section 7. Subsection (13) of section 477.013, Florida Statutes, is amended to read:

477.013 Definitions.—As used in this chapter:

(13) "Skin care services" means the treatment of the skin of the body, other than the head, face, and scalp, by the use of a sponge, brush, cloth, or similar device to apply or remove a chemical preparation or other substance, except that chemical peels may be removed by peeling an applied preparation from the skin by hand. Skin care services must be performed by a licensed cosmetologist or facial specialist within a licensed cosmetology or specialty salon, and such services may not involve massage therapy, as defined in s. 480.033(3), through manipulation of the superficial tissue.

Section 8. Paragraph (a) of subsection (1) of section 477.0135, Florida Statutes, is amended to read:

477.0135 Exemptions.—

(1) This chapter does not apply to the following persons

when practicing pursuant to their professional or occupational responsibilities and duties:

(a) Persons authorized under the laws of this state to practice medicine, surgery, osteopathic medicine, chiropractic medicine, massage therapy, naturopathy, or podiatric medicine.

Section 9. Subsection (4) of section 480.034, Florida Statutes, is amended to read:

480.034 Exemptions.—

(4) An exemption granted is effective to the extent that an exempted person's practice or profession overlaps with the practice of massage therapy.

Section 10. Subsection (2) of section 480.035, Florida Statutes, is amended to read:

480.035 Board of Massage Therapy.—

(2) Five members of the board shall be licensed massage therapists and shall have been engaged in the practice of massage therapy for not less than 5 consecutive years prior to the date of appointment to the board. The Governor shall appoint each member for a term of 4 years. Two members of the board shall be laypersons. Each board member shall be a high school graduate or shall have received a high school equivalency diploma. Each board member shall be a citizen of the United States and a resident of this state for not less than 5 years. The appointments are ~~will be~~ subject to confirmation by the Senate.

Section 11. Subsection (14) of section 480.043, Florida Statutes, is amended to read:

480.043 Massage establishments; requisites; licensure; inspection; human trafficking awareness training and policies.—

(14) Except for the requirements of subsection (13), this section does not apply to a physician licensed under chapter 457, chapter 458, chapter 459, or chapter 460 who employs a licensed massage therapist to perform massage therapy on the physician's patients at the physician's place of practice. This subsection does not restrict investigations by the department for violations of chapter 456 or this chapter.

Section 12. Paragraphs (a), (b), (c), (f), (g), (h), (i), and (o) of subsection (1) of section 480.046, Florida Statutes, are amended to read:

480.046 Grounds for disciplinary action by the board.—

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

(a) Attempting to procure a license to practice massage therapy by bribery or fraudulent misrepresentation.

(b) Having a license to practice massage therapy revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly

relates to the practice of massage therapy or to the ability to practice massage therapy. Any plea of nolo contendere shall be considered a conviction for purposes of this chapter.

(f) Aiding, assisting, procuring, or advising any unlicensed person to practice massage therapy contrary to ~~the provisions of~~ this chapter or to department or board ~~a~~ rule ~~of the department or the board~~.

(g) Making deceptive, untrue, or fraudulent representations in the practice of massage therapy.

(h) Being unable to practice massage therapy with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department ~~shall have~~, upon probable cause, may ~~authority to~~ compel a massage therapist to submit to a mental or physical examination by physicians designated by the department. Failure of a massage therapist to submit to such examination when so directed, unless the failure was due to circumstances beyond her or his control, constitutes ~~shall constitute~~ an admission of the allegations against her or him, consequent upon which a default and final order may be entered without the taking of testimony or presentation of evidence. A massage therapist affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of

massage therapy with reasonable skill and safety to clients.

(i) Gross or repeated malpractice or the failure to practice massage therapy with that level of care, skill, and treatment which is recognized by a reasonably prudent massage therapist as being acceptable under similar conditions and circumstances.

(o) Practicing massage therapy at a site, location, or place which is not duly licensed as a massage establishment, except that a massage therapist, as provided by ~~rules adopted by the~~ board rule, may provide massage therapy services, excluding colonic irrigation, at the residence of a client, at the office of the client, at a sports event, at a convention, or at a trade show.

Section 13. Section 480.0465, Florida Statutes, is amended to read:

480.0465 Advertisement.—Each massage therapist or massage establishment licensed under ~~the provisions of~~ this act shall include the number of the license in any advertisement of massage therapy services appearing in a newspaper, airwave transmission, telephone directory, or other advertising medium. Pending licensure of a new massage establishment pursuant to ~~the provisions of~~ s. 480.043(7), the license number of a licensed massage therapist who is an owner or principal officer of the establishment may be used in lieu of the license number for the establishment.

Section 14. Paragraphs (a), (b), and (c) of subsection (1) of section 480.047, Florida Statutes, are amended to read:

480.047 Penalties.—

(1) It is unlawful for any person to:

(a) Hold himself or herself out as a massage therapist or to practice massage therapy unless duly licensed under this chapter or unless otherwise specifically exempted from licensure under this chapter.

(b) Operate any massage establishment unless it has been duly licensed as provided herein, except that nothing herein shall be construed to prevent the teaching of massage therapy in this state at a board-approved massage therapy school.

(c) Permit an employed person to practice massage therapy unless duly licensed as provided herein.

Section 15. Section 480.052, Florida Statutes, is amended to read:

480.052 Power of county or municipality to regulate massage therapy.—A county or municipality, within its jurisdiction, may regulate persons and establishments licensed under this chapter. Such regulation shall not exceed the powers of the state under this act or be inconsistent with this act. This section shall not be construed to prohibit a county or municipality from enacting any regulation of persons or establishments not licensed pursuant to this act.

