Tab 1	**SB 410** by **Berman (CO-INTRODUCERS) Cruz, Farmer, Rodriguez, Rader, Rouson**; (Identical to H 00579) Long-acting Reversible Contraception Pilot Program

206192	A	S	RCS	AHS, Berman	Delete L.86 - 93:	04/16 03:33 PM

Tab 2	**CS/SB 634** by **CF, Rouson (CO-INTRODUCERS) Berman, Perry, Hooper, Mayfield**; (Similar to CS/CS/CS/H 00315) Child Welfare

524848	A	S	RCS	AHS, Rouson	Delete L.72 - 286:	04/16 03:34 PM

Tab 3	**SB 748** by **Harrell**; (Identical to H 06049) Florida Veterans' Hall of Fame

Tab 4	**CS/SB 884** by **HP, Baxley**; (Compare to H 00509) Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors

Tab 5	**CS/SB 1192** by **HP, Bean (CO-INTRODUCERS) Baxley, Rouson**; (Compare to CS/H 00831) Electronic Prescribing

799536	A	S	RCS	AHS, Bean	btw L.88 - 89:	04/16 03:37 PM
731540	A	S	RCS	AHS, Bean	Delete L.90 - 91:	04/16 03:37 PM
483502	AA	S	RCS	AHS, Bean	Delete L.5 - 7:	04/16 03:37 PM

Tab 6	**SB 1526** by **Harrell**; (Compare to CS/CS/H 00023) Telehealth

763358	D	S	RE	AHS, Harrell	Delete everything after	04/17 08:52 AM
~~809042~~	AA	S	WD	AHS, Hooper	Delete L.16:	04/17 08:52 AM
~~648844~~	AA	S	WD	AHS, Hooper	btw L.60 - 61:	04/17 08:52 AM
277068	AA	S	RE	AHS, Harrell	Delete L.100:	04/17 08:52 AM
862704	D	S	FAV	AHS, Harrell	Delete everything after	04/18 12:51 PM

Tab 7	**CS/SB 1592** by **CF, Harrell**; (Similar to CS/CS/1ST ENG/H 01349) Assisted Living Facilities

Tab 8	**CS/SB 1620** by **HP, Gainer (CO-INTRODUCERS) Passidomo**; (Similar to CS/H 00885) Health Care Licensing Requirements

828958	A	S	RCS	AHS, Gainer	Delete L.25 - 46:	04/16 03:40 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Bean, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, April 16, 2019
TIME: 1:00—4:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Harrell, Vice Chair; Senators Book, Diaz, Farmer, Flores, Hooper, Passidomo, Rader, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 410** Berman (Identical H 579)	Long-acting Reversible Contraception Pilot Program; Requiring the Department of Health to establish a long-acting reversible contraception pilot program in Duval, Hillsborough, and Palm Beach Counties; requiring the department to contract with family planning providers to implement the pilot program; requiring the department to submit a report to the Governor and the Legislature by a specified date, etc. HP 04/08/2019 Favorable AHS 04/16/2019 Fav/CS AP	Fav/CS Yeas 9 Nays 1
2	**CS/SB 634** Children, Families, and Elder Affairs / Rouson (Similar CS/CS/CS/H 315)	Child Welfare; Citing this act as "Jordan's Law"; requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; requiring the Department of Law Enforcement to provide certain information to law enforcement officers relating to specified individuals; requiring that the guardian ad litem training program include training on the recognition of and responses to head trauma and brain injury in children younger than a specified age, etc. CF 04/01/2019 Fav/CS AHS 04/16/2019 Fav/CS AP	Fav/CS Yeas 10 Nays 0
3	**SB 748** Harrell (Identical H 6049)	Florida Veterans' Hall of Fame; Removing limitations regarding the use of state funds for the administration of the hall of fame and for the reimbursement of travel expenses for members of the Florida Veterans' Hall of Fame Council, etc. MS 04/10/2019 Favorable AHS 04/16/2019 Favorable AP	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 884** Health Policy / Baxley (Compare H 509)	Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors; Defining the terms “certified master social worker” and “practice of generalist social work”; requiring the Department of Health to certify an applicant for designation as a certified master social worker under certain circumstances; requiring the use of applicable professional titles by licensees, certificate holders, provisional licensees, and registrants on social media and other specified materials, etc. HP 03/25/2019 Not Considered HP 04/01/2019 Fav/CS AHS 04/16/2019 Favorable AP	Favorable Yeas 9 Nays 0
5	**CS/SB 1192** Health Policy / Bean (Compare CS/H 831)	Electronic Prescribing; Requiring certain health care practitioners to electronically generate and transmit prescriptions for medicinal drugs upon license renewal or by a specified date; revising the definitions of the terms “prescribing decision” and “point of care”; revising the authority for electronic prescribing software to display information regarding a payor’s formulary under certain circumstances, etc. HP 04/08/2019 Fav/CS AHS 04/16/2019 Fav/CS AP	Fav/CS Yeas 10 Nays 0
6	**SB 1526** Harrell (Compare CS/CS/H 23, H 947)	Telehealth; Prohibiting Medicaid managed care plans from using providers who exclusively provide services through telehealth to achieve network adequacy; defining the terms “telehealth” and “telehealth provider”; prohibiting a telehealth provider from using telehealth to prescribe a controlled substance; prohibiting a health maintenance organization from requiring a subscriber to receive services via telehealth, etc. HP 03/25/2019 Favorable AHS 04/16/2019 Fav/1 Amendment AP	Fav/1 Amendment (862704) Yeas 6 Nays 4

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**CS/SB 1592** Children, Families, and Elder Affairs / Harrell (Similar CS/CS/H 1349, Compare CS/H 7019, CS/S 184)	Assisted Living Facilities; Prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to an assisted living facility under certain circumstances; requiring a facility to initiate an investigation of an adverse incident within hours and provide a report of such investigation to the Agency for Health Care Administration within 15 days; including medical examinations within criteria used for admission to an assisted living facility; revising provisions relating to facility staff training requirements, etc. CF 04/08/2019 Fav/CS AHS 04/16/2019 Favorable AP	Favorable Yeas 10 Nays 0
8	**CS/SB 1620** Health Policy / Gainer (Similar CS/H 885)	Health Care Licensing Requirements; Exempting certain physicians from specified licensing requirements when providing certain services to veterans in this state; requiring such physicians to submit specified documentation to the Department of Health; requiring an exempted physician to attest that he or she will provide medical services only to veterans under certain conditions, etc. HP 04/08/2019 Fav/CS AHS 04/16/2019 Fav/CS AP	Fav/CS Yeas 10 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/SB 410 (808586)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Senator Berman and others
SUBJECT:	Long-acting Reversible Contraception Pilot Program
DATE:	April 18, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	**Favorable**
2.	Loe	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

I. Summary:

PCS/SB 410 directs the Department of Health (DOH) to establish a long-acting reversible contraception (LARC) pilot program in Duval, Hillsborough, and Palm Beach counties. The DOH must contract with eligible family planning providers to deliver the services. A report on the effectiveness of the pilot program is due to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2021.

The bill has no impact on state revenues or state expenditures.

The bill takes effect on July 1, 2019.

II. Present Situation:

Unintended Pregnancy Rates

After a long period of little to no change in the unintended pregnancy rate, a study published in *The New England Journal of Medicine* in 2016 showed that the rate changed significantly in the United States in the time period between 2008 and 2011.[1] In 2008, the rate of unintended pregnancy was 54 per 1,000 women and girls aged 15 to 44. By 2011, this rate had declined by 18 percent to 45 unintended pregnancies for 1,000 women and girls aged 15 to 44.[2] The study's authors noted that this was the first substantial decline in the unintended pregnancy rate since at least 1981, and declines were recorded in all racial and ethnic groups.[3] The authors attributed the

[1] Lawrence B. Finer, Ph.D., and Mia R. Zolna, M.P.H., *Declines in Unintended Pregnancy in the United States, 2008-2011,* NEW ENG. J. MED. 2016; 374; 843-852, *available at* https://www.nejm.org/doi/full/10.1056/NEJMsa1506575 (last visited April 3, 2019).
[2] Finer and Zolna, *supra* note 1, at 843.
[3] Finer and Zolna, *supra* note 1, at 847.

likely cause for the decline predominantly to the change in the type and frequency of contraception used over time, noting that use of long-acting methods, such as intrauterine devices (IUD), had grown in popularity during that span from 4 percent to 12 percent across almost all demographic groups.[4]

In the United States for 2011, approximately 45 percent of all pregnancies were unintended.[5] Adolescents especially use contraceptive methods with relatively higher failure rates, such as condoms, withdrawal, or oral contraceptive pills.[6] In Florida, the unintended pregnancy rate was 58 per 1,000 women in 2010 for females aged 15 - 44, and the teen pregnancy rate was 50 per 1,000 women.[7] For 2017, the repeat birth rate for teens was 15 percent or 1,626 births.[8]

In 2010, nearly 9 million women received family planning services from publicly supported providers nationwide.[9] A study by the *Guttmacher Institute* determined that such services resulted in net savings to the public of $10.5 billion in 2010.[10] Averted costs included unintended pregnancies prevented, sexually transmitted diseases treated early or averted, HIV testing costs and preventive care, cervical cancer testing and prevention screenings. For every public dollar spent, it was estimated that $7.09 was saved.[11]

Types of Long Acting Reversible Birth Control Methods

The LARC methods are the most effective forms of reversible birth control available, with fewer than one in 100 women using a LARC method becoming pregnant, the same range as for sterilization.[12] LARC methods include an IUD or a birth control implant. Both methods last for several years, are reversible, and can be removed at any time.

An IUD is a small, T-shaped, plastic device that is inserted and left inside the uterus. There are two types of IUDs. The hormonal IUD releases progestin and is approved for up to 5 years. The copper IUD does not contain hormones and is approved for up to 10 years.[13]

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[4] Finer and Zolner, *supra* note 1, at 851.
[5] Finer and Zoler, *supra* note 1, at 843.
[6] American College of Obstetricians and Gynecologists, *Committee Opinion: Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, (October 2012), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception, (last visited April 3, 2019).
[7] Guttmacher Institute, *State Facts About Unintended Pregnancy: Florida (2014)*, http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/FL.pdf (last visited April 3, 2019.)
[8] FL HealthCharts, Florida Birth Query System, *Births- Repeat Births to Tens by Year of Birth by County (2017)*, http://www.flhealthcharts.com/FLQUERY/Birth/BirthRpt.aspx (report generated on April 3, 2019).
[9] Jennifer J. Frost, et al, *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the U.S. Publicly Funded Family Planning Program, Original Investigation*, The Millbank Quarterly, Vol. 92, No. 4, 2014 (pp. 667-720), https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080 (last visited on April 3, 2019).
[10] Jennifer J. Frost, et al, *supra* note 9, at 669.
[11] Jennifer J. Frost, et al, *supra* note 9, at 696.
[12] American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists: Long Acting Reversible Contraception: Implants and Intrauterine Devices (Number 186, November 2017, Replaces Practice Bulletin Number 121, July 2011)*, https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices (last visited April 3, 2019).
[13] American College of Obstetricians and Gynecologists, *supra note 12.*

The birth control implant is a single flexible rod about the size of a matchstick that is inserted in the upper arm under the skin and releases progestin. The implant lasts for 3 years.

Both the IUD and the implant may be placed or removed by a health care provider. There are few side effects to either method, and almost all women are eligible for an IUD or implant.[14]

While being cost-effective over the long-term, the high up-front costs of the LARC methods may be a barrier to widespread use, as the wholesale cost of an IUD or implant can be as high as $1600, plus the cost of insertion.[15] In February 2015, the federal Food and Drug Administration approved a new IUD, Liletta, which was developed by a non-profit organization and was originally made available by that organization to public clinics for as low as $50, a savings to the clinics of more than $700.[16] A Liletta patient savings card is available for qualified patients who may not qualify for services in the clinics or county health departments allowing the patient to pay $100 for a Liletta IUD.[17]

Most insurance plans under the federal Patient Protection and Affordable Care Act and Medicaid cover contraception and the associated services with no out-of-pocket costs; however, individuals without insurance coverage may face other financial hurdles such as high out of pocket costs or transportation issues. The American College of Obstetricians and Gynecologists (ACOG) also recognized these as barriers to the widespread use of LARCs by adolescents in particular in its updated *Committee on Adolescent Health Care Long-Acting Reversible Contraception Working Group* opinion document in May 2018. Also cited in that document are concerns with a provider's own lack of familiarity with or misconceptions about the methods, access issues, and a provider's concerns about the safety of LARC use in adolescents (ages 9 - 11).[18]

Women aged 25 - 34 and women who have already had at least one child use LARC at the highest rates.[19] LARC use has more than doubled among Hispanic and non-Hispanic white women in the most recent time periods after having had one of the lowest participation rates.[20] Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods.[21] For example, adolescent women are more than twice as likely as women aged 30 or older to experience a pill failure.[22]

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[14] Brooke Winner, et al., *Effectiveness of Long-Acting Reversible Contraception*, N ENGL J MED 366; 21, nejm.org, May 24, 2012.
[15] Bhadra Shah, M.D., *How Much Does an IUD Cost Without Insurance?* https://spendonhealth.com/iud-cost-without-insurance/ (last visited April 3, 2019).
[16] Karen Weise, *Warren Buffet's Family Secretly Funded a Birth Control Revolution,* Bloomberg Business (July 30, 2015), http://www.bloomberg.com/news/articles/2015-07-30/warren-buffett-s-family-secretly-funded-a-birth-control-revolution (last visited April 3, 2019).
[17] Liletta Patient Savings Program, https://www.liletta.com/acquiring/savings-card (last visited April 3, 2019).
[18] American College of Obstetricians and Gynecologists, *supra* note 12, at 2.
[19] Amy Branum, M.S.P.H, Ph.D., and Jo Jones, Ph.D., , U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Health Statistics, *Trends in Long-Acting Reversible Contraception Use Among U.S. Women Aged 15-44 (February 2015)* https://www.cdc.gov/nchs/data/databriefs/db188.pdf (last visited April 3, 2019).
[20] *Amy Branum*, *supra* note 19, at 5.
[21] American College of Obstetricians and Gynecologists, *supra note 6*, at 1.
[22] Heather D. Boonstra, *Leveling the Playing Field: The Promise of Long-Acting Reversible Contraceptives for Adolescents*, Guttmacher Policy Review, Vol. 16, p. 14, https://www.guttmacher.org/pubs/gpr/16/4/gpr160413.html (last visited April 3, 2019).

Current Family Planning Services

County Health Departments

The DOH currently provides comprehensive family planning services, including LARC services, in all 67 Florida counties.[23] Funding for these services has been provided through a Title X federal grant in the past and through state general revenue pharmacy funds. The DOH's Family Planning Program (FPP) has received consistent funding of approximately $4.7 million in general revenue for contraceptives over the last 5 years.[24] These funds are allocated to the DOH's Bureau of Statewide Pharmacy. Ordering higher-cost contraceptives such as LARCs is done through the Family Planning Waiver (FPW) and paid for through funds that are separate and distinct from the general revenue funds.

The Central Pharmacy at DOH purchases LARC methods through a pharmacy distributor at 340B[25] prices, and county health departments (CHD) pharmacies are then able to keep a supply of LARCS on hand, allowing for better access for clients to these methods.[26] For Medicaid recipients, the Central Pharmacy purchases LARC methods at market-value cost and receives a Medicaid match upon placement of the LARC device.[27] Only one discount (340B pricing or Medicaid match) can be applied.

Spending on LARCs since FY 2013-2014[28]			
State Fiscal Year	**General Revenue**	**Title X Federal Funds**	**Total Funds**
2013-2014	$1,827,561	$47,058	$1,874,625
2014-2015	$1,060,045	$377,237	$1,437.282
2015-2016	$2,899,732	$210,956	$3,110,688
2016-2017	$1,469,080	$0	$1,469,080
2017-2018	$2,404,782	$0	$2,404,782

According to the DOH, more than 120,000 individuals received family planning services in 2016 with 68 percent of the clients having incomes at or below 150 percent of the federal poverty level.[29] For a family of two, 150 percent of the federal poverty level is $25,365.[30] Of those

[23] The only exception to LARC services not being provided in a county health department (CHD) is when there is personnel turnover and there is not a trained provider available for LARC methods. The DOH Family Planning Program Office requires that each CHD have a trained provider for LARC methods.
[24] Email from Bryan P. Wendel, Department of Health, *infra* note 37.
[25] The 340B Drug Discount Program is a federal government program created in 1992 that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices.
[26] Department of Health, *Summary of Long Acting Reversible Contraceptive (LARC) Utilization in Department of Health County Health Departments, (*on file with Senate Committee on Health Policy) (April 4, 2019).
[27] Department of Health, *Summary of Long Acting Reversible Contraceptive (LARC) Utilization in Department of Health County Health Departments, (*on file with Senate Committee on Health Policy) (April 4, 2019).
[28] Florida Department of Health, *Summary of Long Acting Reversible Contraceptive (LARC) Utilization in Department of Health County Health Departments (*on file with Senate Committee on Health Policy) (April 4, 2019).
[29] Florida Department of Health, *Family Planning Fact Sheet*, http://www.floridahealth.gov/programs-and-services/womens-health/family-planning/fp-facts.html (last visited April 3, 2019).
[30] 2019 Federal Poverty Guidelines, https://aspe.hhs.gov/2019-poverty-guidelines (last visited April 3, 2019).

served by the DOH for family planning services, 39.4 percent were covered by public insurance, such as Medicaid and 29.2 percent were uninsured.[31]

Men and women served under the DOH's family planning program have access to FDA-approved birth control methods and supplies, abstinence counseling, pregnancy testing, physical examinations, screenings, and HIV counseling and testing.[32] Services are provided on a sliding scale, based on family size and income, resulting in persons under 100 percent of the federal poverty level paying no fees. For every dollar spent on family planning services, an estimated $1.44 was saved as a result of averting expenditures for public programs that support women with unintended pregnancies and their infants.[33]

The majority of family planning services are delivered at CHD clinic sites. There are 150 total Title X clinics in Florida.[34] A small number of CHDs contract with outside providers for family planning services, including the three below.[35]

Numbers of Clinic Sites, including Contracted Sites[36]	
Duval CHD	5
Hillsborough CHD	11
Palm Beach CHD	9

In State Fiscal Year 2017-2018, the CHDs provided family planning services to 13,384 clients who were using a LARC method or 12.23 percent of all clients.[37] The table below illustrates the total number of family planning services in the proposed pilot counties and statewide.

Long Acting Reversible Contraceptives (LARCs) Use by County, Florida Fiscal Year 2017-2018[38]									
	Age <15-19			**Age 20-45+**			**Total**		
County	**# of Clients with LARCs**	**# of Clients**	**%**	**# of Clients with LARCs**	**# of Clients**	**%**	**Total # of Clients with LARCs**	**Total Clients**	**%**
Duval	135	704	19.18%	585	3,195	18.31%	720	3,899	18.47%
Hillsborough	73	321	22.74%	987	4,376	22.55%	1,060	4,697	22.57%
Palm Beach	125	1,192	10.49%	931	6,488	14.35%	1,056	7,680	13.75%
Statewide	1,810	18,744	9.66%	11,574	90,724	12.76%	13,384	109,468	12.23%

[31] Florida Department of Health, *Family Planning Fact Sheet*, http://www.floridahealth.gov/programs-and-services/womens-health/family-planning/fp-facts.html (last visited April 3, 2019).
[32] Florida Department of Health, *Family Planning*, http://www.floridahealth.gov/programs-and-services/womens-health/family-planning/index.html (last visited April 3, 2019).
[33] Florida Department of Health, *supra note 26.*
[34] Florida Department of Health, *Title X Family Planning Program, (*on file with the Senate Committee on Health Policy).
[35] Florida Department of Health, *2016 Agency Bill Analysis - SB 1116*, Dec. 16, 2015, (on file with Senate Health Policy Committee).
[36] Florida Department of Health, *Title X Family Planning Program,* (on file with the Senate Committee on Health Policy).
[37] Email from Bryan P. Wendel, Government Analyst II, Department of Health, to Jennifer Lloyd, Senate Health Policy Committee (Jan. 13, 2016) (on file with Senate Committee on Health Policy).
[38] Florida Department of Health, *Title X Family Planning Program,* (on file with the Senate Committee on Health Policy).

Florida Medicaid Program

Family planning services are also covered under Medicaid for recipients of child-bearing age and include reimbursement for:

- New and established patient visits;
- Required laboratory tests;
- Selection of contraceptive method, provision of supplies;
- Post examination review;
- Counseling visits;
- Supply visits;
- HIV Counseling;
- Coverage for insertion and removal of IUD;
- Services associated with decision to use long-acting injectable or implantable contraceptives; and
- Pregnancy testing.[39]

Family planning services for Medicaid recipients are funded through Title XIX federal funds and state general revenue. The statutory authority for these services is under s. 381.0051, F.S.

Family planning services are also provided through a family planning waiver (FPW) for females aged 14 through 55 who lose Medicaid coverage at the end of their 60 days postpartum coverage and who have family income at or below 185 percent of the federal poverty level at the time of their annual redetermination, or for females who have lost their Medicaid coverage. Enrollees must also not be otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or other health insurance coverage with family planning services. Eligibility is limited to 2 years after losing Medicaid coverage and must be re-determined every 12 months.

The FPW was first implemented in 1998 and has been through several extension periods. The most recent extension was requested through December 31, 2022 in June 2017, following a 30-day public comment period.[40]

Covered services under the FPW are limited to those services and supplies whose primary purpose is family planning. Those services under the FPW include:

- Approved methods of contraception;
- Sexually transmitted infection (STI) testing;
- Sexually transmitted disease (STD) testing;
- Pap smears and pelvic exams;
- Approved sterilizations;
- Drugs, supplies, or devices related to women's health services; and

[39] Agency for Health Care Administration, *Practitioner Services Coverage and Limitations Handbook*, pgs. 51-55, http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Practitioner%20Services%20Handbook_Adoption.pdf (last visited April 3, 2019).

[40] Agency for Health Care Administration, *Family Planning Waiver – 1115 Research and Demonstration Waiver #11-W-00135/4: Public Notice Document* (May 1 – 30, 2017), http://ahca.myflorida.com/medicaid/Family_Planning/pdf/Public_Notice_Document_05-01-2017.pdf (last visited April 3, 2019).

- Contraceptive management, patient education, and counseling.[41]

The FPW does not cover emergency room visits, inpatient services, or any other non-family planning related services.

The FPW has four specific objectives:
- Increase access to family planning services;
- Increase child spacing intervals through effective contraceptive use;
- Reduce the number of unintended pregnancies in Florida; and
- Reduce Florida Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Florida Medicaid-eligible pregnancy-related services.