Section 16. Subsections (1) and (2) of section 480.0535,

Florida Statutes, are amended to read:

480.0535 Documents required while working in a massage establishment.—

(1) In order to provide the department and law enforcement agencies the means to more effectively identify, investigate, and arrest persons engaging in human trafficking, a person employed by a massage establishment and any person performing massage <u>therapy</u> therein must immediately present, upon the request of an investigator of the department or a law enforcement officer, valid government identification while in the establishment. A valid government identification for the purposes of this section is:

(a) A valid, unexpired driver license issued by any state, territory, or district of the United States;

(b) A valid, unexpired identification card issued by any state, territory, or district of the United States;

(c) A valid, unexpired United States passport;

(d) A naturalization certificate issued by the United States Department of Homeland Security;

(e) A valid, unexpired alien registration receipt card (green card); or

(f) A valid, unexpired employment authorization card issued by the United States Department of Homeland Security.

(2) A person operating a massage establishment must:

(a) Immediately present, upon the request of an

investigator of the department or a law enforcement officer:

1. Valid government identification while in the establishment.

2. A copy of the documentation specified in paragraph (1)(a) for each employee and any person performing massage therapy in the establishment.

(b) Ensure that each employee and any person performing massage therapy in the massage establishment is able to immediately present, upon the request of an investigator of the department or a law enforcement officer, valid government identification while in the establishment.

Section 17. Section 627.6407, Florida Statutes, is amended to read:

627.6407 Massage.—Any policy of health insurance that provides coverage for massage shall also cover the services of persons licensed to practice massage therapy pursuant to chapter 480, where the massage therapy, as defined in chapter 480, has been prescribed by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, as being medically necessary and the prescription specifies the number of treatments.

Section 18. Section 627.6619, Florida Statutes, is amended to read:

627.6619 Massage.—Any policy of health insurance that provides coverage for massage shall also cover the services of

persons licensed to practice massage therapy pursuant to chapter 480, where the massage therapy, as defined in chapter 480, has been prescribed by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, as being medically necessary and the prescription specifies the number of treatments.

Section 19. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing

services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the

following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage <u>therapy</u> as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage <u>therapy</u> or acupuncture, and a licensed massage therapist or

licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation

is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 20. Subsection (37) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(37) All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage <u>therapy</u> pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 as medically necessary and the prescription specifies the number of treatments. Such massage services are subject to the same terms, conditions, and limitations as those of other covered services.

Section 21. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1443 Certification for Prescriptive Authority
SPONSOR(S): Santiago & others
TIED BILLS: **IDEN./SIM. BILLS:** SB 448

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 BM	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The nation has a shortage of mental health care professionals which is only expected to worsen with time. When assessing unmet need, Florida has the second-highest psychiatrist shortage in the nation, with a shortage of approximately 1,000 psychiatrists, which is projected to increase by 48 percent by 2030.

In Florida, psychiatrists and psychologists both treat mental health conditions using psychotherapy and evidence-based interventions and have overlapping education and training. However, while a psychiatrist may prescribe medication to treat mental health conditions, a psychologist may not. Currently, if psychologists determine that medication is necessary for effective treatment of their patients, they must coordinate with a psychiatrist or other prescribing practitioner who will prescribe the medication for their patients. This can cause delays in treatment and increase costs to the patient.

HB 1443 creates a certification for prescriptive authority that would allow licensed psychologists meeting certain criteria to prescribe medication. The bill provides eligibility criteria, requirements for initial and renewal applications, and conditions under which psychologists may use their certificate of prescriptive authority. The bill imposes various duties on the Board of Psychology (Board) and creates an interim panel that will sunset once it submits rule recommendations to the Board.

The bill has various fiscal impacts on the Department of Health and the Agency for Health Care Administration, which can be absorbed within existing resources. The bill has no fiscal impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Mental Health Professionals

Psychiatrists and psychologists both treat mental health conditions and have overlapping education and training, but psychologists generally may not prescribe medication. This limits the range of treatment they may offer to their patients.

A psychiatrist is a physician who specializes in mental health, including substance use disorders.[1] Psychiatrists assess and treat mental illness through a combination of psychotherapy, medications, and psychosocial interventions.[2] To become a psychiatrist, one must complete a four-year psychiatry residency program after medical school with the option of additional specialized training in subspecialties.[3] The residency program typically involves one year in a hospital setting followed by three years of studying diagnosis and treatment of mental health, including psychotherapy and the use of psychotropic medication.[4]

Psychologists also treat patients with mental and emotional health problems through combinations of psychotherapy and other evidence-based interventions. If psychologists determine medication would be helpful for the treatment of a patient, they must work with a prescribing physician to provide it.[5] Psychologists must complete a doctoral-level degree, which typically involves four to six years of full-time study after completing an undergraduate degree, and includes a one-year full-time supervised internship.[6] Coursework includes the study of individual differences and the biological, cognitive, and social bases of behavior, as well as specific training in psychological assessment and therapy.[7] Most states also require an additional year of supervised practice for licensure.