During the most recent reporting period on the FPW, the state highlighted these findings from its waiver:
- Increased the average birth interval from 17 months to 18.5 months during Demonstration Year 17 (SFY 2014/2015);
- Dispensed more than 283,000 contraceptive items between July 2016 and June 2017 to participants in the FPW (Demonstration Year 19);
- Posted a decrease in the number of unintended pregnancies by 1,735;
- Saved Florida Medicaid $25.3 million in DY 17 in averted costs by reducing unintended pregnancies.[42]

Family planning services and supplies under Medicaid are funded with a 90-percent federal matching rate while costs relating to the processing of claims is matched at 50 percent.[43]

III. Effect of Proposed Changes:

The bill creates s. 381.00515, F.S., to establish the LARC pilot program within the DOH. The pilot program is established in Duval, Hillsborough, and Palm Beach counties with the purpose of improving the provision of LARC services in those counties. Under the pilot program, the DOH is directed to contract with eligible family planning providers to implement the program. A contract for LARC services must include:
- Provision of intrauterine devices, implants, and injections to participants;
- Training for provider staff regarding LARC devices, counseling strategies, and the management of side effects;
- Technical assistance to providers regarding issues such as coding, billing, pharmacy rules, and clinic management due to increased use of LARC services;
- General support to providers to expand service capacity of family planning clinics; and

[41] Agency for Health Care Administration, *Extension of the Florida Medicaid Family Planning Waiver*, (June 27, 2014) p. 23, http://ahca.myflorida.com/Medicaid/Family_Planning/pdf/FPW_Extension_Request_6-27-14_final.pdf (last visited April 3, 2019).
[42] Agency for Health Care Administration, *Florida's Medicaid 1115 Family Planning Waiver Post Award Forum* (November 1, 2017), *Presentation – Public Meeting*, https://ahca.myflorida.com/medicaid/mcac/docs/2017-11-01_Meeting/FPW_Waiver_Post_Award_Forum_11-1-2017.pdf (last visited April 3, 2019).
[43] Agency for Health Care Administration, *supra* note 41, at 32.

- Marketing and community outreach regarding the availability of LARC services and other currently available contraceptive services.

The bill also directs the DOH to seek federal grants and funds from other sources to supplement state funds provided for the pilot program.

By January 1, 2021, the DOH must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the effectiveness of the pilot program. The report must be published on the DOH's website. The report must include, but need not be limited to:

- An assessment of the operation of the pilot program, including any progress made in the reduction of unintended pregnancies and subsequent births, especially among teenagers;
- An assessment on the effectiveness of the pilot program in increasing the availability of LARC services;
- The number and location of family planning providers who participated in the pilot program;
- The number of clients served by family planning providers;
- The number of times LARC services were provided by participating family planning providers;
- The average cost per client served;
- The demographic characteristics of clients served;
- The sources and amounts of funding used for the pilot program;
- A description of federal grants the DOH applied for in order to provide LARC services, including the outcomes of the grant applications;
- An analysis of the return on investment associated with the provision of LARC services with regard to tax dollars saved on health and social services;
- A description and analysis of marketing and outreach activities conducted to promote the availability of LARC services; and
- Recommendations for improving the pilot program.

The bill takes effect on July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Implementation of the LARC pilot program is contingent on the DOH receiving an appropriation from the Legislature; therefore, the bill has no impact on state revenues or state expenditures. The DOH indicates that, if the pilot program is implemented, it will need to hire one additional other personal services employee at a cost of $55,180, inclusive of compensation and applicable expenses, to implement the reporting requirements of the bill; however, such increase in state expenditures will be absorbed within existing resources.[44]

The bill may have a positive fiscal impact to the Medicaid program if the pilot program results in fewer unintended pregnancies.[45] Each birth covered by Medicaid costs the state on average $17,854 while the highest priced LARC ranges from $800 to $1,000.[46] The extent of the cost savings is indeterminate.

VI. Technical Deficiencies:

None.

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[44] *See* Department of Health, *House Bill 579 Analysis* (January 28, 2019) (on file with the Senate Committee on Health Policy) and Email from Ty Gentle, Budget Director, Florida Department of Health (on file with the Senate Appropriations Subcommittee on Health and Human Services) (April 10, 2019).

[45] An evaluation of Florida's Medicaid Family Planning Waiver showed the total number of averted, unintended births due to being provided a range of reproductive health services was 2,422. The average Medicaid birth costs were $17,854 and averted birth cost savings was $43.2 million. Total Family Planning Waiver costs were $5.7 million. Therefore, the overall savings to the Florida Medicaid program due to implementation of the waiver was approximately $37.6 million. *See* Florida State University, Department of Behavioral Health Sciences and Social Medicine, *Florida Medicaid Family Planning Waiver Program: Final Evaluation Report (DY) 18 (SFY 2015-2016) and DY 19 (SFY 2016-2017) MED 184: Deliverable 7* (June 28, 2018), p.35, http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/contracts/med184/MED184_Deliverable_7_Final_Evaluation_Report.pdf (last visited April 3, 2019).

[46] Agency for Health Care Administration, *supra* note 41.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.00515 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS by Appropriations Subcommittee on Health and Human Services on April 16, 2019:
The committee substitute conditions the implementation of the Long-Acting Reversible Contraception pilot program on receipt of an appropriation from the Legislature.

B. Amendments:

None.

206192

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/16/2019	.	
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	.	
	.	

Appropriations Subcommittee on Health and Human Services (Berman) recommended the following:

Senate Amendment (with title amendment)

Delete lines 86 - 93

and insert:

(4) Implementation of the pilot program is subject to a legislative appropriation.

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

And the title is amended as follows:

Delete lines 16 - 18

206192

and insert:
the report; establishing that implementation of the pilot program is subject to an appropriation; providing an

By Senator Berman

31-00481B-19 2019410__

A bill to be entitled

An act relating to a long-acting reversible contraception pilot program; creating s. 381.00515, F.S.; requiring the Department of Health to establish a long-acting reversible contraception pilot program in Duval, Hillsborough, and Palm Beach Counties; providing the purpose of the pilot program; requiring the department to contract with family planning providers to implement the pilot program; requiring such contracts to include specified provisions; requiring the department to apply for grants for additional funding; requiring the department to submit a report to the Governor and the Legislature by a specified date; requiring the department to publish the report on its website; specifying requirements for the report; providing an appropriation; requiring the department to distribute appropriated funds equally among the participating counties; providing an effective date.

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

Section 1. Section 381.00515, Florida Statutes, is created to read:

381.00515 Long-acting reversible contraception pilot program.—

(1) The Department of Health shall establish a long-acting reversible contraception (LARC) pilot program in Duval, Hillsborough, and Palm Beach Counties. The purpose of the pilot

31-00481B-19 2019410__

program is to improve the provision of LARC services to women residing in the pilot program counties. The department shall contract for LARC services with eligible family planning providers to implement the pilot program in each of the three counties. Each contract must provide for all of the following:

(a) The provision of LARC services, including the administration of implants, injections, and intrauterine devices to participants.

(b) The training of provider staff regarding the provision of LARC services, counseling strategies, and the management of side effects.

(c) Technical assistance to providers regarding issues such as coding, billing, pharmacy rules, and clinic management necessitated by the increased use of LARC services.

(d) General support to providers to expand their service capacity.

(e) Marketing and community outreach regarding the availability of LARC services and other currently available contraceptive services.

(f) Other services that the department considers necessary to ensure the health and safety of women who receive LARC services.

(2) The department shall apply for grants from federal agencies and other sources to supplement state funds provided for the pilot program.

(3) By January 1, 2021, the department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the effectiveness of the pilot program. The department shall publish the report on

its website. The report must include, but need not be limited to:

(a) An assessment of the operation of the pilot program, including any progress made in reducing the number of unintended pregnancies and subsequent births, especially among teenagers.

(b) An assessment of the effectiveness of the pilot program in increasing the availability of LARC services.

(c) The number and location of family planning providers that participated in the pilot program.

(d) The number of clients served by participating family planning providers.

(e) The number of times LARC services were provided by participating family planning providers.

(f) The average cost per client served.

(g) The demographic characteristics of clients served.

(h) The sources and amounts of funding used for the pilot program.

(i) A description of federal grants the department applied for in order to provide LARC services, including the outcomes of the grant applications.

(j) An analysis of the return on investment associated with the provision of LARC services with regard to tax dollars saved on health and social services.

(k) A description and analysis of marketing and outreach activities conducted to promote the availability of LARC services.

(l) Recommendations for improving the pilot program.

Section 2. For the 2019-2020 fiscal year, the sum of $100,000 in nonrecurring funds is appropriated from the General

Revenue Fund to the Department of Health for the purpose of implementing this act. The department shall distribute the funds equally among the three counties participating in the pilot program. These funds may not be used to supplant or reduce any other appropriation of state funds to family planning providers or to the department for family planning services.

Section 3. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-16-19
Meeting Date

410
Bill Number (if applicable)

Topic Long Acting Reversible Contraception

Amendment Barcode (if applicable)

Name Barbara DeVane

Job Title MS

Address 625 E. Brevard ST
Street

Phone 251-4280

Tallahassee FL 32308
City *State* *Zip*

Email barbaradevane1@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL NOW

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

410
Bill Number (if applicable)

Topic Long Acting Reversible Contraception

Amendment Barcode (if applicable)

Name Ingrid Delgado

Job Title Associate for Social Concerns & Respect Life

Address 201 W Park Av
Street

Phone

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Florida Conference of Catholic Bishops

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/CS/SB 634 (906584)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senator Rouson and others
SUBJECT:	Child Welfare
DATE:	April 18, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 634 is titled "Jordan's Law" and makes a number of changes to the laws related to the child welfare system in an attempt to address issues that were identified in the case of Jordan Belliveau, a two-year old boy who was killed by his mother in Pinellas County.

The bill requires the Department of Children and Families (DCF or department) and the Florida Department of Law Enforcement (FDLE) to share certain information on a parent or caregiver who is the subject of a child protective investigation. The bill requires a law enforcement officer who has an interaction with a parent or caregiver and the interaction results in the officer having a concern about the health, safety or wellbeing of the child, the officer is required to notify the Florida Central Abuse Hotline (hotline) and provide information about the interaction. The hotline is then required to determine if any further action is appropriate.

The bill requires specified child welfare professionals, judges, guardians ad litem, and law enforcement officers to receive training on the recognition of and response to head trauma and brain injury in children under six years old. The training costs for these professionals can be absorbed within existing resources within the respective agencies with the exception of the training of law enforcement staff, which is subject to an appropriation.

The bill allows the department to create and implement a pilot program in up to three judicial circuits to more effectively provide case management services for dependent children under the age of six. The bill requires an evaluation by October 1, 2024.

The provisions contained in the bill are subject to appropriation (See Section V).

The bill takes effect July 1, 2019.

II. Present Situation:

Jordan Belliveau

Jordan Belliveau, Jr., was murdered by his mother in September 2018 when he was two years old. At the time of his death, the family was under court-ordered protective supervision as Jordan, who had been removed from his parent's custody in October 2016, was reunified with his mother, 21-year old Charisee Stinson, in May 2018. In addition to the open service case, there was also an active child abuse investigation due to ongoing domestic violence between his mother and father, 22-year-old Jordan Belliveau, Sr.

Due to lack of communication to the court, lack of communication between the Pinellas County Sheriff's Office and the DCF, and lack of evidence provided by Directions for Living, the contracted case management organization for Eckerd Connects, the community-based care lead agency, regarding the parent's case plan compliance, ongoing family issues that created an unsafe home environment for Jordan were never addressed. Jordan was initially reported missing by his mother in September 2018 and a statewide Amber Alert was issued. His body was found by law enforcement four days after his death. His mother was charged with aggravated child abuse and first-degree murder. His mother admitted to killing Jordan by hitting him, which caused the back of his head to hit a wall in their home.

Special Review of the Case Involving Jordan Belliveau Jr.

Case Summary

Given the circumstances of the case, former Interim Secretary Rebecca Kapusta immediately initiated a special review to evaluate the circumstances surrounding Jordan's death and to assess the services provided during the 17 months he remained removed from the home and continuing upon his reunification with his mother in May 2018. The multidisciplinary team was not only comprised of individuals who specialize in child welfare, but also those with mental health, and domestic violence expertise (both from a treatment and law enforcement perspective) to address the reunification decision and actions that occurred when subsequent concerns were identified.[1]

Jordan's family first came in contact with the DCF in October 2016 when a report was made to the hotline alleging Jordan was in an unsafe home environment that included gang violence. Jordan was placed in foster care after his mother was unable to obtain alternative housing. He

[1] Department of Children and Families, Special Review of the Case Involving Jordan Belliveau, Jr. (Jan. 11, 2019), *available at* http://www.dcf.state.fl.us/newsroom/docs/Belliveau%20Special%20Review%202018-632408.pdf. (Last visited March 25,2019).

was subsequently adjudicated dependent on November 1, 2016, and placed in foster care. His parents were offered a case plan with tasks including finding stable housing and receiving mental health services and counseling.

Throughout Jordan's case, his mother and father were either non-compliant or only partially compliant with their case plans. Nevertheless, due to lack of communication to the court and lack of evidence provided by the case management organization, Directions for Living, regarding compliance, Jordan was eventually reunified with his mother and father. After reunification and while still under judicial supervision, domestic violence continued between the parents, with Jordan's father being arrested for domestic violence against Jordan's mother in July 2018. However, the incident was not immediately reported to the hotline upon his arrest, and thus the incident was not reported to the court at a hearing the next day regarding Jordan's reunification.

When the incident was reported to the hotline three weeks later, a child protective investigation was conducted by the Pinellas County Sheriff's Office. However, the investigator determined that Jordan was not currently in danger, and therefore, found there was no need to remove him from the home. Given the ongoing and escalating level of violence between the parents, the inability to control the situation in the home, and the risk of harm posed to Jordan should his parent engage in further altercations, an unsafe home environment should have been identified.

However, with no concerns for Jordan's safety raised after the investigation or during subsequent hearings, there was no consideration for an emergency modification of his placement and Jordan was reunited with his father. On August 31, 2018, a case manager visited Jordan's parents to discuss several issues regarding lack of cooperation with the Guardian ad Litem and case plan tasks. The case manager emphasized the continued need for Jordan's parents to participate in services or risk losing custody of Jordan. Less than 24 hours after the visit, Jordan was reported missing by his mother. Four days later his body was found. Jordan's mother admitted to killing him by hitting him in a "moment of frustration" which "in turn caused the back of his head to strike an interior wall of her home."[2]

Findings in the Report

- The decision to reunify Jordan was driven primarily by the parents' perceived compliance to case plan tasks and not behavioral change. There was a noted inability by all parties involved to recognize and address additional concerns that became evident throughout the life of the case. Instead, case decisions were solely focused on mitigating the environmental reasons Jordan came into care and failed to address the overall family conditions.
- Following reunification, policies and procedures to ensure child safety and wellbeing were not followed. In addition, Directions for Living case management staff did not take action on the mother's lack of compliance and her failure to participate with the reunification program prior to and following reunification.
- When the new child abuse report was received in August 2018, alleging increased volatility between the parents, present danger was not appropriately assessed and identified. The assessment by the Pinellas County Sheriff's child protective investigator (CPI) was based solely on the fact that the incident wasn't reported to the hotline when it initially occurred.

[2] *Id*.

The CPI failed to identify the active danger threats occurring within the household that were significant, immediate, and clearly observable. Given the circumstances, a modification of Jordan's placement should have been considered.

- Despite the benefit of co-location, there was a noted lack of communication and collaboration between the Pinellas County Sheriff's Office CPID unit and Directions for Living case management staff in shared cases involving Jordan and his family, especially regarding the August 2018 child abuse investigation.
- In addition to the lack of communication and collaboration between frontline investigations and case management staff noted above, there was an absence of shared ownership between all entities involved throughout the life of Jordan's case which demonstrates a divided system of care. In addition, the lack of multidisciplinary team approach resulted in an inability to adequately address the identified concerns independent of one another.
- The biopsychosocial assessments failed to consider the history and information provided by the parents and resulted in treatment plans that were ineffective to address behavioral change. Moreover, there was an over-reliance on the findings of the biopsychosocial assessments as to whether focused evaluations were warranted (e.g., substance abuse, mental health, domestic violence, etc.), despite the abundance of information to support such evaluations were necessary.[3]

Conclusion

The report's findings and conclusion do not indicate that Jordan's death was the result of any shortcomings or loopholes in the law or lack of training related to the identification of brain injury, but rather due to the multiple failures of individuals working with children in the child welfare system to communicate, coordinate and cooperate:

> Complex child welfare cases are difficult enough when high caseloads and continual staff turnover plague an agency. However, it is further impacted when those involved in the case (protective investigations, case management, clinical providers, legal, Guardians ad Litem, and the judiciary) fail to work together to ensure the best decisions are being made on behalf of the child and their family.
>
> This case highlights the fractured system of care in Circuit 6, Pinellas County, with each of the various parts of the system operating independently of one another, without regard or respect as to the role their part plays in the overall child welfare system. Until the pieces of the local child welfare system are made whole, decision-making will continue to be fragmented and based on isolated views of a multi-faceted situation.[4]

Current Training Requirements

Currently, all case managers, Guardian ad Litem staff and volunteers, dependency court judges, child protective investigators, Children's Legal Services' attorneys, and law enforcement officers are required to complete required training for their position. Typically, this is done as preservice

[3] *Id*.
[4] *Id*.

and continuing education training. None of the required training includes the recognition of and response to head trauma and brain injury in a child under age six.[5]

DCF/Law Enforcement Data Systems

Florida Safe Families Network

The Florida Safe Families Network (FSFN) is the department's Statewide Automated Child Welfare Information System. The FSFN serves as the statewide electronic case record for all child abuse investigations and case management activities in Florida for the department. It was designed to capture all reports of child maltreatment, investigations, and service history information in a single electronic child welfare record for each child reported, investigated, and served.

Florida Crime Information Center

The Florida Crime Information Center (FCIC), administered by the Florida Department of Law Enforcement, is a state database that houses actionable criminal justice information. When law enforcement comes in contact with an individual, the officer runs the individual's identifying information in the FCIC to see if there are any open wants or warrants for their arrest. The FDLE's Criminal Justice Information Services (CJIS) is the central repository of criminal history records for the state and provides criminal identification screening to criminal justice and non-criminal justice agencies.[6] The CJIS helps ensure the quality of data available on the FCIC system. Only agencies approved by the FDLE can view or enter information in the CJIS.

III. Effect of Proposed Changes:

Section 1 provides the short title to the bill. The bill is titled "Jordan's Law" after Jordan Belliveau, a two-year old child in Florida's child welfare dependency system, who was murdered by his mother in September 2018.

Section 2 amends s. 25.385, F.S., relating to standards for instruction of circuit and county court judges in domestic violence cases, to require the Florida Court Educational Council to establish standards for periodic instruction of circuit and county court judges who have responsibility for dependency cases related to the recognition of and responses to head trauma and brain injury in children under six years old.

Section 3 creates s. 39.0142, F.S., relating to notifying law enforcement of parent or caregiver names, to require the FDLE, subject to an appropriation, to enter the name of a parent or caregiver who is the subject of a child protective investigation into the FCIC to notify local law enforcement agencies that this individual is involved in the child welfare system.

If a law enforcement officer has an interaction with a parent or caregiver and the interaction results in the officer having a concern about the health, safety or wellbeing of the child, the

[5] For specific training requirements see ss. 25.385, 39.8296, 402.402, 409.988, 943.13 and 943.135, F.S.
[6] Florida Department of Law Enforcement, Criminal Justice Information Services, *Available at*: http://www.fdle.state.fl.us/CJIS/CJIS-Home.aspx (Last visited Mar. 25, 2019)

officer must report the details of the interaction to the hotline. The hotline is then required to determine if further action is appropriate.

The bill also requires the department to remove the name of the parent or caregiver from the FCIC when there is no longer an active investigation or when judicial supervision has ended.

Section 4 amends s. 39.8296, F.S., relating to the statewide Guardian ad Litem Office, to require that training for guardians ad litem include information on the prevention, symptoms, risks, and responses to head trauma and brain injury in children under six years old.

Section 5 amends s. 402.402, F.S. relating to child protection and child welfare personnel and attorneys employed by the department, to require specialized training for all child protective investigators, child protection investigation supervisors, and attorneys handling child welfare cases. The specialized training must include information on the prevention, symptoms, risks, and responses to head trauma and brain injuries in children under six years old. This training requirement applies to employees in the department and the sheriff's offices that conduct child abuse investigations.

Section 6 amends s. 409.988, F.S., relating to duties of the community-based care lead agencies (CBC), to require that all individuals employed by a CBC who provide care to dependent children receive training on the recognition of and responses to head trauma and brain injury in a children under six years old. The bill also requires CBCs to provide intensive family reunification services that combine child welfare and mental health services for families with dependent children under 6 years old.

Section 7 amends s. 409.996, F.S., relating to duties of the DCF, to allow the department, subject to an appropriation, to create and implement a program in up to three judicial circuits to more effectively provide case management services for dependent children under the age of 6. The bill provides requirements for the program and requires an evaluation by October 1, 2024.

Section 8 creates s. 943.17297, F.S., relating to training in the recognition of and response to head trauma and brain injury, subject to an appropriation, to require the Criminal Justice Standards and Training Commission (CJSTC) to establish standards, including, but not limited to, the training requirements under s. 39.0143, F.S., for the instruction of law enforcement officers on the recognition of and responses to head trauma and brain injury in a children under six years old. Each law enforcement officer must successfully complete the training as part of the basic recruit training to obtain initial certification or as a part of continuing training or education.

Section 9 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Florida Department of Children and Families (DCF)

The fiscal impact of the bill's requirement to develop and implement specific training for guardians ad litem, child protection, child welfare and attorneys employed by the DCF, all individuals employed by a CBC who provide care to dependent children, and circuit and county court judges[7] is insignificant and can be absorbed within the existing resources of each entity.

Implementation of specific training for law enforcement officers is subject to an appropriation.

Implementation of sections 3 and 7 of the bill is subject to an appropriation. However, if an appropriation is provided, the fiscal impact of the sections 3 and 7 of bill is significant. To implement the requirements of section 3:

- The DCF estimates the need for an additional 17 central abuse hotline counselors at an annual recurring cost of $1,205,819; additionally, the DCF estimates a need for

[7] Office of State Courts Administrator, *2019 Judicial Impact Statement, CS/SB 634* (April 14, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

between $160,000 and $270,000 to implement the data exchange requirements with the Florida Department of Law Enforcement.[8]

- The Florida Department of Law Enforcement estimates that the cost of creating an interface with DCF's Florida Safe Families Network will require $312,000 nonrecurring funds from the General Revenue Fund.[9]

To implement the requirements of section 7, the DCF estimates that the case management pilot program, which requires CBC case managers to carry caseloads of no more than 15 cases at a time, would have a significant yet indeterminate fiscal impact on state expenditures.[10]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Both the DCF and the FDLE have raised questions and concerns about section 3 of the bill which requires the DCF to notify law enforcement of the names of parents or caregivers who are the subject of a child protective investigation.

In order to enter data in the FCIC system, the DCF would need to reach agreement with the FDLE regarding the creation of a new status file type (as used by law enforcement personnel in the notification of active protection orders). This new status file type would be shared between the department's CCWIS (Comprehensive Child Welfare Information System), an electronic case file of record, and FCIC. This would require approval by the FDLE and changes in the existing DCF/FDLE Criminal Justice user agreement. The FDLE could require the department to develop a validation process to ensure all records are accurate and current and meet the FDLE's standard for "entering agencies" to have staff available within one hour for the inquiring officer. The department is unclear as to whether access to hotline counselors will satisfy this requirement and FDLE may request actual contact with the child protective investigator or case manager assigned to the family.[11]

The FDLE has raised the following questions relating to provisions in the bill:

- Impacts to FDLE's FCIC system:
  - The FCIC system houses actionable criminal justice information. This proposal represents a shift in FCIC policy to house raw investigative information which has not been vetted and may later be determined to be unfounded.
  - System and training documentation will have to be updated.
  - Law enforcement agencies will have to be trained on the new FCIC file.

[8] Florida Department of Children and Families, *2019 Agency Bill Analysis, SB 634* (April 4, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[9] Florida Department of Law Enforcement, *2019 Agency Bill Analysis, SB 634* (April 4, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[10] *Supra* note 8.
[11] *Supra* note 8.

- The DCF will have to be audited to ensure proper entry and removal of records. Entries will have to meet minimum criteria (name, race, sex, and date of birth). Individuals reported to the hotline by first name, nickname, or street name only will not be able to be entered until the minimum criteria have been gathered.[12]

- Impact on Local Law Enforcement:
  - Local law enforcement agencies would have to develop new policy and procedures for notification to the DCF when having contact with a person in this file. The bill is unclear as to what constitutes "having interaction with" an individual. For example, would a traffic infraction require the officer to check for this data? The bill is also unclear as to whether law enforcement has the authority to detain or delay this individual until notification to the DCF can be accomplished.[13]

- Additional Considerations:
  - The DCF is a non-criminal justice entity; the central abuse hotline has a criminal justice designation and has access to query FCIC. Thus it is reasonable to believe this group will be responsible for all entry and removal since they are the only entity with access to FCIC. Their current certification level is "limited access" as they only make inquiries. The FDLE will have to invest time in certifying these individuals as "full access" system users so that they can make entries into FCIC.[14]
  - The changes required to create the interface between the FDLE and the DCF cannot be done by the July 1, 2019 effective date. A change to June 30, 2021 is recommended.[15]

VIII. Statutes Affected:

The bill amends the following sections of the Florida Statutes: 25.385, 39.8296, 402.402, 409.988, and 409.996.

The bill creates ss. 39.0142 and 943.17297 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CSCS by Appropriations Subcommittee on Health and Human Services on April 16, 2019:
The committee substitute inserts "subject to appropriation," is sections 3, 7 and 8 of the bill. Therefore, section 3 relating to required law enforcement notifications, section 7 relating to the creation and implementation of a pilot program, and section 8 relating to law enforcement training will not be implemented unless an appropriation is provided.

[12] *Supra* note 9.
[13] *Id*.
[14] *Id*.
[15] *Id*.

CS by Children Families, and Elder Affairs on April 1, 2019:
The CS:

- Removes non-specific training development language.
- Removes the requirement for AHCA to establish a targeted case management pilot in the Sixth and Thirteenth Judicial Circuits.
- Requires law enforcement to only contact the central abuse hotline when there is an encounter with a parent or caregiver that causes the officer to concerns about the health, safety or well-being of a child.

B. Amendments:

None.

524848

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/16/2019	.	
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Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

Senate Amendment (with title amendment)

Delete lines 72 - 286

and insert:

caregiver names.—Subject to an appropriation, the Department of Law Enforcement shall provide information to a law enforcement officer stating whether a person is a parent or caregiver who is currently the subject of a child protective investigation for alleged child abuse, abandonment, or neglect or is a parent or caregiver of a child who has been allowed to return to or remain

524848

in the home under judicial supervision after an adjudication of dependency. This information shall be provided via a Florida Crime Information Center query into the department's child protection database.

(1) If a law enforcement officer has an interaction with a parent or caregiver as described in this section and the interaction results in the officer having a concern about a child's health, safety, or well-being, the law enforcement officer shall report the relevant details of the interaction to the central abuse hotline immediately after the interaction even if the requirements of s. 39.201, relating to reporting of knowledge or suspicion of abuse, abandonment, or neglect, are not met.

(2) The central abuse hotline shall provide any relevant information to:

(a) The child protective investigator, if the parent or caregiver is the subject of a child protective investigation; or

(b) The child's case manager and the attorney representing the department, if the parent or caregiver has a child under judicial supervision after an adjudication of dependency.

Section 4. Paragraph (b) of subsection (2) of section 39.8296, Florida Statutes, is amended to read:

39.8296 Statewide Guardian Ad Litem Office; legislative findings and intent; creation; appointment of executive director; duties of office.—

(2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a Statewide Guardian Ad Litem Office within the Justice Administrative Commission. The Justice Administrative Commission shall provide administrative support and service to the office

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to the extent requested by the executive director within the available resources of the commission. The Statewide Guardian Ad Litem Office shall not be subject to control, supervision, or direction by the Justice Administrative Commission in the performance of its duties, but the employees of the office shall be governed by the classification plan and salary and benefits plan approved by the Justice Administrative Commission.

(b) The Statewide Guardian Ad Litem Office shall, within available resources, have oversight responsibilities for and provide technical assistance to all guardian ad litem and attorney ad litem programs located within the judicial circuits.

1. The office shall identify the resources required to implement methods of collecting, reporting, and tracking reliable and consistent case data.

2. The office shall review the current guardian ad litem programs in Florida and other states.

3. The office, in consultation with local guardian ad litem offices, shall develop statewide performance measures and standards.

4. The office shall develop a guardian ad litem training program, which shall include, but not be limited to, training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age. The office shall establish a curriculum committee to develop the training program specified in this subparagraph. The curriculum committee shall include, but not be limited to, dependency judges, directors of circuit guardian ad litem programs, active certified guardians ad litem, a mental health professional who specializes in the treatment of children, a member of a child advocacy group, a representative

of the Florida Coalition Against Domestic Violence, and a social worker experienced in working with victims and perpetrators of child abuse.

5. The office shall review the various methods of funding guardian ad litem programs, shall maximize the use of those funding sources to the extent possible, and shall review the kinds of services being provided by circuit guardian ad litem programs.

6. The office shall determine the feasibility or desirability of new concepts of organization, administration, financing, or service delivery designed to preserve the civil and constitutional rights and fulfill other needs of dependent children.

7. In an effort to promote normalcy and establish trust between a court-appointed volunteer guardian ad litem and a child alleged to be abused, abandoned, or neglected under this chapter, a guardian ad litem may transport a child. However, a guardian ad litem volunteer may not be required or directed by the program or a court to transport a child.

8. The office shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court an interim report describing the progress of the office in meeting the goals as described in this section. The office shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court a proposed plan including alternatives for meeting the state’s guardian ad litem and attorney ad litem needs. This plan may include recommendations for less than the entire state, may

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include a phase-in system, and shall include estimates of the cost of each of the alternatives. Each year the office shall provide a status report and provide further recommendations to address the need for guardian ad litem services and related issues.

Section 5. Subsections (2) and (4) of section 402.402, Florida Statutes, are amended to read:

402.402 Child protection and child welfare personnel; attorneys employed by the department.—

(2) SPECIALIZED TRAINING.—All child protective investigators and child protective investigation supervisors employed by the department or a sheriff's office must complete the following specialized training:

(a) Training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age.

(b) Training that is either focused on serving a specific population, including, but not limited to, medically fragile children, sexually exploited children, children under 3 years of age, or families with a history of domestic violence, mental illness, or substance abuse, or focused on performing certain aspects of child protection practice, including, but not limited to, investigation techniques and analysis of family dynamics. The specialized training may be used to fulfill continuing education requirements under s. 402.40(3)(e). Individuals hired before July 1, 2014, shall complete the specialized training by June 30, 2016, and individuals hired on or after July 1, 2014, shall complete the specialized training within 2 years after hire. An individual may receive specialized training in multiple areas.

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(4) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD WELFARE CASES.—Attorneys hired on or after July 1, 2014, whose primary responsibility is representing the department in child welfare cases shall, within the first 6 months of employment, receive training in all of the following:

(a) The dependency court process, including the attorney's role in preparing and reviewing documents prepared for dependency court for accuracy and completeness.~~;~~

(b) Preparing and presenting child welfare cases, including at least 1 week shadowing an experienced children's legal services attorney preparing and presenting cases.~~;~~

(c) Safety assessment, safety decisionmaking tools, and safety plans.~~;~~

(d) Developing information presented by investigators and case managers to support decisionmaking in the best interest of children.~~; and~~

(e) The experiences and techniques of case managers and investigators, including shadowing an experienced child protective investigator and an experienced case manager for at least 8 hours.

(f) The recognition of and responses to head trauma and brain injury in a child under 6 years of age.

Section 6. Paragraph (f) of subsection (1) and subsection (3) of section 409.988, Florida Statutes, are 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 appropriate training and meet the minimum employment standards established by the department.

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Appropriate training shall include, but is not limited to, training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age.

(3) SERVICES.—A lead agency must provide dependent children with services that are supported by research or that are recognized as best practices in the child welfare field. The agency shall give priority to the use of services that are evidence-based and trauma-informed and may also provide other innovative services, including, but not limited to, family-centered and cognitive-behavioral interventions designed to mitigate out-of-home placements and intensive family reunification services that combine child welfare and mental health services for families with dependent children under 6 years of age.

Section 7. Subsection (24) is added to section 409.996, Florida Statutes, to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that services are delivered in accordance with applicable federal and state statutes and regulations.

(24) Subject to an appropriation, the department, in collaboration with the lead agencies serving the judicial circuits selected in paragraph (a), may create and implement a program to more effectively provide case management services for dependent children under 6 years of age.

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(a) The department may select up to three judicial circuits in which to develop and implement a program under this subsection. Priority shall be given to a circuit that has a high removal rate, significant budget deficit, significant case management turnover rate, and the highest numbers of children in out-of-home care or a significant increase in the number of children in out-of-home care over the last 3 fiscal years.

(b) The program shall:

1. Include caseloads for dependency case managers comprised solely of children who are under 6 years of age, except as provided in paragraph (c). The maximum caseload for a case manager shall be no more than 15 children if possible.

2. Include case managers who are trained specifically in:

a. Critical child development for children under 6 years of age.

b. Specific practices of child care for children under 6 years of age.

c. The scope of community resources available to children under 6 years of age.

d. Working with a parent or caregiver and assisting him or her in developing the skills necessary to care for the health, safety, and well-being of a child under 6 years of age.

(c) If a child being served through the program has a dependent sibling, the sibling may be assigned to the same case manager as the child being served through the program; however, each sibling counts toward the case manager's maximum caseload as provided under paragraph (b).

(d) The department shall evaluate the permanency, safety, and well-being of children being served through the program and

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submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, detailing its findings.

Section 8. Section 943.17297, Florida Statutes, is created to read:

943.17297 Training in the recognition of and responses to head trauma and brain injury.—Subject to an appropriation, the commission shall establish

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

And the title is amended as follows:

Delete lines 9 - 42

and insert:

officers relating to specified individuals, subject to an appropriation; providing how such information shall be provided to law enforcement officers; providing requirements for law enforcement officers and the central abuse hotline relating to specified interactions with certain persons and how to relay details of such interactions; amending s. 39.8296, F.S.; requiring that the guardian ad litem training program include training on the recognition of and responses to head trauma and brain injury in children younger than a specified age; amending s. 402.402, F.S.; requiring certain investigators, supervisors, and attorneys to complete training on the recognition of and responses to head trauma and brain injury in specified children; amending s. 409.988, F.S.; requiring lead agencies to provide certain individuals


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with training on the recognition of and responses to head trauma and brain injury in specified children; authorizing lead agencies to provide intensive family reunification services that combine child welfare and mental health services to certain families; amending s. 409.996, F.S.; requiring the department and certain lead agencies to create and implement a program to more effectively provide case management services to specified children, subject to an appropriation; providing criteria for selecting judicial circuits for participation the program; specifying requirements of the program; requiring the Department of Children and families to evaluate the effectiveness of the program and submit a report to the Legislature and Governor by a specified date; creating s. 943.17297, F.S.; requiring the Criminal Justice Standards and Training Commission to incorporate specified training for law enforcement officers, subject to an appropriation; requiring law enforcement officers, as of a

By the Committee on Children, Families, and Elder Affairs; and Senators Rouson, Berman, and Perry

586-03713-19 2019634c1

A bill to be entitled

An act relating to child welfare; providing a short title; amending s. 25.385, F.S.; requiring the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges for dependency cases; creating s. 39.0142, F.S.; requiring the Department of Law Enforcement to provide certain information to law enforcement officers relating to specified individuals; providing how such information shall be provided to law enforcement officers; providing requirements for law enforcement officers and the central abuse hotline relating to specified interactions with certain persons and how to relay details of such interactions; amending s. 39.8296, F.S.; requiring that the guardian ad litem training program include training on the recognition of and responses to head trauma and brain injury in children younger than a specified age; amending s. 402.402, F.S.; requiring certain investigators, supervisors, and attorneys to complete training on the recognition of and responses to head trauma and brain injury in specified children; amending s. 409.988, F.S.; requiring lead agencies to provide certain individuals with training on the recognition of and responses to head trauma and brain injury in specified children; authorizing lead agencies to provide intensive family reunification services that combine child welfare and mental health services to certain families; amending s. 409.996,

586-03713-19 2019634c1

F.S.; requiring the department and certain lead agencies to create and implement a program to more effectively provide case management services to specified children; providing criteria for selecting judicial circuits for participation the program; specifying requirements of the program; requiring the Department of Children and families to evaluate the effectiveness of the program and submit a report to the Legislature and Governor by a specified date; creating s. 943.17297, F.S.; requiring the Criminal Justice Standards and Training Commission to incorporate specified training for law enforcement officers; requiring law enforcement officers, as of a specified date, to successfully complete such training as part of basic recruit training or continuing training or education; providing an effective date.

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

Section 1. This act may be cited as "Jordan's Law."

Section 2. Section 25.385, Florida Statutes, is amended to read:

25.385 Standards for instruction of circuit and county court judges ~~in handling domestic violence cases~~.—

(1) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases, and the council shall provide such instruction on a periodic and timely basis.

~~(2)~~ As used in this subsection, ~~section:~~

~~(a)~~ the term "domestic violence" has the meaning set forth in s. 741.28.

~~(b) "Family or household member" has the meaning set forth in s. 741.28.~~

(2) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the recognition of and responses to head trauma and brain injury in a child under 6 years of age. The council shall provide such instruction on a periodic and timely basis.

Section 3. Section 39.0142, Florida Statutes, is created to read:

39.0142 Notifying law enforcement officers of parent or caregiver names.—The Department of Law Enforcement shall provide information to a law enforcement officer stating whether a person is a parent or caregiver who is currently the subject of a child protective investigation for alleged child abuse, abandonment, or neglect or is a parent or caregiver of a child who has been allowed to return to or remain in the home under judicial supervision after an adjudication of dependency. This information shall be provided via a Florida Crime Information Center query into the department's child protection database.

(1) If a law enforcement officer has an interaction with a parent or caregiver as described in this section and the interaction results in the officer having a concern about a child's health, safety, or well-being, the law enforcement officer shall report the relevant details of the interaction to the central abuse hotline immediately after the interaction even if the requirements of s. 39.201, relating to reporting of

knowledge or suspicion of abuse, abandonment, or neglect, are not met.

(2) The central abuse hotline shall provide any relevant information to:

(a) The child protective investigator, if the parent or caregiver is the subject of a child protective investigation; or

(b) The child's case manager and the attorney representing the department, if the parent or caregiver has a child under judicial supervision after an adjudication of dependency.

Section 4. Paragraph (b) of subsection (2) of section 39.8296, Florida Statutes, is amended to read:

39.8296 Statewide Guardian Ad Litem Office; legislative findings and intent; creation; appointment of executive director; duties of office.—

(2) STATEWIDE GUARDIAN AD LITEM OFFICE.—There is created a Statewide Guardian Ad Litem Office within the Justice Administrative Commission. The Justice Administrative Commission shall provide administrative support and service to the office to the extent requested by the executive director within the available resources of the commission. The Statewide Guardian Ad Litem Office shall not be subject to control, supervision, or direction by the Justice Administrative Commission in the performance of its duties, but the employees of the office shall be governed by the classification plan and salary and benefits plan approved by the Justice Administrative Commission.

(b) The Statewide Guardian Ad Litem Office shall, within available resources, have oversight responsibilities for and provide technical assistance to all guardian ad litem and attorney ad litem programs located within the judicial circuits.

1. The office shall identify the resources required to implement methods of collecting, reporting, and tracking reliable and consistent case data.

2. The office shall review the current guardian ad litem programs in Florida and other states.

3. The office, in consultation with local guardian ad litem offices, shall develop statewide performance measures and standards.

4. The office shall develop a guardian ad litem training program, which shall include, but not be limited to, training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age. The office shall establish a curriculum committee to develop the training program specified in this subparagraph. The curriculum committee shall include, but not be limited to, dependency judges, directors of circuit guardian ad litem programs, active certified guardians ad litem, a mental health professional who specializes in the treatment of children, a member of a child advocacy group, a representative of the Florida Coalition Against Domestic Violence, and a social worker experienced in working with victims and perpetrators of child abuse.

5. The office shall review the various methods of funding guardian ad litem programs, shall maximize the use of those funding sources to the extent possible, and shall review the kinds of services being provided by circuit guardian ad litem programs.

6. The office shall determine the feasibility or desirability of new concepts of organization, administration, financing, or service delivery designed to preserve the civil

and constitutional rights and fulfill other needs of dependent children.

7. In an effort to promote normalcy and establish trust between a court-appointed volunteer guardian ad litem and a child alleged to be abused, abandoned, or neglected under this chapter, a guardian ad litem may transport a child. However, a guardian ad litem volunteer may not be required or directed by the program or a court to transport a child.

8. The office shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court an interim report describing the progress of the office in meeting the goals as described in this section. The office shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court a proposed plan including alternatives for meeting the state's guardian ad litem and attorney ad litem needs. This plan may include recommendations for less than the entire state, may include a phase-in system, and shall include estimates of the cost of each of the alternatives. Each year the office shall provide a status report and provide further recommendations to address the need for guardian ad litem services and related issues.

Section 5. Subsections (2) and (4) of section 402.402, Florida Statutes, are amended to read:

402.402 Child protection and child welfare personnel; attorneys employed by the department.—

(2) SPECIALIZED TRAINING.—All child protective investigators and child protective investigation supervisors

employed by the department or a sheriff's office must complete the following specialized training:

(a) Training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age.

(b) Training that is either focused on serving a specific population, including, but not limited to, medically fragile children, sexually exploited children, children under 3 years of age, or families with a history of domestic violence, mental illness, or substance abuse, or focused on performing certain aspects of child protection practice, including, but not limited to, investigation techniques and analysis of family dynamics. The specialized training may be used to fulfill continuing education requirements under s. 402.40(3)(e). Individuals hired before July 1, 2014, shall complete the specialized training by June 30, 2016, and individuals hired on or after July 1, 2014, shall complete the specialized training within 2 years after hire. An individual may receive specialized training in multiple areas.

(4) ATTORNEYS EMPLOYED BY THE DEPARTMENT TO HANDLE CHILD WELFARE CASES.—Attorneys hired on or after July 1, 2014, whose primary responsibility is representing the department in child welfare cases shall, within the first 6 months of employment, receive training in all of the following:

(a) The dependency court process, including the attorney's role in preparing and reviewing documents prepared for dependency court for accuracy and completeness.~~;~~

(b) Preparing and presenting child welfare cases, including at least 1 week shadowing an experienced children's legal services attorney preparing and presenting cases.~~;~~

(c) Safety assessment, safety decisionmaking tools, and safety plans.~~;~~

(d) Developing information presented by investigators and case managers to support decisionmaking in the best interest of children.~~; and~~

(e) The experiences and techniques of case managers and investigators, including shadowing an experienced child protective investigator and an experienced case manager for at least 8 hours.

(f) The recognition of and responses to head trauma and brain injury in a child under 6 years of age.

Section 6. Paragraph (f) of subsection (1) and subsection (3) of section 409.988, Florida Statutes, are 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 appropriate training and meet the minimum employment standards established by the department. Appropriate training shall include, but is not limited to, training on the recognition of and responses to head trauma and brain injury in a child under 6 years of age.

(3) SERVICES.—A lead agency must provide dependent children with services that are supported by research or that are recognized as best practices in the child welfare field. The agency shall give priority to the use of services that are evidence-based and trauma-informed and may also provide other innovative services, including, but not limited to, family-centered and cognitive-behavioral interventions designed to mitigate out-of-home placements and intensive family

reunification services that combine child welfare and mental health services for families with dependent children under 6 years of age.

Section 7. Subsection (24) is added to section 409.996, Florida Statutes, to read:

409.996 Duties of the Department of Children and Families.—The department shall contract for the delivery, administration, or management of care for children in the child protection and child welfare system. In doing so, the department retains responsibility for the quality of contracted services and programs and shall ensure that services are delivered in accordance with applicable federal and state statutes and regulations.

(24) The department, in collaboration with the lead agencies serving the judicial circuits selected in paragraph (a), may create and implement a program to more effectively provide case management services for dependent children under 6 years of age.

(a) The department may select up to three judicial circuits in which to develop and implement a program under this subsection. Priority shall be given to a circuit that has a high removal rate, significant budget deficit, significant case management turnover rate, and the highest numbers of children in out-of-home care or a significant increase in the number of children in out-of-home care over the last 3 fiscal years.

(b) The program shall:

1. Include caseloads for dependency case managers comprised solely of children who are under 6 years of age, except as provided in paragraph (c). The maximum caseload for a case

manager shall be no more than 15 children if possible.

2. Include case managers who are trained specifically in:

a. Critical child development for children under 6 years of age.

b. Specific practices of child care for children under 6 years of age.

c. The scope of community resources available to children under 6 years of age.

d. Working with a parent or caregiver and assisting him or her in developing the skills necessary to care for the health, safety, and well-being of a child under 6 years of age.

(c) If a child being served through the program has a dependent sibling, the sibling may be assigned to the same case manager as the child being served through the program; however, each sibling counts toward the case manager's maximum caseload as provided under paragraph (b).

(d) The department shall evaluate the permanency, safety, and well-being of children being served through the program and submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, detailing its findings.

Section 8. Section 943.17297, Florida Statutes, is created to read:

943.17297 Training in the recognition of and responses to head trauma and brain injury.—The commission shall establish standards for the instruction of law enforcement officers in the subject of recognition of and responses to head trauma and brain injury in a child from under 6 years of age to aid an officer in the detection of head trauma and brain injury due to child

abuse. By July 1, 2021, each law enforcement officer must successfully complete the training as part of the basic recruit training for a law enforcement officer, as required under s. 943.13(9), or as a part of continuing training or education required under s. 943.135(1).

Section 9. This act shall take effect July 1, 2019.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: April 1, 2019

I respectfully request that **Senate Bill # 634**, relating to Child Welfare, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Darryl Rouson

Senator Darryl Rouson
Florida Senate, District 19

File signed original with committee office

2019 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	CS/SB 634
BILL TITLE:	**Child Welfare**
BILL SPONSOR:	Senator Rouson
EFFECTIVE DATE:	July 1, 2019

COMMITTEES OF REFERENCE
1) Children, Families and Seniors Subcommittee
2) Appropriations Committee
3) Health and Human Services Committee
4)
5)

CURRENT COMMITTEE
Appropriations Committee

SIMILAR BILLS	
BILL NUMBER:	CS/CS/HB 315
SPONSOR:	Representative Latvala

PREVIOUS LEGISLATION	
BILL NUMBER:	NA
SPONSOR:	NA
YEAR:	NA
LAST ACTION:	NA

IDENTICAL BILLS	
BILL NUMBER:	NA
SPONSOR:	NA

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	April 4, 2019 For further information, please contact John Paul Fiore at (850) 488-9410
LEAD AGENCY ANALYST:	John Harper, OCW
ADDITIONAL ANALYST(S):	Jessica Johnson, OCW Mary Ann White, OCW Pat Badland, OCW
LEGAL ANALYST:	Kelly McGrath, OGC
FISCAL ANALYST:	Sue Zwirz, Budget

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill requires the Florida Court Educational Council to establish certain standards for instruction of circuit and county court judges. The Florida Department of Law Enforcement (FDLE) is to provide information to a law enforcement officer stating whether a person or a parent or caregiver is involved in a child protective investigation or an open judicial supervision case. This information will be provided through the Florida Crime Information Center (FCIC) query into the Department of Children and Families (Department) child protection database. Law enforcement officers are required to call the central abuse hotline (Hotline) regarding all interactions between the law enforcement officer and a parent or caregiver when the interaction results in the officer having a concern about a child's health, safety, or well-being even if the requirements of knowledge or suspicion of abuse, abandonment, or neglect, are not met. Certain entities are required to provide training on recognition of and responses to head trauma and brain injury in specified children. The Department is permitted and in collaboration with the Community-Based Care Lead Agencies (CBCs) serving the judicial circuits that are selected to participate in a pilot to create and implement a program that more effectively provides case management services for dependent children under six years of age. Law enforcement officers are required to complete specified training for certification or continued employment.