Mental Health Professional Shortage

One in five adults in the United States, an estimated 47.6 million people, suffer from one or more mental illnesses but 57 percent of them do not receive mental health services.[8] The nation, including Florida, has a shortage of health care providers which is only expected to worsen with time.[9] This projected shortage is even higher for mental health professionals, including psychiatrists and psychologists. Further, it is estimated that only 27 percent of the need for mental health practitioners in the United States has been met.[10]

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[1] American Psychiatric Association, *What is Psychiatry?,* available at https://www.psychiatry.org/patients-families/what-is-psychiatry (last visited January 20, 2020).
[2] Id.
[3] E.g., child and adolescent psychiatry, geriatric psychiatry, forensic (legal) psychiatry, addiction psychiatry, pain medicine.
[4] Psychotropic medications are those which are used to treat mental health conditions such as schizophrenia, bipolar disorder, ADHD, or depression, and can include antipsychotics, antidepressants, and antianxiety medication. To prescribe any psychotropic drug that is a controlled substance, the prescribing practitioner must have a license with the federal Drug Enforcement Agency.
[5] American Psychological Association, *What Do Practicing Psychologists Do?,* (last rev. June 2014), available at https://www.apa.org/helpcenter/about-psychologists (last visited January 20, 2020).
[6] Id.
[7] Id.
[8] U.S. Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, (Aug. 2019), available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf, (last visited January 20, 2020).
[9] U.S. Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, First Quarter of Fiscal Year 2020 Designated HPSA Quarterly Summary* (Dec. 31, 2019), available at: https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited January 20, 2020). To access report, click on "Designated HPSA Quarterly Summary."
[10] Id.

Currently, there are approximately 2,100 psychiatrists and 5,700 psychologists in Florida.[11] When assessing unmet need, Florida has the second-highest psychiatrist shortage in the nation, with a shortage of approximately 1,000 psychiatrists.[12] With low growth in the psychiatrist workforce and approximately 46 percent of psychiatrists being over 65 years of age, this shortage is projected to increase by 48 percent by 2030.[13]

Psychology Regulation in Florida

The Psychological Services Act (Act) regulates the practice of psychology.[14] The Board of Psychology, within the Department of Health (DOH), regulates the practice of psychology and adopts rules to implement the provisions of the Act.[15]

To obtain a license to practice psychology, one must:[16]

- Have completed a doctoral degree in psychology from an accredited psychological education program;[17]
- Have completed at least 2 years or 4,000 hours of experience in the field of psychology in association with or under the supervision of a licensed psychologist;
- Pass a national exam and an exam on Florida laws and rules; and
- Submit an application and pay a nonrefundable fee.

The practice of psychology includes observation, evaluation, and modification of human behavior by using scientific and applied psychological principles, methods, and procedures to improve mental and psychological health.[18] However, a psychologist may not prescribe medication. Currently, if psychologists determine that medication is necessary for effective treatment of their patients, they must coordinate with a physician or other prescribing practitioner who will prescribe the medication for their patients. Generally, the prescribing practitioner must first observe the patient before prescribing medication, which can cause delays in treatment and increase costs to the patient.

Prescriptive Authority for Psychologists

Five states and some federal programs grant psychologists prescriptive authority to fill the gap created by the psychiatrist shortage. In these jurisdictions, psychologists must obtain advanced training after licensure which can include completion of a specialized training program or a master's degree in psychopharmacology.[19]

Federal Systems with Prescriptive Authority for Psychologists

In 1991, the U.S. Department of Defense created the Psychopharmacology Demonstration Project to determine the feasibility of training military clinical psychologists to prescribe psychotropic drugs safely

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[11] U.S. Health Resources and Services Administration, Bureau of Health Workforce, *State-Level Projections of Supply and Demand For Behavioral Health Occupations: 2016-2030,* (Sept. 2018), available at: https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf (last visited Mar. 1, 2019); and Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2018-2019*, 16, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf (last visited January 21, 2020).

[12] Id.

[13] Id. *See also* U.S. Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, Jan. 24, 2013, available at: https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf (last visited Mar. 1, 2019).

[14] Chapter 490, F.S.

[15] Section 490.004, F.S.

[16] Section 490.005, F.S.

[17] For individuals who received their education prior to July 1, 1999, a psychology program that was comparable to an approved program may also satisfy this educational requirement. *See* s. 409.03(3)(a), F.S.

[18] Section 490.003(4). F.S.

[19] Psychopharmacology is the study of the use of medications in treating mental disorders.

and effectively.[20] Participants had to complete a two-year medical school didactic program followed by a nine-month practicum in an inpatient psychiatric setting. The program lasted until 1997 and produced 10 prescribing psychologists who were then assigned at military posts across the nation. This was the first formal effort to train psychologists to prescribe psychotropic medication. An evaluation of the graduates in their respective posts found that they filled critical needs and provided quality care with no adverse incidents.[21]

Additionally, the U.S. Public Health Service Commissioned Corps is a team of public health professionals under the federal Department of Health and Human Services that serve in various federal agencies to deliver health care to underserved and vulnerable populations, provide mental health and drug abuse services, and respond to natural or man-made disasters, among other things.[22] Serving clinical psychologists may obtain prescriptive authority and an estimated 30 psychologists are serving in such capacity across various federal agencies.[23]

States with Prescriptive Authority for Psychologists

Currently, Idaho, Illinois, Iowa, Louisiana, and New Mexico grant prescriptive authority to licensed psychologists. Requirements vary among states, but all require a period of training after licensure and passage of an exam. Some require collaboration with the patient's primary care physician or require a psychologist to practice under the supervision of a physician for a certain period before a certificate may be granted.

Comparison of State Requirements for Psychologist Prescriptive Authority				
State	Additional Training	Certification Exam	PCP Collaboration	Conditions
Idaho[24]	Postdoctoral master's degree in clinical psychopharmacology	Yes	No	2 years prescribing under physician supervision
Illinois[25]	Postdoctoral master's degree in clinical psychopharmacology	Yes	No	Collaborative agreement with a physician
Iowa[26]	Postdoctoral master's degree in clinical psychopharmacology	Yes	No	• 2 years practicing under physician supervision • Collaborative agreement with a physician
Louisiana[27]	Postdoctoral master's degree in clinical psychopharmacology	Yes	Yes	None
New Mexico[28]	• 450 hours of didactic instructional training • 400 hours of practicum experience with at least 100 patients	Yes	Yes	2 years prescribing under physician supervision

[20] American College of Neuropsychopharmacology, *DoD Prescribing Psychologists: External Analysis, Monitoring, and Evaluation of the Program and its Participants, Final Report* (May 1998), available at: http://documents.theblackvault.com/documents/dod/readingroom/2/966.pdf (last visited January 21, 2020).
[21] Id.
[22] U.S. Department of Health and Human Services, Surgeon General, *U.S. Public Health Service Commissioned Corps,* available at https://www.surgeongeneral.gov/corps/index.html (last visited January 21, 2020).
[23] Tori DeAngelis, *Prescribing Psychologists Working in the Federal System,* American Psychological Association PracticeUpdate, (Nov. 9, 2017), available at: https://www.apaservices.org/practice/update/2017/11-09/psychologists-federal-system (last visited January 21, 2020).
[24] Idaho Code Ann. §§ 54-2316 through 54-2318.
[25] 225 ILL. COMP. STAT. 15.
[26] IOWA CODE §154B.
[27] LA. REV. STAT. ANN. § § 1360.51-1360.72.
[28] N.M. STAT. ANN. §§ 60-9-1 through 60-9-19; N.M. Code R. §§ 16.22.1 through 16.22.30.

Psychopharmacology Exam for Psychologists

The Association of State and Provincial Psychology Boards (ASPPB), which is responsible for developing the national psychology exam, developed a Psychopharmacology Exam for Psychologists for states to certify a psychologist's competency in prescriptive authority.[29]

To qualify to sit for the exam, one must:[30]

- Hold an active license for independent practice as a psychologist at the doctoral level with demonstrated training and experience as a health services provider;
- Submit a self-attestation that the psychologist's licensure is in good standing with no current or pending disciplinary actions;
- Present an official transcript demonstrating successful completion of all coursework of a post-doctoral psychopharmacology training program from a regionally accredited institution in the U.S. or a provincially or territorially chartered institution in Canada. The psychopharmacology program must be designated by the American Psychology Association or demonstrate coursework that meets the criteria outlined for such designation; and
- Submit an attestation verifying that the applicant has been a health service provider for a period of at least two years.

Effect of the Proposed Changes

HB 1443 creates a certification for prescriptive authority that would allow licensed psychologists meeting certain criteria to prescribe medication in their course of treatment. The bill provides eligibility criteria, requirements for initial and renewal applications, and conditions under which psychologists may use their certificate of prescriptive authority. The bill imposes various duties on the Board of Psychology and creates an interim panel that will sunset once it submits rule recommendations to the Board.

Prescriptive Authority

The bill allows certified psychologists to prescribe, administer, discontinue, or distribute without charge drugs or controlled substances which are recognized or customarily used in the diagnosis, treatment, or management of a person with a psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorder. Currently, if psychologists determine that medication is necessary for effective treatment of their patients, they must coordinate with a physician to prescribe the medication, which can be difficult or cause delays in treatment. This would allow psychologists to provide a complete continuum of mental health treatment to their patients on their own in a timely manner.

This prescriptive authority also includes the ability to order necessary lab tests, diagnostic exams, procedures necessary to obtain lab tests or diagnostic exams, or other directly related procedures within the scope of practice of psychology.

Certificate Eligibility Criteria

The bill requires the Board to certify eligible psychologists and establish procedures to review education and training requirements for the certification. To obtain a certificate for prescriptive authority, a psychologist must:

- Have a valid and current license to practice psychology;
- Have a doctoral degree in psychology;

[29] Association of State and Provincial Psychology Boards, *Psychopharmacology Examination for Psychologists, Candidate Handbook*, available at https://cdn.ymaws.com/www.asppb.net/resource/resmgr/pep/PEP_Candidate_Handbook.pdf (last visited January 21, 2020).
[30] Id.

- Pass a board-approved examination developed by a nationally recognized body to demonstrate competency in prescriptive authority;[31]
- Have completed an organized sequence of study in a program that offers intensive didactic education covering certain specific topics[32] and consistent with the American Psychological Association's policies on educating psychologists in preparation for prescriptive authority; and
- Have relevant training and practice under a licensed psychologist sufficient to demonstrate competency in the psychopharmacological treatment of a diverse patient population consistent with the American Psychological Association's policies on educating psychologists in preparation for prescriptive authority.

The bill requires the Board to determine the number of hours of didactic instruction needed to ensure the knowledge and skills required to prescribe drugs in a safe and effective manner. Educational and training completed as part of a doctoral program in psychology or postdoctoral training or fellowship in psychology may be used to meet the education and training requirements of the certificate. Additionally, a psychologist who has completed the U.S. Department of Defense Psychopharmacology Demonstration Project or has comparable prescriptive authority under another health care practitioner license in Florida is exempt from the training requirements under the bill.

The bill requires the Board to adopt rules to establish a method to renew the certificate of prescriptive authority, which must occur every two years in conjunction with the general licensure renewal. A psychologist must complete 20 hours of continuing education related to prescriptive authority every two years to be eligible.

The bill requires the Board of Psychology to adopt rules to deny, modify, suspend, or revoke prescriptive authority certification. The Board may require remediation of a deficiency if it determines that a prescribing psychologist has a deficiency in training or practice that could jeopardize the health, safety, or welfare of the public.

Prescribing Psychologist Duties

The bill requires a prescribing psychologist to use the certificate in accordance with the Board's adopted rules. A prescribing psychologist may not prescribe without a current and valid certificate of prescriptive authority.