2. SUBSTANTIVE BILL ANALYSIS

PRESENT SITUATION:

Section 2.
The Florida Court Educational Council is required to establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases.

Section 3.
Chapter 39, Florida Statutes (F.S.), does not currently require FDLE to provide information to a law enforcement officer stating whether a person is a parent or caregiver who is currently the subject of a child protective investigation for alleged child abuse, abandonment, or neglect or is a parent or caregiver of a dependent child who is receiving services. This information is not currently provided through FCIC.

Section 4.
Section 39.8296(2), F.S., requires the Statewide Guardian ad Litem Office to establish a curriculum committee to develop the training program for Guardians ad Litem.

Section 5.
Section 402.402(2), F.S., requires all child protective investigators and child protective investigation supervisors employed by the Department or a sheriff's office to complete specialized training within two years of being hired. The training either focuses on servicing a specific population or focuses on performing certain aspects of child protection practice. The specialized training may be used to fulfill continuing education requirements under s. 402.40(3)(e), F.S. In s. 402.402(4), F.S., Children Legal Services (CLS) attorneys are also required within the first six months of employment, to receive training but the training does not address head trauma and brain injury.

Section 6.
Section 409.988, F.S., outlines the duties and services that CBCs must meet. Section 409.988(1)(f), F.S., requires CBCs to ensure that all individuals providing care for dependent children to receive appropriate training. Section 409.988(3), F.S., requires the CBCs to provide dependent children with services that are supported by research or recognized as best practices in the child welfare field and must give priority to the use of services that are evidence-based and trauma-informed and may also provide other innovative services, including, but not limited to, family-centered and cognitive-behavioral interventions designed to mitigate out-of-home placements.

The Department currently contracts with CBCs to provide a comprehensive behavioral health care assessment for all children placed in out-of-home care. Additionally, child protective investigators determine the parent's need for a professional evaluation as one of five 'Conditions for Return' assessed at the time of the child's removal. Each respective CBC is responsible for developing, implementing, and evaluating the service array (e.g., safety management, treatment, preventative, and reunification services) available in their respective local systems of care. Since July 2016, the integration of child welfare and behavioral health has been a statewide initiative to improve outcomes for families with behavioral health conditions served by child welfare.

Section 7.

Section 409.996, F.S. addresses the Department's duties in contracting for the delivery, administration, or management of care for children in the child protection and child welfare system.

Section 8.
Section 943.1729, F.S., allows the Criminal Justice Standards and Training Commission to incorporate community policing concepts into the course curriculum required for law enforcement officers to obtain initial certification. Some of the training include basic skills training in juvenile sexual offender investigation, continued employment training related to juvenile sexual offender investigation and training in identifying and investigating elder abuse and neglect. The trainings do not include recognition and treatment of head trauma and brain injury.

EFFECT OF THE BILL:

Section 1.
Provides a short title for the act that is cited as "Jordan's Law."

Section 2.
This section amends s. 25.385, F.S., to require the Florida Court Educational Council to establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the recognition of and responses to head trauma and brain injury in a child under six years of age. The instruction must be provided on a periodic and timely basis.

Section 3.
This section creates s. 39.0142, F.S., requiring FDLE to provide information to a law enforcement officer stating whether a person is a parent or caregiver who is currently the subject of a child protective investigation for alleged child abuse, abandonment, or neglect or is a parent or caregiver of a dependent child who is receiving services. The information shall be provided via a FCIC query into the Department's child protection database known as the Florida Safe Families Network (FSFN). If a law enforcement officer has contact with the named parent or caregiver and the interaction results in the officer having a concern about the child's health, safety, or well-being, officer shall notify the Department immediately by calling the Hotline and providing a synopsis of the interaction even if the requirements of s. 39.201, F.S., relating to the knowledge or suspicion of abuse, abandonment, or neglect, are not met. The Hotline shall provide any relevant information to the:

- Child protective investigator; or
- The child's case manager and attorney representing the department.

Section 4.
This section amends s. 39.8296, F.S., requiring the Statewide Guardian ad Litem Office to expand its training to include recognition of and responses to head trauma and brain injury in a child under six years of age including at a minimum, the prevention, symptoms, risks, and treatment of head trauma or brain injuries.

Section 5.
This section amends s. 402.402, F.S., to include an additional training requirement for all child protective investigators, child protective investigator supervisors, and Children's Legal Services' (CLS) attorneys to receive specialized training that includes the recognition of and responses to head trauma and brain injury in children under six. CLS attorneys must receive this additional training within six months of employment.

Section 6.
This section amends s. 409.988(1)(f), F.S., to expand the duties of the CBCs to ensure that all individuals providing care for dependent children receive appropriate training that includes the training requirements under s. 402.402(2), F.S., on the recognition of and responses to head trauma and brain injury in a child under six years old.

Section 409.988(3), F.S., is amended to require the CBCs to provide intensive family reunification services that combine child welfare and mental health services for families with dependent children under six years of age. The Department supports the further development and use of intensive family reunification services that combine child welfare and mental health services for all families struggling with behavioral health issues, but particularly targeted toward those families with children under six years of age.

Section 7.
Section 409.996(24), F.S., permits the Department in collaboration with the lead agencies serving the judicial circuits that are selected to participate in a pilot to create and implement a program that more effectively provides case management services for dependent children under six years of age. If the pilot program is created, the bill permits the Department to select up to three judicial circuits to develop and implement the pilot programs with priority given to a circuit that has:

- A high removal rate;
- Significant budget deficit:
- Significant case management turnover rate; and
- The highest numbers of children in out-of-home care or a significant increase in the number of children in out-of-home care over the last three fiscal years.

The bill provides program requirements including caseloads of no more than 15 cases, if possible. Case manager caseloads must be limited to children under six years of age unless siblings are included in the same case. If siblings are included in the case, they should be included in the caseload count. Case managers are required to receive training regarding child development, specific practices of child care, available community resources, engagement of parents in the development of skills necessary to care for the health, safety and well-being of a child under six years of age. Lastly, if the program is created, the Department is required to evaluate the permanency, safety, and well-being of children served through the program and to submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives by October 1, 2024.

Section 8.
This section creates s. 943.17297, F.S., to require the Criminal Justice Standards and Training Commission to establish the basic skills training in the recognition and treatment of head trauma and brain injury as outlined in s. 39.0143, F.S. This instruction for law enforcement officers is to aid the officer in the detection of head trauma and brain injury due to child abuse. By July1, 2021, each law enforcement officer must successfully complete the training as part of the basic recruit training required for a law enforcement officer to obtain initial certification as required under s. 943.13(9), F.S., or as a part of continuing training or education required under s. 943.135(1), F.S.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? NO

If yes, explain:	NA
What is the expected impact to the agency's core mission?	NA
Rule(s) impacted (provide references to F.A.C., etc.):	Chapters 65C-28, 65C-29 and 65C-30, F.A.C., will need to be amended to provide guidance to child welfare professionals on implementing the requirements of the bill once enacted.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown at this time.
Provide a summary of the proponents' and opponents' positions:	NA

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? YES

If yes, provide a description:	Should a program be created, the Department shall evaluate the permanency, safety, and well-being of children being served through the program.
Date Due:	October 1, 2024
Bill Section Number(s):	Section 7., s. 409.996(24), F.S.

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL? NO

Board:	NA

Board Purpose:	NA
Who Appoints:	NA
Appointee Term:	NA
Changes:	NA
Bill Section Number(s):	NA

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	None
Expenditures:	None
Does the legislation increase local taxes or fees?	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	NA

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	None
Expenditures:	**Training** - $35,000 It will cost an estimated $35,000 to develop a training on the recognition of and response to head trauma and brain injury in a child under six years of age. This will include the cost of research, a front-end analysis to further define scope, subject matter experts, and the design and development of materials. This cost was estimated based on meeting the minimum requirements outlined in the bill and the costs of other trainings that have been developed with similar length and scope. This topic is conducive to online learning and does not include classroom-based materials and trainer time. For existing CPIs and CPI supervisors this training can be used toward meeting their ongoing in-service requirements. For future staff, including CLS attorneys, this training can be included in the pre-service curriculum. Based on this consideration, it is estimated there will be no additional costs related to staff salaries or benefits. **Hotline - Total cost for Hotline = $1,205,818.66** Law enforcement is required to report all interactions between a law enforcement officer and a parent or caregiver that results in the officer having a concern about child's health, safety, or well-being, the law enforcement officer shall report the relevant details to the Hotline immediately after the interaction even if the requirements of s. 39.201, F.S., relating to reporting of knowledge or suspicion of abuse, abandonment, or neglect, are not met. The Hotline staff is required to provide any relevant information to a child protective investigator or a case manager and the attorney representing the Department.

37,000 individuals at any given time are on active judicial supervision with the Department. This is an underestimate because there could be more than two perpetrators identified in a household or the case. It also does not take into consideration that additional calls regarding child protective investigations could also be coming in.

210 calls monthly or 2,500 annually is the average number of assessments per counselor.

An additional 37,000 assessments called into the Hotline require 15 counselors (37,000 divided by 2,500 = 14.8) and 2 supervisors (15 divided by 7 = 2.1).

(Note: due to rounding issues the calculations will not be exact. See attached spreadsheet)

Abuse Registry Counselors salary and benefits = $ 52,651.86 x 15 = $ 789,777.90

Base salary - $ 34,218.67 and Total benefits - $ 18,433.19

Total Expense = $156,330 x 15 = 242,280.00

Travel = $5,730 x 15 = $85,950

Recurring expense = $5,993 x 15 = $89,895

Nonrecurring expense = $4,429 x 15 = $66,435

Human Resources = $329 x 15 = $4,935

Total Need for FY 2019-2020 = $ 1,036,992.90

Total Recurring Need = $ 970,557901

Total Nonrecurring Need = $ 66,435.00

Abuse Registry Counselor Supervisor salary and benefits = $67,681.88 x 2 = $135,363.76

Base Salary - $46,177.16 and Total benefits - $21,504.72

Total Expense = $16,152 x 2 = $32,304

Travel = $5,730 per supervisor x 2 = $11,460

Recurring expense = $5,993 x 2 = $11,986

Nonrecurring expense = $4,429 x 2 = $8,858

Human Resources - $329 x 2 = $658

Total Need for FY 2019-20 = 168,325.76

Total Recurring Need = $159,467.76

Total Nonrecurring Need = $8,858

This bill could also impact the Crime Intelligence Unit by requiring additional criminal records checks, but that is indeterminate at this time.

Case Management Pilot – Indeterminate

Section 409.988(24), F.S., permits the Department in collaboration with the Community-based Care Lead agencies serving the judicial circuits that are selected to participate in a pilot to create and implement a program that more effectively provide case management services for dependent children under six years of age. If the program is created, the bill requires the Department to select up to three judicial circuits to develop and implement the pilot programs.

The bill provides program requirements including caseloads of no more than 15 cases, if possible, mandatory case management training regarding children under six years of age, and siblings to be included in the program and in the caseload count. These requirements regarding caseloads, inclusion of siblings

	and mandatory training may add a fiscal impact that the Department would be expected to pay the CBCs that choose to participate in the pilot program, but the projected cost is indeterminate at this time.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	NA

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	None
Expenditures:	If the training for the recognition and treatment of head trauma and brain injury is conducted using an on-line format, no additional funds will be needed to develop or provide this training. This includes additional costs related to staff salaries and benefits. For existing certified child welfare community-based care staff and contractors, this training can be used toward meeting the ongoing in-service training requirements to maintain certification. For future staff this training can be included in the pre-service training curriculum. **Case Management Pilot** – as explained in the Impact to State Government section the projected cost of the pilot is indeterminate, but the pilot may have a cost as it requires additional case managers to ensure caseloads of no more than 15 cases per case manager, additional required training, and the inclusion of siblings in the pilot.
Other:	NA

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	No
Does the bill decrease taxes, fees or fines?	No
What is the impact of the increase or decrease?	NA
Bill Section Number:	NA

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	The bill requires law enforcement to be notified of the identities of all parents, caregivers, and alleged perpetrators in child abuse investigations and in active judicial supervision cases through an inquiry from FCIC to FSFN.
If yes, describe the anticipated impact to the agency including any fiscal impact.	The estimated IT target cost is between $160,000-$270,000. The below assumptions have been used to project the costs. Assumptions: 1. Implement a brand new single Restful web service with expected sub-second response/performance

	2. Receive a set of search criteria from FDLE, most likely the information available to FDLE from a Driver's License search that is already performed (ie; First Name, Last Name, Date of Birth, Sex, Race) 3. Perform a search against FSFN Investigation and Case Data 4. Return a set of search results to be determined during design 5. Write an audit record of the search request and response 6. No Reporting considerations 7. No Training considerations 8. No updates made to FSFN 9. No automated alerts to case manager or CPI 10. Project will require a contract amendment with IBM and Federal/ACF approval prior to start 11. Does not include any FDLE costs to invoke the web service, send the search criteria, and receive the results

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	No
If yes, describe the anticipated impact including any fiscal impact.	NA

ADDITIONAL COMMENTS

Section 25.385(2), F.S., requires the Florida Court Educational Council to establish standards for instruction of circuit and county court judges who have responsibility for dependency cases regarding the recognition of and response to head trauma and brain injury. Magistrates often hear dependency cases. It is unclear as to whether there is an equal expectation that magistrates also be included in this training.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	None

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

634
Bill Number (if applicable)

Topic ~~[illegible]~~

Amendment Barcode (if applicable)

Name JERRY PAUL

Job Title

Address
Street

Phone 850-386-5267

City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing SARASOTA/MANATEE/DESOTO YMCA

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	SB 748
INTRODUCER:	Senator Harrell
SUBJECT:	Florida Veterans' Hall of Fame
DATE:	April 15, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Caldwell	MS	**Favorable**
2.	Gerbrandt	Kidd	AHS	**Recommend: Favorable**
3.			AP	

I. Summary:

SB 748 removes the current prohibition on the use of state funds for the:

- Administration of the Florida Veterans' Hall of Fame (Hall of Fame); and
- Travel expenses incurred by members of the Florida Veterans' Hall of Fame Council (Council).

The Hall of Fame is displayed at the Capitol and contains plaques honoring military veterans who have been inducted for making a significant contribution to the state.

The bill has an indeterminate fiscal impact on state expenditures.

The bill takes effect July 1, 2019.

II. Present Situation:

The 2011 Legislature established the Florida Veterans' Hall of Fame (Hall of Fame) to recognize and honor military veterans who have made a significant contribution to the state during or after military service.[1] The Department of Management Services located the Hall of Fame on the Plaza Level of the Capitol Building, along the northeast front wall, in consultation with the Florida Department of Veterans' Affairs (FDVA) on design and theme.[2]

The Hall of Fame is administered by the Florida Department of Veterans' Affairs (FDVA).[3] Within the FDVA, the Florida Veterans' Hall of Fame Council (Council) operates as an advisory council for the Hall of Fame.[4] The Council is composed by seven members, four of whom are

[1] Chapter 2011-168 L.O.F.; Section 265.003(1), F.S.
[2] Section 265.003(2)(b), F.S.
[3] Section 265.003(2)(a), F.S.
[4] Section 265.003(3)(a), F.S.

members of a congressionally chartered veterans service organization. The Council is staffed with one member each, selected by the Governor, President of the Senate, Speaker of the House of Representatives, Attorney General, Chief Financial Officer, Commissioner of Agriculture, and the Executive Director of the FDVA.[5] A veteran who has received other than an honorable discharge from military service is disqualified from serving on the Council.

The process for the selection of inductees to the Hall of Fame is as follows. First, the Council annually accepts nominations for persons to be considered as inductees. Among the names received, the Council provides a list of up to 20 nominees to the FDVA for submission to the Governor and Cabinet. The Governor and Cabinet then make the final selection.[6]

The Council is authorized to establish a formal induction ceremony to coincide with Veterans' Day.[7]

Council members serve uncompensated, although members may be reimbursed for incurred travel expenses. However, s. 265.003, F.S., prohibits state funds being used for both the administration of the Hall of Fame and for travel expenses incurred by members of the Council.[8]

The Department of Veterans' Affairs states that the activities of the Florida Hall of Fame are currently supported with funding from the Florida Veterans Foundation and private donations.[9]

III. Effect of Proposed Changes:

The bill removes the current prohibition on the use of state funds for the administration of the Florida Veterans' Hall of Fame.

The bill also removes the current prohibition on the use of state funds for travel expenses of members of the Florida Veterans' Hall of Fame Council.

The bill takes effect July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The mandate restrictions do not apply because the bill does not require counties and municipalities to spend funds, reduce the counties' or municipalities' ability to raise revenue, or reduce the percentage of state tax shared with counties and municipalities.

B. Public Records/Open Meetings Issues:

None.

[5] Section 265.003(3)(a), F.S.
[6] Section 265.003(4)(a), F.S.
[7] Section 265.003(5), F.S.
[8] Section 265.003(2)(a) and (3)(c), F.S.
[9] Department of Veterans' Affairs, *2019 Agency Legislative Bill Analysis, SB 748* (Aug. 22, 2018)(on file with the Senate Committee on Military and Veterans Affairs and Space).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to the FDVA, SB 748 will allow the FDVA to fund the administration of the Hall of Fame and reimburse council members for travel.[10] The extent of funding required is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill substantially amends section 265.003, Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

[10] *Supra* note 9.

B. Amendments:

None.

By Senator Harrell

25-01625-19 2019748__

A bill to be entitled

An act relating to the Florida Veterans' Hall of Fame; amending s. 265.003, F.S.; removing limitations regarding the use of state funds for the administration of the hall of fame and for the reimbursement of travel expenses for members of the Florida Veterans' Hall of Fame Council; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) and paragraph (c) of subsection (3) of section 265.003, Florida Statutes, are amended to read:

265.003 Florida Veterans' Hall of Fame.—

(2) There is established the Florida Veterans' Hall of Fame.

(a) The Florida Veterans' Hall of Fame is administered by the Florida Department of Veterans' Affairs ~~without appropriation of state funds~~.

(3)

(c) Members of the council may not receive compensation or honorarium for their services. Members may be reimbursed for travel expenses incurred in the performance of their duties, as provided in s. 112.061~~; however, no state funds may be used for this purpose~~.

Section 2. This act shall take effect July 1, 2019.

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

THE FLORIDA SENATE

APPEARANCE RECORD

4/16/2019
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

748
Bill Number (if applicable)

Topic FL Veterans' Hall of Fame

Amendment Barcode (if applicable)

Name Jessica Hunter

Job Title Deputy Legislative & Cabinet Affairs Director

Address The Capitol, Suite 2105
Street
Tallahassee FL 32399
City *State* *Zip*

Phone (850) 487-1533

Email hunterj@fdva.state.fl.us

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Florida Dept. of Veterans' Affairs

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 884
INTRODUCER:	Health Policy Committee and Senator Baxley
SUBJECT:	Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors
DATE:	April 15, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.	Loe	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 884 requires the Department of Health (DOH) to certify an individual who has applied to the DOH and meets the requirements for designation as a certified master social worker to practice generalist social work in Florida.

The bill has no impact on state revenues or expenditures.

The bill takes effect July 1, 2019.

II. Present Situation:

Regulation of Certified Master Social Workers

The DOH is authorized[1] to certify an applicant for designation as a certified master social worker if the applicant:

- Submits an application and nonrefundable fee to the DOH at least 60 days before the examination to qualify to take the exam;
- Submits an official transcript that the applicant has received:
  - A doctoral degree in social work, or

[1] Section 491.0145, Florida Statutes.

  - A master's degree in social work with an emphasis on clinical practice or administration in seven content areas;[2]
- Submits proof of at least three years' experience in clinical services or administrative experience; and
- Has passed the national Advanced Generalist level examination developed by the Association of Social Work Boards.[3]

Any person who holds a master's degree in social work from institutions outside the United States may apply to the DOH for certification if the academic training in social work has been evaluated as equivalent to a degree from a school accredited by the Council on Social Work Education. The applicant must submit to the DOH a copy of the academic training from the Foreign Equivalency Determination Service of the Council on Social Work Education.

A certified master social worker is not licensed or authorized to provide clinical social work services.[4]

Display of Licenses and Use of Professional Titles

An individual licensed in Florida as aclinical social worker, marriage and family therapist, or mental health counselor or certified as a master social worker is required to display their licenses at each practice location.[5] The aforementioned licensees must display their name and respective professional title on all promotional materials, cards, brochures, stationery, advertisements, and signs that name the licensee.

A registered intern or provisional licensee in clinical social work, marriage and family therapy, or mental health counseling must display his or her valid registration or provisional license at each location where the intern is completing experience requirements or a provisional licensee is practicing, and each must also include the term "intern" or "provisional licensee" on all promotional materials, cards, brochures, stationery, advertisements, and signs that name the intern or provisional licensee.

III. Effect of Proposed Changes:

Section 1 amends s. 491.003, F.S., to define the terms "certified master social worker" and the "practice of generalist social work." A "certified master social worker" is a person licensed under ch. 491, F.S., to practice generalist social work. "General social work" is the application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, or communities. The term includes the application of specialized knowledge and advanced practice skills in non-diagnostic assessment, treatment planning,

[2] *See* s. 491.0145(2), F.S. The seven content areas include agency administration and supervision, program planning and evaluation, staff development, research, community organization, community services, social planning, and human service advocacy.
[3]The Department of Health, Board of Clinical Social work, Marriage & Family Therapy and Mental health Counseling, *Certified Master Social Worker*, available at https://floridasmentalhealthprofessions.gov/licensing/certified-master-social-worker/ (last visited Mar.20, 2019).
[4] Section 491.0145(6), F.S.
[5] Section 491.0149, Florida Statutes.

implementation and evaluation, case management, information and referral, supervision, consultation, education, research, advocacy, community organization, and the development, implementation, and administration of policies, programs, and activities.

Section 2 amends s. 491.004, F.S., to remove obsolete language relating to the initial appointment of members by the Governor to the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

Section 3 amends s. 491.0145, F.S., to require, rather than authorize, the DOH to certify an applicant for designation as a certified master social worker who meets application, financial, education, experience, and examination requirements. The bill grants rulemaking authority to the DOH for the regulation of certified master social workers, and makes other technical and conforming changes.

Section 4 amends s. 491.0149, F.S., to add social media to the list of promotional materials required to include the professional title of all licensees and certificate holders, interns, and provisional licensees in the professions of social work, marriage and family therapy, and mental health counseling. The bill also requires a generalist social worker to include the words "certified master social worker" or the letters "CMSW" on all promotional materials that name the licensee.