A prescribing psychologist must:

- Maintain a record of all prescribed drugs for each patient;
- Comply with the Board's rules related to the certificate of prescriptive authority;
- Consult and collaborate with a patient's primary care provider and concur with such physician before prescribing a drug, altering a drug treatment, or discontinuing a drug; and
- Issue prescriptions in a manner consistent with Board rules and comply with all applicable state and federal laws.

Additionally, the bill limits a prescribing psychologist's prescriptive authority. Specifically, a prescribing psychologist may not prescribe drugs to a patient without a primary care provider or delegate prescriptive authority to another person.

Prescribing psychologists who receive authorization to prescribe controlled substances must file their Drug Enforcement Agency registration number with the Board within 10 days of receiving the

[31] Under the bill, the Psychopharmacology Examination for Psychologists offered by the Association of State and Provincial Psychology Boards is an example of an exam developed by a nationally recognized body to demonstrate competency in prescriptive authority.
[32] Under the bill, this program must include coursework specific to basic sciences, neuroscience, physical examination, interpretation of laboratory tests, pathological basis of disease, clinical medicine, clinical neurotherapeutics, systems of care, pharmacology, clinical pharmacology, psychopharmacology, psychopharmacology research, and professional, ethical, and legal issues.

authorization. The Board must keep a current record of any prescribing psychologists authorized to prescribe controlled substances.

List of Prescribing Psychologists

Under the bill, the Board of Psychology must submit an initial list of prescribing psychologists to the Board of Pharmacy. The list must contain the name, certificate number, and effective date of the prescriptive authority certification for each prescribing psychologist. The Board of Psychology must promptly notify the Board of Pharmacy of any changes to the list, including changes related to certification, revocation, suspension, modification, denial, or reinstatement of a psychologist's prescriptive authority.

Interim Panel

The bill requires the Board to establish a panel by October 1, 2020, to make recommendations for proposed rules governing prescriptive authority for psychologists. The bill requires the panel to consist of the following five members:

- A psychiatrist, selected by the Board of Medicine.
- A board-certified pediatrician, selected by the Board of Medicine.
- A pharmacist who holds a doctoral degree in pharmacy, selected by the Board of Pharmacy.
- Two psychologists who currently serve on the Board of Psychology or hold postdoctoral master's degrees in clinical psychopharmacology, selected by the Board of Psychology.

The bill requires the panel to submit its recommendations for proposed rules by May 1, 2021, and repeals the related subsection on the same date.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 490.017, F.S., relating to certification for prescriptive authority.
Section 2: Provides an effective date of October 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Department of Health

   DOH will experience a recurring increase in workload and costs associated with certification, regulation, and enforcement of psychologists with prescriptive authority. It is indeterminate the number of psychologists that will apply for certification, but it is estimated current resources are adequate to absorb these costs.

   DOH will incur nonrecurring costs related to rulemaking, application and certificate development, updating and maintenance of the psychology website, and modifications to the LEIDS licensing system to accommodate the new certification. Current resources are adequate to absorb these costs.

Agency for Health Care Administration

AHCA may experience increased enrollment in the Medicaid program to the extent that psychologists with prescriptive authority want to prescribe to Medicaid patients. AHCA will also have to update its Medicaid billing system to allow reimbursement claims for drugs prescribed by a psychologist with prescriptive authority. Current resources are adequate to absorb these costs.

It is possible there may be some increased prescribing of drugs due to the bill, however, appropriate prescribing may decrease hospitalizations. It is estimated the fiscal impact will be nominal.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a positive impact on psychologists who obtain the certificate of prescriptive authority under the bill. Certified psychologists will be able to provide a broader range of services and treatment to their patients.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board of Psychology has sufficient 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 certification for prescriptive authority; creating s. 490.017, F.S.; providing definitions; requiring the Board of Psychology to certify specified psychologists to exercise prescriptive authority; requiring the board to develop and implement certain procedures to review requirements for certification; requiring rulemaking by the board; providing application requirements for certification; requiring the board to establish a method for certification renewal; authorizing the use of prescriptive authority by a prescribing psychologist; providing requirements for prescribing psychologists; requiring prescribing psychologists authorized to prescribe controlled substances to file specified information within a certain time after such authorization; requiring the board to maintain a record of such psychologists; requiring the board to provide a list containing specified information relating to prescribing psychologists to the Board of Pharmacy; requiring the board to notify the Board of Pharmacy of any changes to such list; requiring the board to establish an interim panel by a specified date; providing for duties, composition, and expiration of the panel; requiring the panel to submit

its recommendations to the board by a specified date; providing an effective date.

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

Section 1. Section 490.017, Florida Statutes, is created to read:

490.017 Certification for prescriptive authority.—

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

(a) "Clinical experience" means a period of training and practice in which a person, under the supervision of a psychologist licensed under this chapter, learns and conducts diagnoses and interventions.

(b) "Controlled substance" has the same meaning as in s. 893.02.

(c) "Drug" has the same meaning as in s. 499.003.

(d) "Prescribing psychologist" means a psychologist licensed under this chapter who has received a certification for prescriptive authority from the board which has not been modified, suspended, or revoked.

(e) "Prescription" has the same meaning as in s. 465.003.

(f) "Prescriptive authority" means the certification to prescribe, administer, discontinue, or distribute without charge drugs or controlled substances recognized or customarily used in the diagnosis, treatment, or management of an individual with a

psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorder. The term includes the certification to order laboratory tests, diagnostic examinations, and procedures necessary to obtain laboratory tests or diagnostic examinations or other procedures directly related thereto within the scope of the practice of psychology.

(2) DUTIES OF THE BOARD.—The board shall:

(a) Certify psychologists who meet the requirements listed in subsection (3) to exercise prescriptive authority.

(b) Develop and implement procedures to review education and training requirements for certification.

(c) Adopt rules to deny, modify, suspend, or revoke a psychologist's certification for prescriptive authority. The board may require remediation by a prescribing psychologist of deficiencies in his or her training or practice upon a determination that such deficiencies could reasonably be expected to jeopardize the health, safety, or welfare of the public.

(3) APPLICATION REQUIREMENTS.—

(a) A psychologist licensed under this chapter who applies for certification for prescriptive authority shall provide, through an official transcript or other official document deemed satisfactory by the board, proof of the following:

1. A valid and current license.

2. Graduation from a doctoral program in psychology.

3. A passing score on an examination developed by a nationally recognized body such as the Psychopharmacology Examination for Psychologists offered by the Association of State and Provincial Psychology Boards and approved by the board to establish competency in prescriptive authority.

4.a. An organized sequence of study in a program offering intensive didactic education consistent with established policies of the American Psychological Association for education of psychologists in preparation for prescriptive authority. The program shall include coursework in the specific areas of basic sciences, neurosciences, physical examination, interpretation of laboratory tests, pathological basis of disease, clinical medicine, clinical neurotherapeutics, systems of care, pharmacology, clinical pharmacology, psychopharmacology, psychopharmacology research, and professional, ethical, and legal issues. The program must consist of an appropriate number of hours of didactic instruction, as determined by the board, to ensure the knowledge and skills required to prescribe drugs in a safe and effective manner.

b. Relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population consistent with established policies of the American Psychological Association for training of psychologists in preparation for prescriptive authority.

The educational and training requirements under this subparagraph may be met as part of a doctoral program in psychology or postdoctoral training or fellowship in psychology.

(b) A psychologist is exempt from the educational and training requirements under paragraph (a) if he or she:

1. Is a physician licensed under chapter 458 or chapter 459, nurse practitioner licensed under chapter 464, or other health care practitioner licensed under chapter 458, chapter 459, or chapter 464 who holds comparable prescriptive authority.

2. Has completed the United States Department of Defense Psychopharmacology Demonstration Project.

(4) CERTIFICATION RENEWAL.—

(a) The board shall establish by rule a method for the renewal of a psychologist's certification for prescriptive authority, which shall occur in conjunction with licensure renewal pursuant to s. 490.007.

(b) Each applicant for renewal shall present satisfactory evidence to the board demonstrating the completion of 20 hours of continuing education instruction relevant to prescriptive authority during the previous 2-year licensure period.

(5) PRESCRIPTIVE AUTHORITY.—

(a) A prescribing psychologist may use his or her certification for prescriptive authority in accordance with rules adopted by the board.

(b) A prescribing psychologist shall:

1. Maintain a record of all prescribed drugs for each patient.

2. Comply with all rules adopted pursuant to this section.

3. Consult and collaborate with a patient's primary care physician and concur with such physician before prescribing a drug, altering a drug treatment plan, or terminating a drug.

(c) A prescribing psychologist may not:

1. Issue a prescription without a valid and current certification for prescriptive authority.

2. Delegate prescriptive authority to another person.

3. Prescribe drugs to a patient who does not have a primary care physician.

(d) A prescription issued by a prescribing psychologist must:

1. Be written in a manner determined by the board to be sufficient.

2. Comply with all applicable state and federal laws.

(6) CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY.—

(a) When authorized to prescribe controlled substances, a prescribing psychologist shall file with the board, within 10 days after such authorization, his or her federal Drug Enforcement Administration registration number.

(b) The board shall maintain a current record of every prescribing psychologist authorized to prescribe controlled substances.

(7) NOTIFICATION TO THE BOARD OF PHARMACY.—

(a) The board shall submit to the Board of Pharmacy an initial list of prescribing psychologists containing:

1. The psychologist's name.

2. The psychologist's certification number.

3. The effective date of the psychologist's certification for prescriptive authority.

(b) The board shall promptly notify the Board of Pharmacy of any changes to the list, including changes relating to the issuance, revocation, suspension, modification, denial, or reinstatement of a psychologist's certification for prescriptive authority.

(8) INTERIM PANEL.—The board shall establish an interim panel by October 1, 2020, to provide recommendations for proposed rules governing certification to exercise prescriptive authority for psychologists. The interim panel shall be comprised of a psychiatrist licensed under chapter 458 or chapter 459 selected by the Board of Medicine, a physician licensed under chapter 458 who is a board-certified pediatrician selected by the Board of Medicine, a pharmacist licensed under chapter 465 who holds a doctoral degree in pharmacy selected by the Board of Pharmacy, and two psychologists licensed under chapter 490 who currently serve on the board or hold postdoctoral master's degrees in clinical psychopharmacology selected by the board. The panel shall submit its

recommendations for proposed rules to the board by May 1, 2021. This subsection expires May 1, 2021.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 6031 Florida Kidcare Program
SPONSOR(S): Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 348

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

SUMMARY ANALYSIS

The Florida Kidcare Program (Kidcare) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997 (CHIP). Kidcare provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for Kidcare is found in part II of ch. 409, F.S. Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act.

Kidcare encompasses four programs: Medicaid for children, the Medikids program, the Children's Medical Services Network and the Florida Healthy Kids program. The Florida Healthy Kids program under the Florida Healthy Kids Corporation (FHKC) provides health coverage to children from age 5 through age 18 who live in households meeting certain eligibility thresholds.

Health care coverage provided under the Healthy Kids program is subject to a $1 million lifetime limit for each enrolled child. If an enrolled child incurs $1 million in health benefits expenditures, the child is disenrolled from the Healthy Kids program. In 2018, the federal Centers for Medicare and Medicaid Services (CMS) informed the Agency for Health Care Administration (AHCA) that Florida's use of the $1 million lifetime coverage limit for the Healthy Kids program was in violation of federal Title XXI regulations related to program eligibility and enrollment. As part of a required corrective action plan, the CMS directed AHCA to either eliminate the annual coverage limit or institute a coverage limit in compliance with federal CHIP regulations.