Section 5 provides that the bill takes effect July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 491.003, 491.004, 491.0145, and 491.0149.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on April 1, 2019:
The CS:

- Defines the terms "certified master social worker" and the "practice of generalist social work;"
- Requires the DOH to certify an applicant as a certified master social worker who meets certain requirements;
- Authorizes the DOH to adopt rules for the regulation of the certified master social workers;
- Requires the use of professional titles by licensees and certificate holders, provisional licensees, and intern registrants on social media; and
- Deletes obsolete language and makes technical and conforming changes.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Baxley

588-03692A-19 2019884c1

A bill to be entitled

An act relating to clinical social workers, marriage and family therapists, and mental health counselors; amending s. 491.003, F.S.; defining the terms "certified master social worker" and "practice of generalist social work"; amending s. 491.004, F.S.; deleting an obsolete provision; amending s. 491.0145, F.S.; requiring the Department of Health to certify an applicant for designation as a certified master social worker under certain circumstances; providing that applicants for designation as a certified master social worker submit their application to the department; deleting a provision relating to an application requirement; authorizing the department to adopt rules; amending s. 491.0149, F.S.; requiring the use of applicable professional titles by licensees, certificate holders, provisional licensees, and registrants on social media and other specified materials; providing an effective date.

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

Section 1. Present subsections (2) through (7) of section 491.003, Florida Statutes, are redesignated as subsections (3) through (8), respectively, present subsections (8) through (17) are redesignated as subsections (10) through (19), respectively, and new subsections (2) and (9) are added to that section, to read:

491.003 Definitions.—As used in this chapter:

588-03692A-19 2019884c1

(2) "Certified master social worker" means a person certified by the department under this chapter to practice generalist social work.

(9) The term "practice of generalist social work" means the application of social work theory, knowledge, and methods and ethics to and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, or communities. The term includes the application of specialized knowledge and advanced practice skills to nondiagnostic assessment, treatment planning, implementation and evaluation, case management, information and referral, supervision, consultation, education, research, advocacy, community organization and the development, implementation, and administration of policies, programs, and activities.

Section 2. Present subsections (4) through (7) of section 491.004, Florida Statutes, are redesignated as subsections (3) through (6), respectively, and present subsection (3) is amended, to read:

491.004 Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.—

~~(3) No later than January 1, 1988, the Governor shall appoint nine members of the board as follows:~~

~~(a) Three members for terms of 2 years each.~~

~~(b) Three members for terms of 3 years each.~~

~~(c) Three members for terms of 4 years each.~~

Section 3. Section 491.0145, Florida Statutes, is amended to read:

491.0145 Certified master social worker.—The department

shall ~~may~~ certify an applicant for a designation as a certified master social worker who, upon applying to the department and remitting the appropriate fee, demonstrates to the department that he or she has met all of the following conditions:

(1) The applicant has submitted ~~The applicant completes~~ an application and has paid ~~to be provided by the department and pays~~ a nonrefundable fee not to exceed $250 to be established by rule of the department. ~~The completed application must be received by the department at least 60 days before the date of the examination in order for the applicant to qualify to take the scheduled exam.~~

(2) The applicant submits proof satisfactory to the department that the applicant has received a doctoral degree in social work, or a master's degree in social work with a major emphasis or specialty in ~~clinical practice or administration, including, but not limited to, agency~~ administration and supervision, program planning and evaluation, staff development, research, community organization, community services, social planning, or ~~and~~ human service advocacy. Doctoral degrees must have been received from a graduate school of social work which at the time the applicant was enrolled and graduated was accredited by an accrediting agency approved by the United States Department of Education. Master's degrees must have been received from a graduate school of social work which at the time the applicant was enrolled and graduated was accredited by the Council on Social Work Education or the Canadian Association of Schools for ~~of~~ Social Work Education or by one that meets comparable standards.

(3) The applicant has had at least 2 ~~3~~ years' experience,

as defined by rule, including, but not limited to, clinical services or administrative activities as defined in subsection (2), 2 years of which must be at the post-master's level under the supervision of a person who meets the education and experience requirements for certification as a certified master social worker, as defined by rule, or licensure as a clinical social worker under this chapter. A doctoral internship may be applied toward the supervision requirement.

(4) Any person who holds a master's degree in social work from institutions outside the United States may apply to the department for certification if the academic training in social work has been evaluated as equivalent to a degree from a school accredited by the Council on Social Work Education. Any such person shall submit a copy of the academic training from the Foreign Equivalency Determination Service of the Council on Social Work Education.

(5) The applicant has passed an examination required by the department for this purpose. ~~The nonrefundable fee for such examination may not exceed $250 as set by department rule.~~

(6) ~~Nothing in~~ This chapter does not ~~shall be construed to~~ authorize a certified master social worker to provide clinical social work services.

(7) The department may adopt rules to implement this section.

Section 4. Section 491.0149, Florida Statutes, is amended to read:

491.0149 Display of license; use of professional title on promotional materials.—

(1)(a) A person licensed under this chapter as a clinical

social worker, marriage and family therapist, or mental health counselor, or certified as a master social worker shall conspicuously display the valid license or certificate issued by the department or a true copy thereof at each location at which the licensee practices his or her profession.

(b)1. A licensed clinical social worker shall include the words "licensed clinical social worker" or the letters "LCSW" on all promotional materials, including cards, brochures, stationery, advertisements, social media, and signs, naming the licensee.

2. A licensed marriage and family therapist shall include the words "licensed marriage and family therapist" or the letters "LMFT" on all promotional materials, including cards, brochures, stationery, advertisements, social media, and signs, naming the licensee.

3. A licensed mental health counselor shall include the words "licensed mental health counselor" or the letters "LMHC" on all promotional materials, including cards, brochures, stationery, advertisements, social media, and signs, naming the licensee.

(c) A generalist social worker shall include the words "certified master social worker" or the letters "CMSW" on all promotional materials, including cards, brochures, stationery, advertisements, social media, and signs, naming the licensee.

(2)(a) A person registered under this chapter as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern shall conspicuously display the valid registration issued by the department or a true copy thereof at each location at which the registered intern is

completing the experience requirements.

(b) A registered clinical social worker intern shall include the words "registered clinical social worker intern," a registered marriage and family therapist intern shall include the words "registered marriage and family therapist intern," and a registered mental health counselor intern shall include the words "registered mental health counselor intern" on all promotional materials, including cards, brochures, stationery, advertisements, social media, and signs, naming the registered intern.

(3)(a) A person provisionally licensed under this chapter as a provisional clinical social worker licensee, provisional marriage and family therapist licensee, or provisional mental health counselor licensee shall conspicuously display the valid provisional license issued by the department or a true copy thereof at each location at which the provisional licensee is providing services.

(b) A provisional clinical social worker licensee shall include the words "provisional clinical social worker licensee," a provisional marriage and family therapist licensee shall include the words "provisional marriage and family therapist licensee," and a provisional mental health counselor licensee shall include the words "provisional mental health counselor licensee" on all promotional materials, including cards, brochures, stationery, advertisements, social media, and signs, naming the provisional licensee.

Section 5. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

COMMITTEES:
Ethics and Elections, *Chair*
Appropriations Subcommittee on Education
Education
Finance and Tax
Health Policy
Judiciary

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR DENNIS BAXLEY
12th District

April 1, 2019

The Honorable Chair Aaron Bean
405 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32309

Dear Chairman Bean,

I would like to request that SB 884 Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors be heard in the next Health Policy Committee meeting.

This bill deals with licensure revisions for Clinical social workers, marriage and family therapists and mental health counselors. It revises intern registration requirements, revises the licensure requirements for clinical social workers, marriage and family therapists and mental health counselors.

I appreciate your favorable consideration.

Onward & Upward,

Senator Dennis Baxley
Senate District 12

DKB/dd

cc: Tonya Kidd, Staff Director

320 Senate Office Building, 404 South Monroe St, Tallahassee, Florida 32399-1100 ● (850) 487-5012
Email: baxley.dennis@flsenate.gov

Bill Galvano
President of the Senate

David Simmons
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

884
Bill Number (if applicable)

Topic Clinical Social Work, Marriage and Family.

Amendment Barcode (if applicable)

Name Corinne Mixon

Job Title Lobbyist

Address 511 N. Adams St
Street

Phone 850 766 5795

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Mental Health Counselors Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-16-19
Meeting Date

884
Bill Number (if applicable)

Topic Social Work Licensure

Amendment Barcode (if applicable)

Name Jim Akin

Job Title Executive Director

Address 1931 Dellwood Dr
Street

Tallahassee FL 32303
City *State* *Zip*

Phone 850-224-2400

Email JAkin.naswfl@socialworkers.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing National Assn. of Social Workers - Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/CS/SB 1192 (805720)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Bean
SUBJECT:	Electronic Prescribing
DATE:	April 16, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.	Loe	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1192 requires a prescription that is electronically generated and transmitted to contain an electronic signature from the prescribing practitioner, and requires such practitioner to, under specified conditions except in certain circumstances, exclusively transmit prescriptions electronically for medicinal drugs upon license renewal or by July 1, 2021, whichever is earlier.

The bill has no impact on state revenues or state expenditures.

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

II. Present Situation:

Federal Regulation on Electronic Prescribing

The federal Drug Enforcement Administration (DEA) implements the Comprehensive Drug Abuse Prevention and Control Act of 1970, often referred to as the Controlled Substances Act (CSA).[1] The DEA publishes the implementing regulations for these statutes in Title 21 of the Code of Federal Regulations, Parts 1300 to 1399. These regulations are designed to ensure an adequate supply of controlled substances for legitimate medical, scientific, research, and

[1] 21 U.S.C. 801–971.

industrial purposes, and to deter the diversion of controlled substances to illegal purposes. The CSA mandates that the DEA establish a closed system of control for manufacturing, distributing, and dispensing controlled substances. Any person who manufactures, distributes, dispenses, imports, exports, or conducts research or chemical analysis with controlled substances must register with the DEA, unless exempt, and must comply with the applicable requirements for the activity.[2]

The Controlled Substances Act (CSA) and Current Regulations

The DEA's regulations were originally adopted at a time when most transactions and prescriptions were done on paper. The CSA provides that a controlled substance in Schedule II may only be dispensed by a pharmacy pursuant to a "written prescription," except in emergency situations.[3] By contrast, for controlled substances in Schedules III and IV, the CSA provides that a pharmacy may dispense pursuant to a "written or oral prescription."[4]

Where an oral prescription is permitted by the CSA, the DEA regulations further provide that a practitioner may transmit to the pharmacy a facsimile of a written, manually signed prescription in lieu of an oral prescription.[5]

For a prescription of a controlled substance to be valid, it must be issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice.[6] The DEA regulations state, "[t]he responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription."[7] The prescription provides a record of the actual dispensing of the controlled substance to the patient and, therefore, is critical to documenting that controlled substances held by a pharmacy have been dispensed legally. The maintenance by pharmacies of complete and accurate prescription records is an essential part of the overall CSA regulatory scheme established by Congress.

The CSA is unique among criminal laws in that it stipulates acts pertaining to controlled substances that are permissible. If the CSA does not explicitly permit an action pertaining to a controlled substance, then, by its lack of explicit permissibility, the action is prohibited. Violations of the CSA can be civil or criminal, which may result in administrative, civil, or criminal proceedings. Remedies under the CSA can range from modification to revocation of DEA registration, monetary penalties, or imprisonment, depending on the nature, scope, and extent of the violation.[8]

Prior to 2010, a major obstacle to electronic prescribing (e-prescribing) was a prohibition by the DEA on e-prescribing controlled substances. However, in 2010, the DEA adopted a rule that

[2] Federal Register, Part II, Department of Justice, Drug Enforcement Administration, 21 C.F.R. Parts 1300, 1304, 1306, and 1311, *Electronic Prescribing of Controlled Substances;* Final Rule (March 31, 2010) *available at* https://www.govinfo.gov/content/pkg/FR-2010-03-31/pdf/2010-6687.pdf p. 16237 (last visited April 8, 2019).
[3] 21 U.S.C. 829(a).
[4] 21 U.S.C. 829(b).
[5] 21 C.F.R. 1306.21(a).
[6] United States v. Moore, 423 U.S. 122 (1975); 21 C.F.R. 1306.04(a).
[7] 21 C.F.R. 1306.04(a).
[8] 21 U.S.C. 841 - 844.

allowed providers to write electronic prescriptions for controlled substances and permitted pharmacies to receive, dispense, and archive these electronic prescriptions.[9] To e-prescribe controlled substances, a health care practitioner must:

- Purchase or use DEA-compliant software that supports e-prescribing;
- Complete the identity-proofing process to acquire a two-factor authentication credential or digital certificate;
- Attach the authentication credential to his or her identity;
- Set access controls so that only individuals who may legally prescribe a controlled substance are allowed to do so; and
- Access the e-prescribing or electronic health record platform.[10]

Medicare E-Prescribing

In 2018, Congress mandated e-prescribing for controlled substances under the Medicare Part D program by January 1, 2021, as a part of a comprehensive bill to address the opioid crisis.[11] The Secretary of the federal Department of Health and Human Services may waive the requirements for a Medicare Part D covered schedule II, III, IV, and V controlled substance to be electronically transmitted in the case of a prescription issued:

- When the practitioner and dispensing pharmacy are the same entity;
- Cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs' Stanford Computerized Researcher Information Profile Technique (SCRIPT) Standard;
- By a practitioner who received a waiver or a renewal for a period of time, not to exceed one year, from the requirement to use electronic prescribing due to economic hardship, technological limitations outside the control of the practitioner, or other exceptional circumstances;
- By a practitioner under circumstances in which it would be impractical for the individual to obtain the substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the individual's medical condition;
- By a practitioner prescribing a drug under a research protocol;
- By a practitioner for a drug for which the FDA requires a prescription to contain elements that are not able to be included in e-prescribing, such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;

---

[9] U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, *Electronic Prescriptions for Controlled Substance (EPCS)*, available at https://www.deadiversion.usdoj.gov/ecomm/e_rx/ (last visited April 10, 2019). *See also* 21 C.F.R. 1306.08, *available at* https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_08.htm (last visited April 10, 2019), and 21 C.F.R. Part 1311, *Requirements for Electronic Orders and Prescriptions*, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=2ccf6f9b1e97a3431d79157294d163da&mc=true&r=PART&n=pt21.9.1311 (last visited April 10, 2019).

[10] *Id*. *See also*, DrFirst, *EPCS: Getting Started with Electronic Prescribing of Controlled Substances*, available at http://www.drfirst.com/wp-content/uploads/EPCS_Infographic_from_DrFirst-1.png (last visited April 3, 2019).

[11] Substance Use-Disorder Prevention that Promotes Opioid Recovery Treatment (SUPPORT) for Patients and Communities Act, Pub. Law No. 115-271 s. 2003 (2018). *See also* U.S. House of Representatives, Energy and Commerce Committee, *HR 6: SUPPORT for Patients and Communities Act*, available at https://www.congress.gov/bill/115th-congress/house-bill/6/text#toc-H7820B15EE005461C9DA95E7E747412DD (last visited April 3, 2019).

- By a practitioner for an individual receiving hospice care that is not covered under the hospice Medicare benefit or a resident of a nursing facility dually eligible for Medicaid and Medicare.[12]

Overview of State E-Prescribing Laws

Florida Law

Prescriptions that are electronically generated and transmitted must contain the name of the prescriber; the name, strength, quantity, and directions for use of the prescribed medicinal drug; and the date the prescription was issued.[13] The prescription must be dated and signed by the prescribing practitioner on the same day the prescription was issued, and the practitioner's signature may be in an electronic format.[14]

E-prescribing software may not interfere with a patient's choice of pharmacy or use any means, such as pop-up ads, advertising, or instant messaging to influence or attempt to influence the prescribing decision of the prescriber at the point of care.[15] E-prescribing software may provide formulary information, as long as nothing makes it more difficult or precludes a prescriber from selecting a specific pharmacy or drug.[16]

E-prescribing is done by health care practitioners through the use of electronic devices such as a computer, tablets, or phones that are equipped with software to securely enter and transmit prescriptions to pharmacies using a special software program and connectivity to a transmission network.[17]

In 2007, the Legislature created s. 408.0611, F.S., to promote the implementation of e-prescribing[18] by health care practitioners, health care facilities, and pharmacies in order to prevent prescription drug abuse, improve patient safety, and reduce unnecessary prescriptions. To that end, the Legislature created a clearinghouse in the Agency for Health Care Administration (ACHA) to provide information on e-prescribing to:

- Convey the process and advantages of e-prescribing;
- Provide information regarding the availability of e-prescribing products, including no-cost or low-cost products; and
- Regularly convene stakeholders to assess and accelerate the implementation of e-prescribing.[19]

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[12] 42 U.S.C. s. 1395W-104,(e)(7)(B), Beneficiary Protections for Qualified Prescription Drug Coverage, *available at* https://www.law.cornell.edu/uscode/text/42/1395w-104, p. 24 (last visited April 8, 2019).
[13] Section 456.42(1), F.S.
[14] *Id.*
[15] Section 456.43, F.S.
[16] *Id.*
[17] The Office of the National Coordinator for Health Information Technology, *What is Electronic Prescribing?* (September 22, 2017) *available at* https://www.healthit.gov/faq/what-electronic-prescribing (last visited April 3, 2019).
[18] Section 408.0611(2)(a), F.S. The term "electronic prescribing" means, at a minimum, the electronic review of the patient's medication history, the electronic generation of the patient's prescription, and the electronic transmission of the patient's prescription to a pharmacy.
[19] Section 408.0611, F.S.

The AHCA is required to work in collaboration with private sector e-prescribing initiatives and relevant stakeholders to create and maintain the clearinghouse. These stakeholders must include organizations that represent health care practitioners, health care facilities, and pharmacies; operate e-prescribing networks; and create e-prescribing products, and regional health information organizations.[20]

Specifically, the AHCA was tasked to provide on its website:

- Information regarding the advantages of e-prescribing, including using medication history data to prevent drug interactions, prevent allergic reactions, and deter doctor-shopping and pharmacy-shopping for controlled substances;
- Links to federal and private sector websites that provide guidance on selecting an appropriate e-prescribing product; and
- Links to state, federal, and private sector incentive programs for the implementation of e-prescribing.[21]

The AHCA annually reports to the Governor and Legislature on the implementation of e-prescribing by health care practitioners, facilities, and pharmacies.[22] The AHCA reports that, as of the end of September 2018, the average number of e-prescribers is 50,200 and almost 10 million e-prescriptions are transmitted each month.[23] Florida's e-prescribing rate has steadily increased since 2007, with an estimated 75.7 percent of all prescriptions being e-prescribed;[24] however, Florida prescribers have been slower to adopt e-prescribing for controlled substances.[25] In 2017, only 7.8 percent of controlled substance prescriptions were e-prescribed.[26]

Laws in Other States

Over the last few years, 15 states have enacted mandatory e-prescribing laws.[27]

State	Effective Date	Applicable Prescriptions
Arizona	January 1, 2019 in large counties; July 1, 2019 in small counties	Schedule II opioids
California	January 1, 2022	All
Connecticut	Currently required	Controlled substances
Iowa	January 1, 2020	All

[20] Section 408.0611(3), F.S.
[21] Section 408.0611,(3)(a), F.S.
[22] Agency for Health Care Administration, Florida Center for Health Information and Transparency, *Florida's Annual Electronic Prescribing Report for 2018* (January 2019), *available at* http://www.fhin.net/eprescribing/docs/reports/Florida2018ePrescribeReport.pdf (last visited April 3, 2019).
[23] *Id.*
[24] *Id.* E-prescribing rate is defined as the amount of e-prescribing relative to all prescriptions that could have been e-prescribed.
[25] Agency for Health Care Administration, Florida Center for Health Information and Transparency, *2018 Florida Electronic Prescribing Quarterly Summary*, available at http://www.fhin.net/eprescribing/dashboard/docs/2018eprescribemetrics.pdf (last visited April 3, 2019).
[26] *Id.*
[27] DrFirst, *E-Prescribing Mandate Map*, available at https://www.drfirst.com/resources/e-prescribing-mandate-map/ (last visited April 8, 2019), and SureScripts, *Electronic Prescribing for Controlled Substances*, available at https://surescripts.com/enhance-prescribing/e-prescribing/e-prescribing-for-controlled-substances/ (last visited April 8, 2019).

State	Effective Date	Applicable Prescriptions
Maine	Currently required	All controlled substances containing opiates
Massachusetts	January 1, 2020	Schedules II-VI controlled substances
Minnesota	Currently required	All
New Jersey	May 1, 2020	Schedule II controlled substances
New York	Currently required	All
North Carolina	January 1, 2020	Schedule II and III opioids
Oklahoma	January 1, 2020	Controlled substances
Pennsylvania	October 24, 2019	Controlled substances
Rhode Island	January 1, 2020	Controlled substances
Tennessee	July 1, 2020	Schedule II controlled substances
Virginia	July 1, 2020	All prescriptions containing opiates

E-Prescribing Software and Systems

National Council for Prescription Drug Programs (NCPDP)

The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit membership organization that uses a consensus-based process for standards development. The NCPDP creates national standards for electronic health care transactions used in prescribing, dispensing, monitoring, managing, and paying for medications and pharmacy services. The organization also develops standardized business systems and best practices that safeguard patients. NCPDP members are pharmacies, pharmacists, physicians, health plans, long-term care providers, claims processors, e-prescribing system vendors, pharmaceutical manufacturers, and government agencies such as the federal Centers for Medicare & Medicaid Services and the Food and Drug Administration.[28]

Stanford Computerized Researcher Information Profile Technique (SCRIPT)

SCRIPT is a standard developed for transmitting prescription information electronically between prescribers, pharmacies, payers, and other entities for new prescriptions, changes of prescriptions, prescription refill requests, prescription fill status notifications, cancellation notifications, relaying of medication history, transactions for long-term care, electronic prior authorization, and other transactions.[29]

The current SCRIPT standard is version 10.6, which is anticipated to sunset on December 31, 2019, and will be replaced by version 2017071 on January 1, 2020.[30]

[28] National Council for Prescription Drug Programs, *Frequently Asked Questions*, available at https://www.ncpdp.org/About-Us/FAQ (last visited April 8, 2019).
[29] National Council for Prescription Drug Programs, *Standards Information*, available at https://www.ncpdp.org/Standards-Development/Standards-Information (last visited April 8, 2019).
[30] National Council for Prescription Drug Programs, *NCPDP SCRIPT Standard Implementation Timeline*, p. 7, (October 2018) *available at* https://www.ncpdp.org/NCPDP/media/pdf/NCPDP_SCRIPT_Version_2017071_Timline__Implementation.pdf (last visited April 8, 2019).

The Cost of E-Prescribing Software

The cost of an e-prescribing system used by prescribers is based on the number of prescribers using the system and the options included in the system. It is estimated that the cost of an electronic health record system for an office with 10 full-time prescribers is approximately $42,332 for implementation and $14,725 for annual maintenance.[31]

III. Effect of Proposed Changes:

Section 1 amends s. 456.42, F.S., to require a prescription that is electronically generated and transmitted to contain an electronic signature from the prescribing practitioner. The bill requires health care practitioners licensed to prescribe medical drugs who maintain an electronic health records (EHR) system,[32] or who prescribe drugs as an owner, employee, or contractor of a licensed health care facility or practice that maintains such a system, and who is prescribing in that capacity, may only electronically transmit prescriptions for such drugs. This requirement takes effect upon renewal of the health care practitioner's license or by July 1, 2021, whichever is earlier, but does not apply if:

- The practitioner and the dispenser are the same entity;
- The prescription cannot be transmitted electronically under the most recently implemented version of the NCPDP SCRIPT program;
- The practitioner has been issued a waiver by the DOH, not to exceed one year, due to demonstrated economic hardship or technological limitations, not reasonably within the practitioner's control, or other exceptional circumstances;
- The practitioner determines that it is impractical for a patient to obtain in a timely manner a drug electronically prescribed and that the delay would adversely impact the patient's medical condition;
- The practitioner is prescribing a drug under a research protocol;
- The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing;
- The prescription is issued to an individual receiving hospice care or who is a resident of a nursing home facility; or
- The practitioner or patient determine that it is in the best interest of the patient to compare prescription drug prices among area pharmacies, and such determination is documented in the patient's medical record.