HB 6031 deletes the $1 million lifetime coverage limit that currently applies to each child enrolled in the Florida Healthy Kids program. With this change, no child would be removed from coverage eligibility by virtue of accumulating benefit claims that exceed a dollar amount threshold.

The bill has an insignificant, negative, recurring fiscal impact to the AHCA and no fiscal impact on local governments. The FHKC should be able to absorb the state and federal costs within existing appropriations and corporate reserve funds. If this bill becomes law, the Social Services Estimating Conference would incorporate the future minimal costs in the official expenditure estimates.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Kidcare Program

The Florida Kidcare Program (Kidcare) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). The federal authority for the CHIP is located in Title XXI of the Social Security Act. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for the Program is found in part II of ch. 409, F.S.

Kidcare encompasses four programs:

- Medicaid for children;
- The Medikids program;
- The Children's Medical Services Network; and
- The Florida Healthy Kids program.

Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the monthly premium cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for monthly premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium.

Eligibility for the Program components that are funded by Title XXI is determined in part by age and household income:

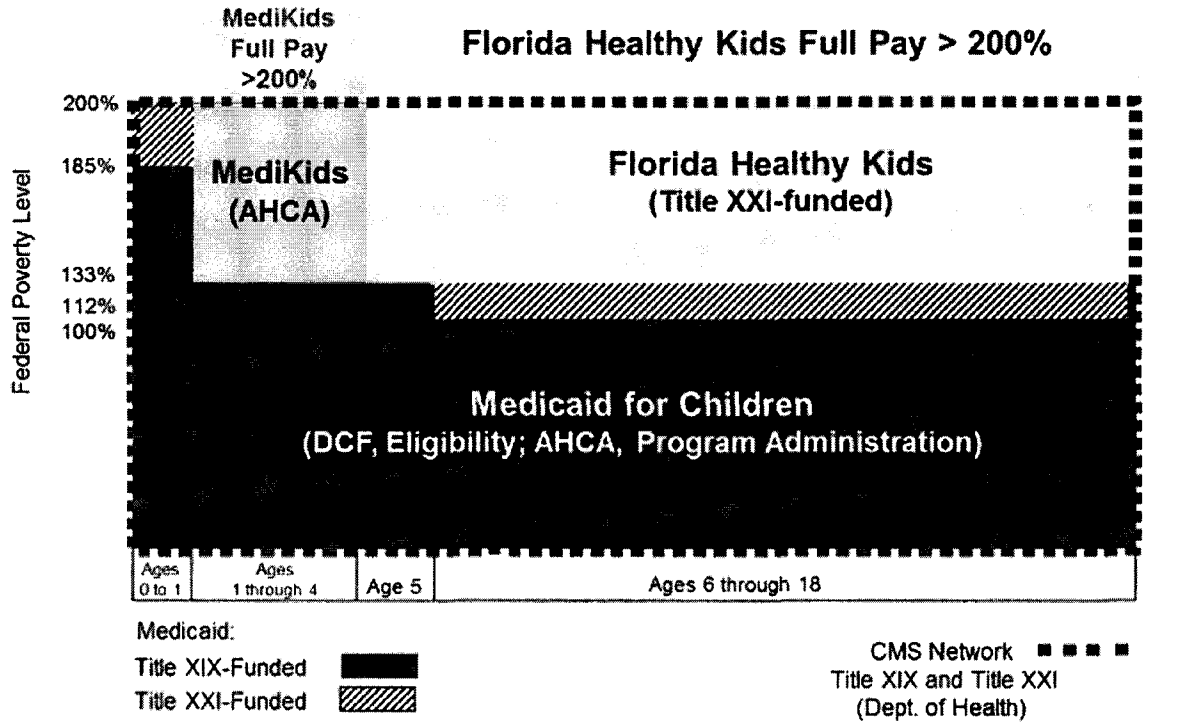
Program	Age Range	Family Income
Medicaid for Children	Birth until age 1	185-200% of federal poverty level (FPL)
Medikids	Age 1 until age 5	133-200% of FPL
Healthy Kids	Age 5 until age 6	133-200% of FPL
	Age 6 until age 19	100-200% FPL
Children's Medical Services Network	Birth until age 19 (children with special needs)	Up to 200% FPL

Kidcare is administered jointly by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Health (DOH), and the Florida Healthy Kids Corporation (FHKC). Each entity has specific duties and responsibilities under Kidcare as detailed in part II of ch. 409, F.S. The DCF determines eligibility for Medicaid, and the FHKC processes all Kidcare applications and determines eligibility for the CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate. The Department of Health assesses whether children meet the Children's Medical Services Network clinical requirements.

At present, more than 2.4 million Florida children are enrolled in Kidcare.[1]

[1] Healthy Kids, *What is Florida KidCare?*, available at: https://www.healthykids.org/kidcare/what/ (last visited January 31, 2020).