Prescribing practitioners who do not have access, in their practice or employment, to an EHR system may still provide written prescriptions to their patients for medicinal drugs. The DOH, in consultation with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, may adopt rules to implement these provisions.

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[31] Amber Porterfield, et. al., Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting, Perspect. Health Inf. Manage. 2014 Spring: 11 (Apr. 2014), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/ (last visited April 8, 2019)

[32] Section 408.051, F.S., defines "electronic health record" as a record of a person's medical treatment which is created by a licensed health care provider and stored in an interoperable and accessible digital format.

Section 2 amends s. 456.43, F.S., to include the prescribing decision of a prescribing practitioner's agent that electronic prescribing software is prohibited from influencing, through economic incentives or any other method of influence, at the point of care, and expands the types of methods electronic prescribing software is prohibited from using to influence such prescribing decision. The bill also extends to a prescribing practitioner's agent the ability for electronic prescribing software to display information regarding a payer's formulary if nothing is designed to preclude, or make more difficult, the selection of a certain medicinal drug.
Sections 3 through **8** make conforming changes to other areas of the Florida Statutes.

Section 9 provides an effective date of January 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.42, 456.43, 409.912, 456.0392, 458.3265, 458.331, 459.0137, and 459.015.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Appropriations Subcommittee on Health and Human Services on April 16, 2019:
The committee substitute:

- Adds an additional exemption of the requirement for certain health care practitioners to electronically transmit all prescriptions upon the practitioner's license renewal or July 1, 2021, whichever occurs earlier; and
- Expands the professional health care boards that are required to consult with the Department of Health when promulgating rules relating to the exemption of the mandatory e-prescribing requirement of certain health care practitioners.

CS by Health Policy on April 8, 2019:
The CS:

- Requires certain health care practitioners to begin issuing all prescriptions through e-prescribing no later than July 1, 2021, if such prescribers have access to an electronic health records (EHR) system;
- Provides an exception to mandatory e-prescribing for those prescribers who do not have access to an EHR system;
- Creates seven exceptions to the requirement that prescribers with access to an EHR system must issue all prescriptions through e-prescribing, which are all consistent with federal-law exceptions to the e-prescribing requirement for the Medicare program;
- Authorizes the DOH to adopt rules in consultation with the Board of Medicine and the Board of Osteopathic Medicine; and
- Makes numerous conforming changes throughout other areas of the Florida Statutes.

B. Amendments:

None.

799536

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/16/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

Senate Amendment

Between lines 88 and 89
insert:
(h) The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document such determination in the patient's medical record.

731540

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/16/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

Senate Amendment (with title amendment)

Delete lines 90 - 91

and insert:

The department, in consultation with the boards that regulate health care practitioners who are licensed by law to prescribe a medicinal drug, may adopt rules to implement

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

And the title is amended as follows:

731540

Delete lines 8 - 9

and insert:

with certain boards, to adopt rules; amending s.

483502

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/16/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

Senate Amendment to Amendment (731540) (with title amendment)

Delete lines 5 - 7
and insert:
The department, in consultation with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, may adopt rules to implement

483502

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete line 13
and insert:
with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, to adopt rules; amending s.

By the Committee on Health Policy; and Senators Bean and Baxley

588-04019-19 20191192c1

A bill to be entitled

An act relating to electronic prescribing; amending s. 456.42, F.S.; requiring certain health care practitioners to electronically generate and transmit prescriptions for medicinal drugs upon license renewal or by a specified date; providing exceptions; authorizing the Department of Health, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, to adopt rules; amending s. 456.43, F.S.; revising the definitions of the terms "prescribing decision" and "point of care"; revising the authority for electronic prescribing software to display information regarding a payor's formulary under certain circumstances; amending ss. 409.912, 456.0392, 458.3265, 458.331, 459.0137, and 459.015, F.S.; 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. Section 456.42, Florida Statutes, is amended to read:

456.42 Written prescriptions for medicinal drugs.—

(1) A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug

588-04019-19 20191192c1

prescribed, and the directions for use of the drug; must be dated; and must be signed by the prescribing practitioner on the day when issued. However, a prescription that is electronically generated and transmitted must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in numerical format, and the directions for use of the drug and must contain the date and an electronic signature, as defined in s. 668.003(4), ~~be dated and signed~~ by the prescribing practitioner only on the day issued~~, which signature may be in an electronic format as defined in s. 668.003(4)~~.

(2) A written prescription for a controlled substance listed in chapter 893 must have the quantity of the drug prescribed in both textual and numerical formats, must be dated in numerical, month/day/year format, or with the abbreviated month written out, or the month written out in whole, and must be either written on a standardized counterfeit-proof prescription pad produced by a vendor approved by the department or electronically prescribed as that term is used in s. 408.0611. As a condition of being an approved vendor, a prescription pad vendor must submit a monthly report to the department that, at a minimum, documents the number of prescription pads sold and identifies the purchasers. The department may, by rule, require the reporting of additional information.

(3) A health care practitioner licensed by law to prescribe a medicinal drug who maintains a system of electronic health records as defined in s. 408.051, or who prescribes medicinal drugs as an owner, an employee, or a contractor of a licensed

health care facility or practice that maintains such a system and who is prescribing in his or her capacity as such an owner, an employee, or a contractor, may only electronically transmit prescriptions for such drugs. This requirement applies to such a health care practitioner upon renewal of the health care practitioner's license or by July 1, 2021, whichever is earlier, but does not apply if:

(a) The practitioner and the dispenser are the same entity;

(b) The prescription cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;

(c) The practitioner has been issued a waiver by the department, not to exceed 1 year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner;

(d) The practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;

(e) The practitioner is prescribing a drug under a research protocol;

(f) The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing; or

(g) The prescription is issued to an individual receiving

hospice care or who is a resident of a nursing home facility.

The department, in consultation with the Board of Medicine and the Board of Osteopathic Medicine, may adopt rules to implement this subsection.

Section 2. Section 456.43, Florida Statutes, is amended to read:

456.43 Electronic prescribing for medicinal drugs.—

(1) Electronic prescribing may ~~shall~~ not interfere with a patient's freedom to choose a pharmacy.

(2) Electronic prescribing software may ~~shall~~ not use any means or permit any other person to use any means to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner or his or her agent at the point of care, including, but not limited to, means such as advertising, instant messaging, ~~and~~ pop-up ads, and similar means ~~to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care. Such means shall not be~~ triggered by or in specific response to the input, selection, or act of a prescribing practitioner or his or her agent in prescribing a certain medicinal drug ~~pharmaceutical~~ or directing a patient to a certain pharmacy. For purposes of this subsection, the term:

(a) ~~The term~~ "Prescribing decision" means a prescribing practitioner's or his or her agent's decision to prescribe any medicinal drug ~~a certain pharmaceutical~~.

(b) ~~The term~~ "Point of care" means the time at which ~~that~~ a

prescribing practitioner or his or her agent prescribes any medicinal drug ~~is in the act of prescribing a certain pharmaceutical~~.

(3) Electronic prescribing software may display ~~show~~ information regarding a payor's formulary if ~~as long as~~ nothing is designed to preclude or make more difficult the selection of ~~the act of a prescribing practitioner or patient selecting~~ any particular pharmacy by a patient or the selection of a certain medicinal drug by a prescribing practitioner or his or her agent ~~pharmaceutical~~.

Section 3. Paragraph (a) of subsection (5) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to

minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the

provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(5)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded

from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency may seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to administer this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lowest of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to,

comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size, patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment if it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing

requirements applicable to his or her practice, as determined by the agency.

5. The agency shall develop and implement a program that requires Medicaid practitioners who issue written prescriptions for medicinal ~~prescribe~~ drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by ~~Medicaid-participating prescribers or~~ prescribers who issue written ~~write~~ prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The

agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage guarantees a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency may contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Value-added programs as a substitution for supplemental rebates are prohibited. The agency may seek any federal waivers to implement this initiative.

8. The agency shall expand home delivery of pharmacy products. The agency may amend the state plan and issue a procurement, as necessary, in order to implement this program. The procurements must include agreements with a pharmacy or pharmacies located in the state to provide mail order delivery services at no cost to the recipients who elect to receive home delivery of pharmacy products. The procurement must focus on serving recipients with chronic diseases for which pharmacy expenditures represent a significant portion of Medicaid pharmacy expenditures or which impact a significant portion of the Medicaid population. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

10.a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency may seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Families, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers

and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high users of care.

11. The agency shall implement a Medicaid prescription drug management system.

a. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to recipients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

12. The agency may contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

15. The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved

by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

16. The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

17. The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused.

Section 4. Section 456.0392, Florida Statutes, is amended to read:

456.0392 Prescription labeling.—

(1) A prescription issued ~~written~~ by a practitioner who is authorized under the laws of this state to prescribe ~~write prescriptions for~~ drugs that are not listed as controlled substances in chapter 893 but who is not eligible for a federal Drug Enforcement Administration number shall include that practitioner's name and professional license number. The pharmacist or dispensing practitioner must include the

practitioner's name on the container of the drug that is dispensed. A pharmacist shall be permitted, upon verification by the prescriber, to document any information required by this section.

(2) A prescription for a drug that is not listed as a controlled substance in chapter 893 which is issued ~~written~~ by an advanced practice registered nurse licensed under s. 464.012 is presumed, subject to rebuttal, to be valid and within the parameters of the prescriptive authority delegated by a practitioner licensed under chapter 458, chapter 459, or chapter 466.

(3) A prescription for a drug that is not listed as a controlled substance in chapter 893 which is issued ~~written~~ by a physician assistant licensed under chapter 458 or chapter 459 is presumed, subject to rebuttal, to be valid and within the parameters of the prescriptive authority delegated by the physician assistant's supervising physician.

Section 5. Paragraph (d) of subsection (3) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

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

(d) A physician authorized to prescribe controlled substances who practices at a pain-management clinic is responsible for maintaining the control and security of his or her prescription blanks or electronic prescribing software ~~and any other method~~ used for prescribing controlled substance pain

medication. A ~~The~~ physician who issues written prescriptions shall comply with the requirements for counterfeit-resistant prescription blanks in s. 893.065 and the rules adopted pursuant to that section. A ~~The~~ physician shall notify, in writing, the department within 24 hours after ~~following~~ any theft or loss of a prescription blank or breach of his or her electronic prescribing software used ~~any other method~~ for prescribing pain medication.

Section 6. Paragraph (qq) of subsection (1) of section 458.331, Florida Statutes, is amended to read:

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

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

(qq) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of a physician's electronic prescribing software ~~other methods for prescribing~~ within 24 hours as required by s. 458.3265(3).

Section 7. Paragraph (d) of subsection (3) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

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

(d) An osteopathic physician authorized to prescribe controlled substances who practices at a pain-management clinic is responsible for maintaining the control and security of his or her prescription blanks or electronic prescribing software

~~and any other method~~ used for prescribing controlled substance pain medication. An ~~The~~ osteopathic physician who issues written prescriptions shall comply with the requirements for counterfeit-resistant prescription blanks in s. 893.065 and the rules adopted pursuant to that section. An ~~The~~ osteopathic physician shall notify, in writing, the department within 24 hours after ~~following~~ any theft or loss of a prescription blank or breach of his or her electronic prescribing software used ~~any other method~~ for prescribing pain medication.

Section 8. Paragraph (ss) of subsection (1) of section 459.015, Florida Statutes, is amended to read:

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

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

(ss) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of an osteopathic physician's electronic prescribing software ~~other methods for prescribing~~ within 24 hours as required by s. 459.0137(3).

Section 9. This act shall take effect January 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/15
Meeting Date

1192
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic E-Prescribing

Name Brewster Bevis

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Tallahassee FL 32301
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Phone

Email bbevis@aif.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16
Meeting Date

1192
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic E Prescribing

Name Chris Hansen

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Tallahassee FL 32301
City *State* *Zip*

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Walgreens

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16
Meeting Date

1192
Bill Number (if applicable)

Topic Bean "Boards Amendment"

731540
Amendment Barcode (if applicable)

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Podiatric Medical Assoc. (Podiatry)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1192
Bill Number (if applicable)

Amend

799536
Amendment Barcode (if applicable)

Topic _____

Name Chris Nuland

Job Title _____

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Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-16-19
Meeting Date

1192
Bill Number (if applicable)

Topic Electronic Prescribing

Amendment Barcode (if applicable)

Name JAKE FARMER

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Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Retail Federation

Appearing at request of Chair: ☐ Yes ☑ ~~No~~

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

Amendment

1192
Bill Number (if applicable)

799536
Amendment Barcode (if applicable)

Topic Electronic Prescribing

Name Dr. John Bailey, DO

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Email jbailey752@comcast.net

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	SB 1526
INTRODUCER:	Senator Harrell
SUBJECT:	Telehealth
DATE:	April 15, 2019
REVISED:	04/16/19

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	**Favorable**
2.	McKnight	Kidd	AHS	**Recommend: Fav/1 amendment**
3.			AP	

Please see Section IX. for Additional Information:

AMENDMENTS - Significant amendments were recommended

I. Summary:

SB 1526 establishes a statutory basis and definition for telehealth. Specifically, the bill:

- Creates s. 456.4501, F.S., as Florida's telehealth statute.
- Provides definitions for telehealth and telehealth provider.
- Establishes the standard of practice for telehealth providers as the same standard applied to in-person care under current law.
- Prohibits a telehealth provider, with limited exceptions, from using telehealth to prescribe a controlled substance.
- Requires a telehealth provider to document a telehealth encounter in the patient's medical records according to the same standards used for in-person services, and such information must be kept confidential.
- Provides an exemption for emergency medical services provided by emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers. The exemption also applies to a health care provider caring for a patient in consultation with another provider or in an on-call or cross coverage situation where the provider has access to the patient's medical records.
- Authorizes the applicable board, or the Department of Health if there is no board, to adopt rules.
- Creates ss. 627.42393 and 641.31093, F.S., prohibiting individual, group, blanket, franchise health insurance and health maintenance organization (HMO) policies from denying coverage for telehealth services on any insurance policy delivered, renewed, or issued, to any insured person in this state on or after January 1, 2020, on the basis of the service being

provided through telehealth if the same service would be covered if provided through an in-person encounter.
- Adds a provision prohibiting the HMO from requiring the subscriber to seek any type of referral or prior approval from a telehealth provider for HMO contracts under s. 641.31, F.S.
- Prohibits Medicaid Managed Medical Assistance (MMA) health plans from using providers who exclusively provide services through telehealth to meet Medicaid provider network adequacy requirements under the Medicaid managed care plan accountability standards.

The fiscal impact of the bill is indeterminate. See Section V.

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

II. Present Situation:

Telehealth and Telemedicine

The term, "telehealth," is sometimes used interchangeably with "telemedicine." Telehealth, however, generally refers to a wider range of health care services that may or may not include clinical services. The American Telemedicine Association refers to telemedicine as the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.[1]

Telehealth often collectively defines the telecommunications equipment and technology that are used to collect and transmit the data for a telemedicine consultation or evaluation. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services.

The federal Health Resource Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical-health care, patient, and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.[2]

For another definition, the federal Centers for Medicare and Medicaid Services (CMS) defines telehealth as:

> The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devises, which are used to collect and transmit data for monitoring and interpretation.[3]

[1] Ron Hedges, *Telemedicine, Information Governance and Litigation: The Chicken and the Egg, IGIQ: A Journal of AHMIA Blog,* (Feb. 15, 2018) https://journal.ahima.org/2018/02/15/telemedicine-information-governance-and-litigation-the-chicken-and-the-egg/ (last visited Mar. 11, 2019).
[2] *Id.*
[3] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services *Telemedicine*, available at https://www.medicaid.gov/medicaid/benefits/telemed/index.html (last viewed March 14, 2019).

Federal Medicaid law does not recognize telemedicine as a distinct service but as an alternative method for the delivery of services. Medicaid defines telemedicine and telehealth separately, using telemedicine to define the interactive communication between the provider and patient and telehealth to describe the technologies, such as telephones and information systems.[4]

The Florida Medicaid Managed Medical Assistance (MMA) contract defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.[5]

Payment Parity Laws

Parity in telehealth can mean two things: service levels or payment amount. At the service level, if a service is available in-person, then an attempt is made to match that same service or benefit coverage through telehealth. In this way, for individuals who are unable to travel or leave their homes, or live in areas where there may be a lack of providers or lack of a certain type of providers, telehealth becomes a viable option for those patients.

Under payment parity, if a provider is paid for a service that is provided in-person and that service is also available via telehealth, then the payment level for the actual services should not be impacted by the mode of the delivery of the actual service if it is the exact same service as an in-person encounter.

Telehealth coverage laws also often include language to prohibit different co-payments, deductibles, or benefit caps for services that are provided via telehealth to avoid cost shifting by insurers.[6]

However, a study by the Millbank Memorial Fund in 2016, found that while at least 31 states passed laws that broadly require coverage or payment for telehealth services, most of these laws had additional provisions limiting the application of that mandate to different terms and conditions of a policyholder's or payer's policy or contract, the modality of the delivery of the service, the types of providers that may deliver the services, or the location the service can be delivered.[7] The study identifies only three states with an explicit mandate for unconditional payment parity: Delaware, Hawaii, and Michigan.[8,9]

Electronic Consultations

Most states with statutes or regulations dealing with telehealth or telemedicine specifically exclude consultations or communications via email or similar communication from the definitions of telehealth and telemedicine.

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[4] *Id.*
[5] Agency for Health Care Administration, Core Contract Provisions (Effective 02/01/2018), Attachment II, p. 30, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-02-01/Attachment_II_Core_Contract_Provisions_Feb_1_2018.pdf (last visited March 18, 2019).
[6] Northeast Telehealth Resource Center, *Examining parity in telehealth laws, mHealth News* (August 10, 2015), http://netrc.org/news/examining-payment-parity-in-telehealth-laws/ (last viewed March 14, 2019).
[7] The Center for Connected Health Policy, *Telehealth Private Payer Laws: Impact and Issues* (August 2017), p. 6, The Millbank Memorial Fund, https://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf (last viewed March 14, 2019).
[8] *Supra* note *6.*
[9] *Id* at *28; Appendix B, Table 1.*

In the United States, more than one-third of patients are referred to a specialist each year, and specialist visits account for more than half of outpatient visits.[10] For a referral to be successful, however, there must be a provider available for the patient. Access to specialists may be inadequate due to lack of specialists in the community or lack of specialists who take a particular patient's insurance, which can also be true for primary care services.[11]

A suggested strategy to improve the integration of primary care referrals to specialists is the utilization of virtual consultations through video conferencing.[12] Primary care physician (PCP) satisfaction with electronic consults (e-consults)[13] is generally good across systems with 70-95 percent of providers reporting high satisfaction.[14] However, in a U.S. Department of Veterans Affairs (VA) study in which 93 percent of PCPs were satisfied, only 53 percent of specialists were satisfied, while 26 percent remained dissatisfied.[15] Overall, patients reported very high levels of satisfaction.[16]

Other positive impacts felt by systems that have implemented e-consults have been decreases in wait times for specialty appointments.[17] At one large facility, a clinician reviewer screened each specialty referral request. If the request was unclear, the request was redirected. All other requests were sorted into four categories: those that could be managed by the referring clinical with specialist guidance without being seen; those needing additional diagnostic work before an appointment could be made; routine appointments that could wait for the next available appointment; and urgent cases that required an expedited appointment.[18] For some specialties, like rheumatology, the wait times decreased from 126 days to 29 days.[19] Among participating providers, 72 percent said e-Referrals improved care and 89 percent said it made tracking referrals easier; however, 42 percent said it was a more burdensome system administratively.[20]

Florida Physician Shortages

Health Professional Shortage Areas (HPSAs) are designated by the HRSA according to criteria developed in accordance with Section 332 of the Public Health Services Act (PHSA). HPSA designations are used to identify areas and groups within the United States that are experiencing a shortage of health professionals. A HPSA can be a geographic area, a population group, or a health care facility. These areas have a shortage of health care professionals or have population groups who face specific barriers to health care. There are three categories for a HPSA designation: primary medical care; dental care; and mental health.

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[10] Ateev Mehrotra, Christopher B. Forest, et al, *Dropping the Baton: Specialty Referrals in the United States,* MILBANK QUARTERLY, 2011 March, v. 89(1), p. 39, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160594/pdf/milq0089-0039.pdf (last visited March 18, 2019).
[11] *Id* at *52.*
[12] *Id* at *56.*
[13] An asynchronous consultative communication between providers occurring within a shared electronic health record or secure web-based platform. E-consults are interactions that occur between providers and is most frequently used between primary care providers and specialty care providers to receive feedback that can be achieved through chart reviews and diagnostic tests. *See:* Varsha G. Vimalananda, Gouri Gupte, *Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis, J Telemed Telecare,* 2015 Sept 21(6) 323-33, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/ (last visited March 18, 2019).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] Alice Hm Chen, et al, *A Safety-Net System Gains Efficiencies Through 'e-Referrals to Specialists,* HEALTH AFFAIRS, (May 2010) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0027 (last visited March 18, 2019).
[18] *Id.*
[19] *Id.*
[20] *Id.*

The primary factor used to determine a HPSA designation is the number of health care professionals relative to the population with consideration of areas with high need. State Primary Care Offices, usually located within a state's main health agency, apply to HRSA for most designation of HPSAs. HRSA will review provider level data, whether providers are actively engaged in clinical practice, if a provider has any additional practice locations, the number of hours served at each location, the populations served, and the amount of time that a provider spends with specific populations.[21] Primary care and mental health HPSAs can receive a score between 0-25. The figure below provides a broad overview of the four components used in Primary Care HPSA scoring:[22]

As of December 31, 2018, Florida had 275 primary care HPSA designations which met 22.09 percent of the need. It was estimated that 1,658 practitioners were needed to remove the HPSA designation for primary care.[23] For mental health, Florida had 183 HPSA designations which met 16.13 percent of the need. To remove the HPSA designation for mental health, Florida would need 409 additional mental health practitioners.[24]

Florida Telehealth and Telemedicine Issues

Florida Board of Medicine

The Florida Board of Medicine (board) regulates the practice of physicians licensed under ch. 458, F.S. In 2013, the board convened a Telemedicine Workgroup to review its rules on telemedicine, which had not been amended since 2003. The 2003 rules focused on standards for the prescribing of medicine via the Internet.

On March 12, 2014, the board's new Telemedicine Rule, 64B8-9.0141 of the Florida Administrative Code (F.A.C.), became effective. The rule defined telemedicine,[25] established standards of care, prohibited the prescription of controlled substances, permitted the establishment of a doctor-patient relationship via telemedicine, and exempted emergency medical services.[26]

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[21] U.S. Department of Health and Human Services, HRSA Health Workforce, *Health Professional Shortage Area (HPSA), Shortage Application and Scoring Process*, Shortage Designation Management System, https://bhw.hrsa.gov/shortage-designation/application-scoring-process (last visited March 18, 2019).
[22] U.S. Department of Health and Human Services, HRSA Health Workforce, *HPSA Application and Scoring Process*, https://bhw.hrsa.gov/shortage-designation/hpsa-process (last visited March 18, 2019).
[23] HRSA Data Warehouse, *Designated Health Professional Shortage Area Statistics – Tab 3: Primary Care* (as of December 31, 2018), https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited March 18, 2019).
[24] HRSA Data Warehouse, *Designated Health Professional Shortage Area Statistics – Tab 5: Mental Health Care Health Professional Shortage Areas, by States*, (as of December 31, 2018) https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited March 18, 2019).
[25] The term, "telemedicine," is defined to mean the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.
[26] Telemedicine, Rule 64B15-14.0081, F.A.C., also went into effect March 12, 2014, for osteopathic physicians.