The following chart summarizes eligibility and funding for Kidcare.[2]



Florida Healthy Kids Lifetime Maximum

Unlike the other components of Florida Kidcare, coverage provided under the Healthy Kids program is subject to a statutory $1 million lifetime limit for each enrolled child.[3] If an enrolled child incurs $1 million in health benefits expenditures, the FHKC removes that child from the Healthy Kids program. The FHKC reports that 12 children have been disenrolled from Health Kids in the past five years by virtue of exceeding the lifetime maximum coverage limit.[4] The FHKC notifies a family when a child has reached $700,000 in covered benefits, reminds the family of the $1 million coverage limit, and informs the family of alternative coverage options.[5]

On November 13, 2018, the federal Centers for Medicare and Medicaid Services (CMS) informed AHCA that Florida's use of the $1 million lifetime coverage limit for the Healthy Kids program was in violation of federal Title XXI regulations related to program eligibility and enrollment.[6] The CMS ordered the AHCA to complete a corrective action plan to address these violations and bring the Healthy Kids program into compliance with relevant federal regulations. The agency initially submitted

[2] Institute for Child Health Policy at University of Florida, *Florida KidCare Program Evaluation 2015*, available at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/PDF/2015_Florida_Kidcare_Evaluation_Report.pdf (last viewed January 31, 2020).
[3] S. 409.815(2)(r), F.S.
[4] E-mail correspondence from Mr. Jeff Dykes, Interim Chief Executive Office for FHKC (September 27, 2019)(On file with the Health Quality Subcommittee).
[5] Agency for Health Care Administration, *Senate Bill 348 Analysis* (October 9, 2019) (On file with the Health Quality Subcommittee).
[6] Correspondence from the Centers for Medicare and Medicaid Services to the Agency for Health Care Administration (November 13, 2018)(On file with the Health Quality Subcommittee). The letter indicates violations of several federal regulations under 42 CFR 457.342.

a correction action plan to the CMS in February of 2019[7]; a revised version of this plan was approved by the CMS on July 26, 2019.[8]

As part of the approved corrective action plan, the AHCA agreed to submit a state plan amendment to the CMS to reflect revised program parameters. If the state wishes to establish a lifetime coverage limit for the Healthy Kids program, it must be in compliance with federal CHIP enrollment and eligibility regulations.[9] The CMS noted that the automatic disenrollment of children who reach a certain coverage threshold is inconsistent with continuous enrollment policies set at the federal level. Moreover, AHCA is required to reset the coverage balances for all children currently enrolled in the Healthy Kids program. Only services provided after January 1, 2020 may be counted towards any revised lifetime coverage limit.[10]

The AHCA has indicated that it will be submitting a state plan amendment to the CMS to reflect these directives, with an effective date of January 1, 2020.[11]

Effect of the Bill

HB 6031 repeals the $1 million lifetime coverage limit that currently applies to each child enrolled in the Florida Healthy Kids program. With this change, no child would be removed from coverage eligibility by virtue of accumulating benefit claims that exceed a dollar amount threshold.

Removing the lifetime coverage limit will result in the expenditure of additional state and federal revenues in support of the Healthy Kids program. See Fiscal Analysis & Economic Impact Statement.

The bill takes effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.815, F.S., relating to health benefits coverage; limitations.
Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The FHKC has developed estimates of the additional federal Medicaid matching funds that would become available to the state following the elimination of the Healthy Kids lifetime limit[12], as follows:

FY 2019-20: $233,668
FY 2020-21: $893,373
FY 2021-22: $947,956

These estimates are based on the payment rate proposals submitted by the three carriers selected to contract with FHKC effective January 1, 2020.[13] The state would continue to collect recurring

[7] Correspondence from the Agency for Health Care Administration to the Centers for Medicare and Medicaid Services (February 11, 2019)(On file with the Health Quality Subcommittee).
[8] Correspondence from the Centers for Medicare and Medicaid Services to the Agency for Health Care Administration (July 26, 2019)(On file with the Health Quality Subcommittee).
[9] Id.
[10] Id.
[11] Supra note 5.
[12] Letter from Mercer Consulting Services to Mr. Jeff Dykes, Chief Financial Officer for FHKC (January 17, 2020)(On file with the Health Care Appropriations Subcommittee).

federal Medicaid funds in future years, relative to what would have been collected under current law.

2. Expenditures:

The FHKC also developed estimates of increased state general revenue spending that may occur following elimination of the Healthy Kids lifetime limit[14], as follows:

FY 2019-20: $42,764
FY 2020-21: $281,163
FY 2021-22: $344,467

These estimates are based on the payment rate proposals submitted by the three carriers selected to contract with FHKC effective January 1, 2020.[15] The state would continue to spend recurring general revenue in future years, relative to what would have been spent under current law. The FHKC should be able to absorb the state and federal costs within existing appropriations and corporate reserve funds. If this bill becomes law, the Social Services Estimating Conference would incorporate the future minimal costs in the official expenditure estimates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

[13] Supra note 12.
[14] Supra note 12.
[15] Supra note 12.

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Florida Kidcare program; amending s. 409.815, F.S.; removing the lifetime maximum cap on covered expenses for a child enrolled in the Florida Healthy Kids program; conforming a cross-reference; providing an effective date.

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

Section 1. Paragraph (r) and present paragraph (u) of subsection (2) of section 409.815, Florida Statutes, are amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

~~(r) *Lifetime maximum.*—Health benefits coverage obtained under ss. 409.810-409.820 shall pay an enrollee's covered expenses at a lifetime maximum of $1 million per covered child.~~

(t) ~~(u)~~ *Enhancements to minimum requirements.*—

1. This section sets the minimum benefits that must be included in any health benefits coverage, other than Medicaid or Medikids coverage, offered under ss. 409.810-409.821. Health

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

benefits coverage may include additional benefits not included under this subsection, but may not include benefits excluded under paragraph (r) ~~(s)~~.

2. Health benefits coverage may extend any limitations beyond the minimum benefits described in this section.

Except for the Children's Medical Services Network, the agency may not increase the premium assistance payment for either additional benefits provided beyond the minimum benefits described in this section or the imposition of less restrictive service limitations.

Section 2. This act shall take effect upon becoming a law.