Two months after the initial rule's implementation, the board proposed an amendment to address concerns that the rule prohibited a physician from ordering controlled substances via telemedicine for hospitalized patients. The board indicated such a prohibition was not intended.[27] Additional changes followed to clarify medical record requirements and the relationship between consulting or cross-coverage physicians.

On December 18, 2015, the board published another proposed rule to allow controlled substances to be prescribed through telemedicine for the limited treatment of psychiatric disorders.[28] The change relating to psychiatric disorders under Rule 64B8-9.0141-Standards for Telemedicine Practice, F.A.C., became effective March 7, 2016.[29]

On February 3, 2017, the board held a public hearing on a proposed amendment to Rule 64B8-9.0141, F.A.C., to prohibit the ordering of low-THC (Tetrahydrocannabinol) cannabis or medical cannabis through telemedicine. Additional public hearings were noticed for April and August of that year on the amended rule; however, the rule was eventually withdrawn in August 2017 without being amended.

On March 7, 2019, a variance request was filed with the board seeking a waiver to the provision which prohibits a physician or physician assistant from providing treatment or treatment recommendations and issuing a prescription based solely on responses to an electronic medical questionnaire. The petitioners argue that the medical questionnaire is used only for certain low acuity medical conditions and a physician reviews the patient's responses which includes the patient's demographics, current medication list and allergies, and when necessary the patient's medical record where the provider has access to it, and the patient is provided a response to his or her request within an hour if the request is made within the hours of 8 a.m. to 7 p.m. Central Time, seven days a week, 365 days a year.[30] The petition lists 14 medical conditions that would be included in the service for patients 18 months of age through 75 years of age.[31] The clinics are currently offered by the Mayo Clinic in Minnesota, Iowa, and Wisconsin. The conditions currently covered are:

- Allergies
- Cold (upper respiratory illness)
- Cold sores
- Conjunctivitis (pink eye)
- Influenza
- Lice
- Oral contraceptives (females ages 18-34)
- Sinusitis (sinus symptoms)
- Smoking cessation (age 18 plus)
- Sore throat

[27] Florida Board of Medicine, *Latest News - Emergency Rule Related to Telemedicine*, http://flboardofmedicine.gov/latest-news/emergency-rule-related-to-telemedicine/ (last visited March 15, 2019).
[28] Vol. 41/244, Fla. Admin. Weekly, Dec. 18, 2015, available at https://www.flrules.org/BigDoc/View_Section.asp?Issue=2011&Section=1 (last visited March 15, 2019).
[29] Florida Board of Medicine, Latest News, Feb. 23, 2016, available at http://flboardofmedicine.gov/latest-news/board-revises-floridas-telemedicine-practice-rule/ (last visited March 15, 2019).
[30] State of Florida, Department of Health, Board of Medicine, Petition for Waiver or Variance, Floyd B. Willis, M.D., et al, Mayo Clinic; Rule No. 64B8-9.0141, F.A.C. (March 8, 2019, Florida Admin. Register, Vol. 45, No. 47 p. 954) (on file with the Senate Committee on Health Policy).
[31] State of Florida, Department of Health, Board of Medicine, Petition for Waiver or Variance, *Id* at 10.

- Sunburn
- Tick exposure
- Urinary tract infections (females ages 12-75)
- Vaginal yeast infections (females ages 18-65).[32]

In June 2019, the program, will add six new conditions:
- Acne
- Athlete's foot
- Impetigo
- Poison ivy
- Shingles
- Pertussis exposure without cough.

After a health care professional, a physician assistant, or nurse practitioner has reviewed the responses, the patient may be contacted if there are discrepancies between the form and an existing medical record with Mayo Health, discrepancies between the responses, or to clarify any information that was submitted electronically. Some patients may be prescribed a legend drug, other patients whose responses suggest a more serious illness or the provider would like to see the patient in person in order to meet the standard of care, may be advised that an in-person visit is necessary.[33] The patient receives an email message letting them know that a clinical note is in his or her patient portal, and if a drug has been prescribed, prescriptions are transmitted electronically to the patient's designated pharmacy via SureScripts service. No controlled substances are prescribed.[34]

Florida Medicaid Program's Use of Telehealth[35]

Medicaid managed care plans may elect to use telemedicine for any service as long as the managed care plan includes a fraud and abuse procedure to detect potential or suspected fraud or abuse in the use of telemedicine services.[36] The Agency for Health Care Administration's (AHCA) Medicaid managed care contracts for the MMA component of Statewide Medicaid Managed Care include specific contractual provisions for managed care plans that elect to use telehealth to deliver services, including, but not limited to:
- Must be licensed practitioners acting within the scope of their licensure.
- Telephone conversations, chart review, electronic mail message, or facsimile transmission are not considered telemedicine.
- Equipment and operations must meet technical safeguards required by 45 CFR 164.312.
- Providers must meet federal and state laws pertaining to patient privacy.
- Patient's record must be documented when telemedicine services are used.
- No reimbursement for equipment costs to provide telemedicine services.

[32] *Id.*
[33] *Id* at *12.*
[34] *Id.*
[35] *See* Agency for Health Care Administration, *Analysis of SB 280* (Oct. 9, 2017) (on file with the Senate Banking and Insurance Committee).
[36] *Id.*

- Must ensure the patient has a choice whether to access services through telemedicine or a face to face encounter.[37]

The MMA contracts also allow an MMA plan to assure access to specialists by providing telemedicine consultations with specialists not listed in the MMA plan's network at a location or via the patient's PCP office within 60 minutes travel time or 45 miles from the patient's zip code.[38] MMA plans must also have policies and procedures specific to telemedicine, if they elect to provide services through this delivery system, relating to fraud and abuse, record-keeping, consent for services, and privacy.

Florida Medicaid statutes and the federal Medicaid laws and regulations consider telemedicine to be a delivery system rather than a distinct service; as such, Florida Medicaid does not have reimbursement rates specific to the telemedicine mode of service. In the fee-for-service system, Florida Medicaid reimburses services delivered via telemedicine at the same rate and in the same manner as if the service were delivered face-to-face.

Medicaid health plans can negotiate rates with providers, so they have the flexibility to pay different rates for services delivered via telemedicine. The managed care plans are required to submit their telemedicine policies and procedures to the AHCA for approval, but are not required to do so prior to use.[39]

Other Statutory References to Telehealth or Telemedicine

Sprinkled throughout the Florida Statutes are numerous other references to the use of telehealth, telemedicine, or teleconference services to deliver health care services, including the following references:

- The Department of Management Services, to facilitate the development of applications, programs, and services, including, but not limited to telework and telemedicine.[40]
- Legislative intent for the Department of Children and Families (DCF) to use telemedicine for the delivery of health care services to children and adults with mental health and substance abuse disorders diagnoses for patient evaluation, case management, and ongoing patient care.[41]
- Recommendations by the DCF for voluntary and involuntary outpatient and inpatient services under ch. 394, F.S., with authorizations or second opinions provided by a physician assistant, a psychiatrist, a clinical social worker, or a psychiatric nurse.[42]

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[37] Agency for Health Care Administration, MMA Contract, Attachment II, Exhibit II-A (Effective 02/01/2018), p. 37, *available at* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-02-01/EXHIBIT_II-A_MMA_Managed_Medical_Assistance_(MMA)_Program_Feb_1_2018.pdf (last visited March 18, 2019).
[38] *Id* at *57*.
[39] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) Policy Transmittal* (March 11, 2016), http://ahca.myflorida.com/medicaid/statewide_mc/pdf/plan_comm/PT_16-06_Telemedicine_03-11-2016.pdf (last visited March 18, 2019).
[40] Section 365.0135(2)(d)4, F.S.
[41] Section 394.453(3), F.S. The provision states, in part: The Legislature further finds the need for additional psychiatrists to be of critical state concern and recommends the establishment of an additional psychiatry program to be offered by one of Florida's schools of medicine currently not offering psychiatry. The program shall seek to integrate primary care and psychiatry and other evolving models of care for persons with mental health and substance use disorders. Additionally, the Legislature finds that the use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.
[42] Sections 394.4655(3)(a)1, and 349.4655(3)(b), F.S.

- Opinions provided under s. 394.467, F.S., relating to admission to a treatment facility to be provided through face-to-face examination, in person, or by electronic means.[43]

Florida Telehealth Advisory Council

In 2016, legislation[44] was enacted that required the AHCA, with assistance from the DOH and the Office of Insurance Regulation (OIR), to survey health care practitioners, facilities, and insurers on telehealth utilization and coverage, and submit a report on the survey findings to the Governor, President of the Senate, and Speaker of the House of Representatives by December 31, 2016. The law also created a 15-member Telehealth Advisory Council and tasked the Council with developing recommendations and submitting a report on the survey findings to the Governor, President of the Senate, and Speaker of the House of Representatives by October 31, 2017.

Federal Telemedicine Provisions

Federal laws and regulations address telemedicine from several perspectives, including prescriptions for controlled substances, Medicare reimbursement requirements and privacy and security standards.

Special Registration Process – Drug Enforcement Agency

In Section 3232 of the federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act signed by President Trump on October 24, 2018,[45] Section 311(h)(2) requires the U.S. Attorney General (Attorney General), no later than one year after enactment, in consultation with the U.S. Department of Health and Human Services (HHS) Secretary, to promulgate regulations specifying the limited circumstances under which a special registration for telemedicine may be issued and the procedure for obtaining the registration. Previously, the federal Controlled Substances Act (CSA) contained language directing the Attorney General to promulgate rules for a special registration process for telemedicine; however, to date, no rule has been issued from the U.S. Department of Justice (DOJ) or the Drug Enforcement Agency (DEA). The Fall 2018 Unified Agenda of Office of Management and Budget had indicated that the DEA planned to publish a proposed rule in the *Federal Register*.[46] A registration process would allow a practitioner[47] to deliver, distribute, dispense, or prescribe via telemedicine a controlled substance to a patient that has not been medically examined in-person by a prescribing practitioner.[48]

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[43] Section 394.467(2), F.S. The examination under this section may be performed by a psychiatrist, a clinical psychologist, or if neither one of those is available, the second opinion may be provided by a physician who has the postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse.

[44] Chapter 2016-240, Laws of Fla. The law designated the Secretary of the Agency for Health Care Administration (AHCA) as the council Chair, and designated the State Surgeon General and Secretary of the Department of Health as a member. The AHCA's Secretary and the State Surgeon General appointed 13 council members representing specific stakeholder groups.

[45] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. Law 115-271, 56-57 (2019).

[46] Victoria Elliot, Congressional Research Service, *The Special Registration for Telemedicine: In Brief* (December 7, 2018), p. 1, *available at* https://fas.org/sgp/crs/misc/R45240.pdf (last visited March 18, 2019).

[47] A practitioner is defined under Section 802(21) of Title 21, U.S.C., as a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

[48] *Supra* note 46 at 2.

Federal law further requires that practitioners meet three general requirements for the special registration:

- Must demonstrate a legitimate need for the special registration.
- Must be registered to deliver, distribute, dispense, or prescribe controlled substances in the state where the patient is located.
- Must maintain compliance with federal and state laws when delivering, distributing, dispensing, and prescribing a controlled substance, unless the prescriber is:
  - Exempt from such registration in all states,[49] or
  - Is an employee or a contractor of the VA who is acting within the scope of his or her contract or is utilizing the registration of a hospital or clinic operated by the VA as permitted under these regulations.[50]

Protection of Personal Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Initial privacy rules were issued in 2000 by the HHS and later modified in 2002. These rules address the use and disclosure of an individual's health information and create standards for privacy rights. Additional privacy and security measures were adopted in 2009, with the Health Information Technology for Economic Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act (ARRA).[51] The Office of the National Coordinator (ONC) under the HITECH Act was given the responsibility of implementing provisions relating to interoperability, accessibility, privacy, and security of health information technology.[52]

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of the entities listed above.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which a medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration, and funding was provided to, in part, strengthen infrastructure and tools to promote telemedicine.[53]

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that the equipment and technology are HIPAA compliant, reduce travel requirements for patients in remote areas, and facilitate home health care and remote patient monitoring.[54]

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[49] The Act exempts certain manufacturers, distributers, and dispensers of controlled substances.
[50] *Supra* note 46 at 5 and 21 U.S.C. ss. 823 and 831(h)(1) (January 2019).
[51] American Recovery and Reinvestment Act (ARRA); Public Law 111-5 (2009).
[52] Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Health IT Legislation* (February 10, 2019), *available at* https://www.healthit.gov/topic/laws-regulation-and-policy/health-it-legislation (last visited March 18, 2019).
[53] ARRA; Public Law 111-5 (2009), s. 3002(b)(2)(C) and s. 3011.
[54] *Supra* note 51.

The HITECH and ARRA legislation also expanded who was considered a "business associate" under the updated security and privacy rules. The final rule in January 2013 modified the definition to include patient safety organizations, health information organization, e-prescribing gateways, and other persons that facilitate data transmissions and vendors of personal health records to one or more persons. These organizations and businesses would be required to enter into business associate agreements under the revised definition.[55]

The final rule also includes two new e-prescribing measures relating to opioids (Schedule II controlled substances) in the performance based scoring methodology for the Medicare's Electronic Health Records Incentive Program. Beginning in Calendar Year (CY) 2019, a query of a state's prescription drug monitoring program (PDMP) is optional; however, this query becomes required in CY 2020.[56] The second measure added is verification of an Opioid Treatment Agreement.[57] As with the PDMP query, the verification of the agreement is also optional for CY 2019 and mandatory in CY 2020.

Prescribing Via the Internet

Federal law has specifically prohibited the prescribing of controlled substances via the Internet without an in-person evaluation. A valid prescription is one that is issued for a legitimate medical purpose in the usual course of professional practice by a practitioner who has conducted at least one in-person medical evaluation of the patient or a covering practitioner.[58] The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[59]

Federal law at 21 U.S.C. s. 829 provides:

> No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

Telemedicine Exception

The DEA and the DOJ issued their own definition of telemedicine in April 2009, as required under the Ryan Haight Online Pharmacy Consumer Protection Act (Haight Act).[60] The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

- The patient and practitioner are located in separate locations;
- The patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substances via the Internet; and

[55] 78 Fed. Reg. 5687, (Jan. 25, 2013) (to be codified at 45 CFR 160.103, Definition of Business associate).
[56] Centers for Medicare and Medicaid Services, *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospect Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule Fact Sheet)* (August 2, 2018), *available at* https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0 (last visited Mar. 19, 2019).
[57] *Id.*
[58] Ryan Haight Online Pharmacy Consumer Protection Act of 2008; Public Law 110-425 (H.R. 6353); 21 U.S.C. sec. 829(e)(2)(A)(2006 Ed., Supplement 4).
[59] *Id.*
[60] *Id.*

- Certain practitioners (VA employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.[61]

However, the Haight Act[62] created an exception for the delivery, distribution, or dispensing of a controlled substance by a practitioner engaged in the practice of telemedicine or for a covering practitioner where the practitioner has conducted the required one, in-person medical evaluation through the practice of telemedicine within the previous 24 months.[63] The practitioner is still subject to the requirement that all controlled substances be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice. The definition of the "practice of telemedicine" includes seven distinct categories or exceptions. Those seven distinct categories require the practice of telemedicine be delivered or conducted:

- To a patient that is located in a hospital or a clinic.
- During an in-person examination with another practitioner.
- Through the Indian Health Service.
- During a public health emergency.
- By a practitioner that has obtained a special registration for telemedicine.
- During a medical emergency situation.
- At the discretion of the DEA.[64]

The DEA regulations require practitioners to meet certain requirements before issuing prescriptions for controlled substances electronically. All controlled substance prescriptions must be issued through an application that can meet standards which include, but is not limited to, user controls and locks, prescriber signature verification, final prescription review and approval by the prescriber, two factor authentication, and record archival and audit functionality.[65]

Medicare Provisions

In a proposed rule issued on November 30, 2018, prescription drug plan sponsors and Medicare Advantage organizations will be required to establish electronic prescription drug programs that comply with e-prescribing standards under the Medicare Prescription Drug, Improvement, and Modernization Act.[66] The law and regulation does not require that prescribers or dispensers comply with the requirement; however, any prescribers and dispensers who electronically transmit and receive prescriptions and certain other pieces of information for covered drugs on behalf of Medicare Part D eligible beneficiaries, directly or through an intermediary, are required to comply with any standards.[67]

U.S. Department of Veterans Affairs Telehealth

The VA has been using telehealth to increase access to health care for veterans through a variety of programs including real-time telehealth, the Polytrauma Rehabilitation Network, TeleMental

[61] Drug Abuse and Prevention, Definitions, 21 U.S.C. s. 802 (54).
[62] *Supra* note 58.
[63] *Id*.
[64] Information from the Congressional Research Service, *The Special Registration for Telemedicine: In Brief* (December 7, 2018), *available at* https://www.everycrsreport.com/files/20181207_R45240_d2f8e1a6693c4181f2c46db32a29f0595dfb5d03.pdf. (last visited March 19, 2019). Based on 21 U.S.C. s. 802(54) and s. 831(h).
[65] Requirements for Electronic Orders and Prescriptions, 21 C.F.R., pt. 1311, sub. C.
[66] Fed. Reg. Vol. 83, No. 231 (Nov. 30, 2018), p. 62164, 423.160.
[67] *Id.*

Health, TeleRehabilitation, and Telesurgery. The VA's telehealth services use real-time technologies to provide health care access through Clinical Video Telehealth (CVT). Examples of services that might be provided include access to a specialty care physician with the patient located at a local clinic closest to the veteran's home and a specialty physician who may not be available at the clinic closest to the veteran's home. Not all of the clinics have the specialty care available and it may be difficult for some of the veterans to travel distances to receive care, so CVT is used to make diagnoses, manage care, perform check-ups, and actually provide care for these veterans.[68]

A VA telehealth report in 2013, on home health services showed that home telehealth services had reduced bed days care 59 percent and hospital admissions by 35 percent, while clinical video telehealth services reduced bed days of care for mental health patients by 38 percent.[69] Clinical video telehealth saved approximately $34.45 per consult and store-and-forward telehealth saved approximately $38.81 per consult in travel costs for the patient.[70]

For the VA, a health care provider who is licensed to practice a health care specialty listed and qualified under 38 U.S.C. 7402(b),[71] is appointed to an occupation within the Veterans Health Administration that is listed as authorized, maintains his or her health credentials as required, and is not a contractor for the VA. The health care provider is authorized to provide telehealth services within the scope of their practice and in accordance with the privileges granted by the VA, irrespective of the state or location within the state where the health care provider or the beneficiary is located.[72] The health care provider must practice within the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, et seq, as well as any other provisions set forth by the VA. This federal regulation preempts state law to achieve an important federal interest to care for veterans.[73]

Federal Trade Commission

In recent years the Federal Trade Commission (FTC) has sent comments or intervened in state and federal actions relating to telehealth and telemedicine rulemaking and litigation and how it relates to competition. In one of its more recent letters on the topic, to the VA, the FTC commented on a proposed telemedicine rule allowing VA telehealth providers to provide services to or from non-federal sites, regardless of whether the provider was licensed in the state where the provider was located.[74] The FTC writes in support of the proposed rules with the following:

> Our findings reinforce the view that the Proposed Rule would enable the use of telehealth to reach underserved areas and VA beneficiaries who are

[68] U.S. Department of Veterans Affairs, *VA Telehealth Services: Real-Time Clinic Based Video Telehealth, https://www.telehealth.va.gov/real-time/index.asp* (last visited March 11, 2019).
[69] Center for Connected Health Policy, *Telehealth Private Payer Laws: Impact and Issues,* Millbank Memorial Fund (August 2017), p. 4, https://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf (last viewed March 14, 2019).
[70] *Id.*
[71] To be eligible for appointment in the Administration, a health care provider must meet the federal qualifications as listed in this statute for a physician, dentist, nurse, director of hospital, domiciliary, center, or outpatient clinic, podiatrist, optometrist, pharmacist, psychologist, social worker, marriage and family therapist, licensed professional mental health counselor, chiropractor, peer specialist, or other health care position as designated by the Secretary.
[72] 38 CFR section 17.417, Health care providers practicing via telehealth.
[73] 38 CFR section 17.417(c), Health care providers practicing via telehealth.
[74] U.S. Federal Trade Commission, Letter to Director of Regulation Policy and Management (November 1, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf (last visited March 18, 2019).

> unable to travel, improving the ability of the VA to utilize its health care resources. Accordingly, we believe that the Proposed Rule would likely increase access to telehealth services, increase the supply of telehealth providers, increase the range of choices available to patients, improve health care outcomes, and reduce the VA's health care costs, thereby benefitting veterans.
>
> …
>
> The VA's Proposed Rule involves the intersection of two important and current FTC advocacy areas that directly affect many consumers: occupational licensing and telehealth. Since the late 1970s, the Commission and its staff have conducted economic and policy studies relating to licensing requirements for various occupations and professions[75], and submitted numerous advocacy comments to state and self-regulatory entities on competition policy and anti-trust law issues relating to occupational regulation, including the regulation of health professions.[76]

The FTC also commented on telemedicine legislation in Alaska, occupational board rules in Delaware, investigated the Texas Board of Medicine, and filed a joint brief with the DOJ over restrictions relating to dentistry in Texas.[77, 78, 79]

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) provides an expedited pathway for medical and osteopathic physicians to qualify to practice medicine across state lines within a Licensure Compact. Currently, 24 states and one territory, which cover 31 medical and osteopathic boards, participate in the IMLC and as of February 2019, six other states have active legislative to join the IMLC.[80, 81]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the IMLC.[82] The providers' applications are expedited by using the information previously submitted in their State of Principal Licensure (SPL). Once the SPL has been established and a

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[75] *See* Carolyn Cox & Susan Foster, BUREAU OF ECON., FED. TRADE COMM'N, The Costs and Benefits of Occupational Regulation (1990), http://www.ramblemuse.com/articles/cox_foster.pdf (last visited March 18, 2019).
[76] *Supra* note 74.
[77] The Alaskan legislation would allow licensed Alaskan physicians located out of state to provide telehealth services in the same manner as in-state providers. *See* https://www.ftc.gov/news-events/press-releases/2016/03/ftc-staff-comment-alaska-legislature-should-consider-potential (last visited March 18, 2019).
[78] In Delaware, there were three situations, one involving whether telepractice was appropriate for Speech/Language Pathologists, another for the occupational board which regulates occupational therapists, and a third for the board which regulates the dietitians and nutritionists. https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/08/ftc-staff-comment-delaware-board-occupational-therapy, https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/11/ftc-staff-comment-delaware-board-speechlanguage , and https://www.ftc.gov/news-events/press-releases/2016/08/ftc-staff-comment-delaware-dieteticsnutrition-board-proposal (last visited March 18, 2019).
[79] In Texas, the FTC began an investigation of whether the Texas Medical Board violated federal antitrust law by adopting rules restricting the practice of telemedicine. *See* https://www.ftc.gov/news-events/press-releases/2017/06/federal-trade-commission-closes-investigation-texas-medical-board (last visited March 18, 2019).
[80] Interstate Medical Licensure Compact, *The IMLC*, https://imlcc.org/ (last visited Mar. 8, 2019).
[81] Interstate Medical Licensure Compact, Draft Executive Committee Meeting Minutes (February 5, 2019), https://imlcc.org/wp-content/uploads/2019/02/2019-IMLC-Executive-Committee-Minutes-February-5-2019-DRAFT.pdf (last visited Mar. 8, 2019).
[82] *Supra* note 80.

Letter of Qualification has been awarded, the physician can select which states to practice in under his or her compact license. However, to qualify for consideration for that compact license, the physician must hold a full, unrestricted medical license from a compact member state and meet one of the following additional qualifications:

- The physician's primary residency is the SPL.
- The physician's practice of medicine occurs in the SPL for at least 25 percent of the time.
- The physician's employer is located in the SPL.
- The physician uses the SPL as his or her state of residence for U.S. federal income tax purposes.

Additionally, the physician must maintain his or her licensure from the SPL at all times. The SPL may be changed after the original qualification. The application cost is $700 plus the cost of the license for the state in which the applicant wishes to practice. The individual state fees vary from a low of $75 in Alabama to a high of $700 in Maine.[83]

A current Senate bill (SB 7078) would enter Florida into the IMLC on July 1, 2019, if enacted into Florida law.

III. Effect of Proposed Changes:

Section 1 amends s. 409.967, F.S., to prohibit Medicaid managed care plans from using providers who exclusively provide services through telehealth, as defined in the bill, to meet the current-law network adequacy standards for Medicaid managed care.

The bill also deletes obsolete language from s. 409.967, F.S.

Section 2 creates s. 456.4501, F.S., and establishes statutory provisions for telehealth. The bill:

- Provides definitions for:
  - Telehealth: the practice of a Florida-licensed telehealth provider's profession in which patient care, treatment, or services are provided through the use of medical information exchanged between one physical location and another through electronic communications. The term excludes audio-only telephone calls, email messages, text messages, U.S. mail or other parcel services, facsimile transmissions, or any combination thereof.
  - Telehealth provider: an individual who provides health care and related services using telehealth and who holds a Florida license under chs. 458 (medical) or 459 (osteopathic), including providers who become Florida-licensed by way of the Interstate Medical Licensure Compact.[84]
- Establishes the practice standard for telehealth as the same standard for providers who provide in-person health care services.
- Provides that no controlled substances may be prescribed by a telehealth provider, except:
  - For the treatment of a psychiatric disorder;
  - For inpatient treatment at a hospital licensed under ch. 395, F.S.;

[83] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).
[84] The Interstate Medical Licensure compact is one component of SB 7078 (2019).

  - For the treatment of a patient receiving hospice services as defined in s. 400.601, F.S.;[85] and,
  - The treatment of a patient in a nursing home facility as defined in s. 400.021, F.S.
- Prohibits the use of an electronic medical questionnaire solely to prescribe medications.
- Places responsibility for quality and safety of equipment on telehealth providers.
- Requires telehealth providers to document in the patient's medical record any health care services rendered using telehealth to the same standards used for in-person services.
- Provides that any medical records generated as a result of a telehealth visit are confidential.[86]
- Clarifies that providers may continue to consult to the extent that such practitioners are acting within the scope of their practice.
- Provides that emergency medical services provided by emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers are excluded from the bill's provisions for telehealth and provides a definition of emergency medical services.
- Provides that health care providers who are providing immediate medical care to a patient with an emergency medical condition are excluded from the bill's provisions for telehealth.
- Provides that, to the extent that a health care provider is acting within his or her scope of practice, the bill does not prohibit:
  - A practitioner caring for a patient in consultation with another practitioner where the practitioner has an ongoing relationship and has agreed to supervise treatment, including prescribed medications; or
  - The health care provider from caring for a patient in on-call or cross-call situations in which another practitioner has access to patient records.
- Provides the applicable board, or the DOH if there is no board, with rulemaking authority.

Sections 3, 4, and 5 creates ss. 627.42393 and 641.31093, F.S., and amends s. 641.31, F.S., to require insurers and HMOs, including the plans that participate in the Medicaid MMA program, to reimburse healthcare providers the same amount for a billed service regardless of the modality of its delivery. The change would affect all policies renewed or contracted for as new contracts as of January 1, 2020. Insurers and HMOs would also be prohibited from:

- Denying coverage for a covered service on the basis of the service being provided through telehealth if the same service would have been covered through an in-person encounter.
- Excluding an otherwise covered service solely because the service is being providing through telehealth rather than through an in-person encounter.
- Charging a greater deductible, copayment, coinsurance amount than would apply if the same service were provided through an in-person encounter.
- Imposing any deductible, copayment, coinsurance amount or other durational benefit limitation or maximum for benefits or services provided via telehealth that is not imposed equally upon all terms and services covered under the policy.

[85] Under s. 400.601(6), F.S., hospice services means "items and services furnished to a patient and family by a hospice or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility."

[86] Patient medical records are confidential under s. 395.3025, F.S., and any Florida licensed facility has a duty to maintain that confidentiality in accordance with the statute. Patient records held by health care providers are confidential under s. 456.056, F.S.

Insurers and HMOs may conduct utilization reviews for appropriateness of service delivery in comparison to in-person encounters and insurers may also elect to limit the covered services offered to enrollees.

Section 6 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Providing a statutory definition for telehealth will add clarity to an area that has lacked a standard in state law. According to many users within the state, including respondents to the Telehealth Survey and the findings within the Telehealth Advisory Council Report mentioned previously, health practitioners indicated a need for a definition of the term, "telehealth." A definition would clarify the use of technological modalities as an acceptable way to treat patients within their scope of practice. Further, health plans noted the need for clarity in the allowable modes for telehealth for coverage and reimbursement purposes.

These changes may encourage the use of telehealth options, which may result in reduced health care costs; increased patient access to providers, especially in medically underserved areas; improved quality and continuity of care; and faster and more convenient treatment resulting in reduction of lost work time and travel costs for patients.

Preventing the unnecessary use of intensive services, such as emergency department visits, can reduce overall health care costs and improve health outcomes.

SB 1526 restricts the use of telehealth to only those persons licensed under ch. 458 (medical doctors) and ch. 459 (osteopathic physicians), F.S., with some limited exceptions for emergency medical care, hospice, and nursing homes. With committee testimony from previous years of telehealth bills, provisions in other state statutes, and current practices ongoing in the community, other non-physician health care professionals are currently providing telehealth services. It is unclear what would happen to their ability to continue to practice under this modality should this bill pass in its current form.

C. Government Sector Impact:

Similar to the private sector impact, these changes may encourage the expanded use of telehealth options by government entities and employers, which may result in reduced health care costs; increased patient access to providers, especially in medically underserved areas; improved quality and continuity of care; and faster and more convenient treatment resulting in reduction of lost work time and travel costs for patients.

According to the AHCA, the bill would not limit a MMA plan's ability to pay for telehealth services beyond those specified in the bill.[87] The direct fiscal impact to the state and local entities should be minimal to address any rulemaking issues and potential changes in health care utilization.

The bill does not specifically make the provisions in newly created ss. 627.42393 or 641.31093, F.S., applicable to plans operating under the Statewide Medicaid Managed Care (SMMC) program as it does not explicitly state the provisions apply to health insurers regulated under ch. 641, F.S., or the SMMC program governed under ch. 409, F.S. However, if it is the intent of the legislation that these changes apply to Medicaid, there is an indeterminate fiscal impact on the Medicaid program. While the AHCA already requires coverage parity for services delivered via telemedicine to the extent that the same service is covered via an in-person encounter, the AHCA has not required payment parity, and the plans still have the flexibility to negotiate mutually agreed upon rates for telehealth services. This may mean that the rates paid by plans differ from the rates paid for an in-person encounter.

To the extent the plans are able to negotiate better rates for telehealth services, requiring the plan to pay the same amount as an in-person encounter could increase costs to the Medicaid managed care plans, which would have to be accounted for in the capitation rates. In addition, the plans are increasingly using value-based purchasing agreements with providers to incentivize higher quality and increasingly efficient delivery of care. Payment mandates such as this are difficult to reconcile under those types of arrangements, which can allow providers to share in savings and take on financial risk if quality or other performance goals are not met.

[87] *See* Agency for Health Care Administration, Analysis of SB 1526 (April 14, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

The fiscal impact is indeterminate at this time as the AHCA does not currently possess comprehensive data on whether plans are paying differently for telehealth.

VI. Technical Deficiencies:

None.

VII. Related Issues:

As noted in Section V., the definition of telehealth as proposed in the bill limits the practice of telehealth to only those physicians licensed under chs. 458 and 459, F.S. It is unclear what adoption of telehealth definition may mean for non-physician health care professionals that are currently using telehealth, either in whole or in part, in their practices.

Additionally, in other states where restrictions on who or which type of professions can participate in telehealth were proposed by the state or its regulatory boards, the FTC submitted comments with concerns that such restrictions were a possible restraint on trade and raised antitrust issues in some cases. In its report, *Options to Enhance Occupational License Portability,* in September 2018, the FTC noted that 30 percent of Americans require an occupational license today up from less than five percent in the 1950s.[88] The report suggested mechanisms in which states could reduce those barriers such as interstate compacts, model laws, mutual recognition, and license portability for cross-state practice.[89]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967 and 641.31.

This bill creates the following sections of the Florida Statutes: 456.4501, 627.42393, and 641.31093.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

Recommended Barcode 862704 by Appropriations Subcommittee on Health and Human Services on April 16, 2019:
The amendment:

[88] Bilal Sayyed, et al, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. iv, https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Mar. 19, 2019).
[89] *Id* at 26.

- Creates s. 456.47, F.S., to establish the use of telehealth to provide services and replaces the provision that created s. 456.4501, F.S. to establish Florida's telehealth statute.
- Revises the definitions for telehealth and telehealth provider.
- Revises the standard of practice for telehealth providers. The amendment authorizes a telehealth provider to use telehealth to perform a patient evaluation if an in-person physical examination is not required and if a patient evaluation is sufficient to diagnose and treat the patient; clarifies that a nonphysician telehealth provider using telehealth and acting within the applicable scope of practice, as established under Florida law, may not be interpreted as practicing medicine without a license; and prohibits controlled substances from being prescribed by a telehealth provider, with limited exceptions.
- Authorizes any Florida-licensed health care practitioner, within the relative scope of practice established by Florida law and rule, to use telehealth to deliver health care services to Florida patients; and authorizes an out-of-state telehealth provider to deliver health care services to Florida patients if they register with the applicable board, or the DOH if there is no board, and meet certain eligibility requirements. The bill was previously limited only to providers who held a Florida license under chs. 458 (medical doctors) or 459 (osteopathic physicians).
- Requires the DOH to use the National Practitioner Data Bank to verify information submitted by an out-of-state telehealth provider and to publish on its website the name and specific background information of each registered out-of-state telehealth provider.
- Requires out-of-state telehealth providers to notify the applicable board, or the DOH if there is no board, of restrictions placed on the health care professional's license to practice or disciplinary actions taken against the health care practitioner within five days after such occurrence.
- Requires a provider to maintain professional liability coverage or financial responsibility (medical malpractice insurance), including for telehealth services provided to patient's not located in the provider's home state, to the same degree that Florida-licensed practitioners must be covered under Florida law.
- Prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.
- Requires an out-of-state telehealth provider, who is a pharmacist, to use a pharmacy holding a Florida permit, a nonresident pharmacy registered in Florida, or a nonresident pharmacy or outsourcing facility holding a nonresident sterile compounding permit to dispense medicinal drugs to Florida patients.
- Authorizes the board, or the DOH if there is no board, to revoke an out-of-state telehealth providers' registration under certain circumstances.
- Establishes, for jurisdictional purposes, that any act that constitutes the delivery of health care services shall be deemed to occur at the place where the patient is physically located at the time the act is performed. This will assist a patient in establishing jurisdiction and venue in Florida in the event he or she pursues a legal action against the telehealth provider.
- Revises exceptions to the registration requirement, providing exceptions for emergencies or for consultations between health care practitioners. Exemptions were

previously limited to only emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers.

- Removes requirements in the bill that would have impacted the Florida Medicaid program, related to:
  - Amending s. 409.967, F.S., to prohibit Medicaid managed care plans from using providers who exclusively provide services through telehealth to achieve network adequacy;
  - Creating s. 627.42393, F.S., to provide reimbursement requirements for health insurers relating to telehealth services;
  - Amending s. 641.31, F.S., to prohibit a health maintenance organization from requiring a subscriber to receive services via telehealth; and
  - Creating s. 641.31093, F.S., to provide reimbursement requirements for health maintenance organizations relating to telehealth services.
- Appropriates $261,389 in recurring funds and $15,020 in nonrecurring funds from the Medical Quality Assurance Trust Fund, and four full-time equivalent positions with associated salary rate of 145,870 to the DOH to offset the workload increase anticipated from the telehealth provider registration requirement.
- Provides an effective date of July 1, 2019.

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LEGISLATIVE ACTION

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Appropriations Subcommittee on Health and Human Services (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 456.47, Florida Statutes, is created to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth

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provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multi-state health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

(2) PRACTICE STANDARDS.—

(a) A telehealth provider has the duty to practice in a manner consistent with his or her scope of practice and the prevailing professional standard of practice for a health care professional who provides in-person health care services to patients in this state.

(b) If the applicable standard of practice does not require an in-person physical examination:

1. A telehealth provider may use telehealth to perform a patient evaluation.

2. If a patient evaluation performed by telehealth under subparagraph 1. is sufficient to diagnose and treat the patient,

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the telehealth provider is not required to research a patient's medical history or to conduct a physical examination of the patient before using telehealth to provide health care services to the patient.

(c) A telehealth provider may not use telehealth to prescribe a controlled substance unless the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

(d) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to a patient.

(e) A nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice, as established by Florida law or rule, is not in violation of s. 458.327(1)(a) or s. 459.013(1)(a).

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential pursuant to ss. 395.3025(4) and 456.057.

(4) REGISTRATION OF OUT-OF-STATE TELEHEALTH PROVIDERS.—

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(a) A health care professional not licensed in this state may provide health care services to a patient located in this state using telehealth if the health care professional registers with the applicable board, or the department if there is no board, and provides health care services within the applicable scope of practice established by Florida law or rule.

(b) The board, or the department if there is no board, shall register a health care professional not licensed in this state as a telehealth provider if the health care professional:

1. Completes an application in the format prescribed by the department;

2. Is licensed with an active, unencumbered license that is issued by another state, the District of Columbia, or a possession or territory of the United States and that is substantially similar to a license issued to a Florida-licensed provider specified in paragraph (1)(b);

3. Has not been the subject of disciplinary action relating to his or her license during the 5-year period immediately prior to the submission of the application;

4. Designates a duly appointed registered agent for service of process in this state on a form prescribed by the department; and

5. Demonstrates to the department that he or she is in compliance with paragraph (e).

The department shall use the National Practitioner Data Bank to verify the information submitted under this paragraph, as applicable.

(c) The website of a telehealth provider registered under

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paragraph (b) must prominently display a hyperlink to the department's website containing information required under paragraph (g).

(d) A health care professional may not register under this subsection if his or her license to provide health care services is subject to a pending disciplinary investigation or action, or has been revoked in any state or jurisdiction. A health care professional registered under this subsection must notify the appropriate board, or the department if there is no board, of restrictions placed on his or her license to practice, or any disciplinary action taken or pending against him or her, in any state or jurisdiction. The notification must be provided within 5 business days after the restriction is placed or disciplinary action is initiated or taken.

(e) A provider registered under this subsection shall maintain professional liability coverage or financial responsibility, that includes coverage or financial responsibility for telehealth services provided to patients not located in the provider's home state, in an amount equal to or greater than the requirements for a licensed practitioner under s. 456.048, s. 458.320, or s. 459.0085, as applicable.

(f) A health care professional registered under this subsection may not open an office in this state and may not provide in-person health care services to patients located in this state.

(g) A pharmacist registered under this subsection may only use a pharmacy permitted under chapter 465, a nonresident pharmacy registered under s. 465.0156, or a nonresident pharmacy or outsourcing facility holding an active permit pursuant to s.

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465.0158 to dispense medicinal drugs to patients located in this state.

(h) The department shall publish on its website a list of all registrants and include, to the extent applicable, each registrant's:

1. Name.

2. Health care occupation.

3. Completed health care training and education, including completion dates and any certificates or degrees obtained.

4. Out-of-state health care license with the license number.

5. Florida telehealth provider registration number.

6. Specialty.

7. Board certification.

8. Five-year disciplinary history, including sanctions and board actions.

9. Medical malpractice insurance provider and policy limits, including whether the policy covers claims that arise in this state.

10. The name and address of the registered agent designated for service of process in this state.

(i) The board, or the department if there is no board, may revoke an out-of-state telehealth provider's registration if the registrant:

1. Fails to notify the applicable board, or the department if there is no board, of any adverse actions taken against his or her license as required under paragraph (d).

2. Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction.

763358

3. Violates any of the requirements of this section.

(5) VENUE.—For the purposes of this section, any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed. Venue for a civil or administrative action initiated by the department, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider may be located in the patient's county of residence or in Leon County.

(6) EXEMPTIONS.—A health care professional who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another state or jurisdiction, and who provides health care services using telehealth to a patient located in this state, is not subject to the registration requirement under this section if the services are provided:

(a) In response to an emergency medical condition as defined in s. 395.002; or

(b) In consultation with a health care professional licensed in this state who has ultimate authority over the diagnosis and care of the patient.

(7) RULEMAKING.—The applicable board, or the department if there is no board, may adopt rules to administer this section.

Section 2. For fiscal year 2019-2020, the sums of $261,389 in recurring funds and $15,020 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health, and four full-time equivalent positions with associated salary rate of 145,870 are authorized for the purpose of implementing s. 456.47, Florida Statutes, as created

763358

by this act.

Section 3. This act shall take effect July 1, 2019.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to telehealth; creating s. 456.47, F.S.; defining terms; establishing standards of practice for telehealth providers; authorizing telehealth providers to use telehealth to perform patient evaluations; providing that telehealth providers, under certain circumstances, are not required to research a patient's history or to conduct physical examinations before providing services through telehealth; authorizing certain telehealth providers to use telehealth to prescribe certain controlled substances under specified circumstances; providing that a nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice is not deemed to be practicing medicine without a license; providing recordkeeping requirements for telehealth providers; providing registration requirements for out-of-state telehealth providers; requiring the Department of Health to publish certain information on its website; authorizing a board, or the department if there is no board, to revoke a telehealth provider's registration

763358

under certain circumstances; providing venue; providing exemptions from telehealth registration requirements; authorizing the applicable board, or the department if there is no board, to adopt rules; providing an appropriation; authorizing positions; providing an effective date.

809042

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/17/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Hooper) recommended the following:

Senate Amendment to Amendment (763358)

Delete line 16

and insert:

telephone calls, e-mail messages, Internet questionnaires, or facsimile transmissions.

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/17/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Hooper) recommended the following:

Senate Amendment to Amendment (763358) (with title amendment)

Between lines 60 and 61

insert:

(f) A prescription for lenses, spectacles, eyeglasses, contact lenses, or other optical devices may not be made based on telehealth services or solely on the refractive error of the human eye as determined by a computer controlled device such as an autorefractor.

648844

11
12 ================ T I T L E A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete line 207
15 and insert:
16 medicine without a license; providing that
17 prescriptions for lenses, spectacles, eyeglasses,
18 contact lenses, or other optical devices may not be
19 made based on telehealth services or solely on
20 determination made through the use of certain
21 computer-controlled devices; providing recordkeeping

277068

LEGISLATIVE ACTION

Senate	.	House
Comm: RE	.	
04/17/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Harrell) recommended the following:

Senate Amendment to Amendment (763358)

Delete line 100

and insert:

paragraph (h).

862704

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
04/18/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 456.47, Florida Statutes, is created to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth

862704

provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multi-state health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).

(2) PRACTICE STANDARDS.—

(a) A telehealth provider has the duty to practice in a manner consistent with his or her scope of practice and the prevailing professional standard of practice for a health care professional who provides in-person health care services to patients in this state.

(b) If the applicable standard of practice does not require an in-person physical examination:

1. A telehealth provider may use telehealth to perform a patient evaluation.

2. If a patient evaluation performed by telehealth under subparagraph 1. is sufficient to diagnose and treat the patient,

862704

the telehealth provider is not required to research a patient's medical history or to conduct a physical examination of the patient before using telehealth to provide health care services to the patient.

(c) A telehealth provider may not use telehealth to prescribe a controlled substance unless the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

(d) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to a patient.

(e) A nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice, as established by Florida law or rule, is not in violation of s. 458.327(1)(a) or s. 459.013(1)(a).

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential pursuant to ss. 395.3025(4) and 456.057.

(4) REGISTRATION OF OUT-OF-STATE TELEHEALTH PROVIDERS.—

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(a) A health care professional not licensed in this state may provide health care services to a patient located in this state using telehealth if the health care professional registers with the applicable board, or the department if there is no board, and provides health care services within the applicable scope of practice established by Florida law or rule.

(b) The board, or the department if there is no board, shall register a health care professional not licensed in this state as a telehealth provider if the health care professional:

1. Completes an application in the format prescribed by the department;

2. Is licensed with an active, unencumbered license that is issued by another state, the District of Columbia, or a possession or territory of the United States and that is substantially similar to a license issued to a Florida-licensed provider specified in paragraph (1)(b);

3. Has not been the subject of disciplinary action relating to his or her license during the 5-year period immediately prior to the submission of the application;

4. Designates a duly appointed registered agent for service of process in this state on a form prescribed by the department; and

5. Demonstrates to the department that he or she is in compliance with paragraph (e).

The department shall use the National Practitioner Data Bank to verify the information submitted under this paragraph, as applicable.

(c) The website of a telehealth provider registered under

862704

paragraph (b) must prominently display a hyperlink to the department's website containing information required under paragraph (h).

(d) A health care professional may not register under this subsection if his or her license to provide health care services is subject to a pending disciplinary investigation or action, or has been revoked in any state or jurisdiction. A health care professional registered under this subsection must notify the appropriate board, or the department if there is no board, of restrictions placed on his or her license to practice, or any disciplinary action taken or pending against him or her, in any state or jurisdiction. The notification must be provided within 5 business days after the restriction is placed or disciplinary action is initiated or taken.

(e) A provider registered under this subsection shall maintain professional liability coverage or financial responsibility, that includes coverage or financial responsibility for telehealth services provided to patients not located in the provider's home state, in an amount equal to or greater than the requirements for a licensed practitioner under s. 456.048, s. 458.320, or s. 459.0085, as applicable.

(f) A health care professional registered under this subsection may not open an office in this state and may not provide in-person health care services to patients located in this state.

(g) A pharmacist registered under this subsection may only use a pharmacy permitted under chapter 465, a nonresident pharmacy registered under s. 465.0156, or a nonresident pharmacy or outsourcing facility holding an active permit pursuant to s.

862704

465.0158 to dispense medicinal drugs to patients located in this state.

(h) The department shall publish on its website a list of all registrants and include, to the extent applicable, each registrant's:

1. Name.

2. Health care occupation.

3. Completed health care training and education, including completion dates and any certificates or degrees obtained.

4. Out-of-state health care license with the license number.

5. Florida telehealth provider registration number.

6. Specialty.

7. Board certification.

8. Five-year disciplinary history, including sanctions and board actions.

9. Medical malpractice insurance provider and policy limits, including whether the policy covers claims that arise in this state.

10. The name and address of the registered agent designated for service of process in this state.

(i) The board, or the department if there is no board, may revoke an out-of-state telehealth provider's registration if the registrant:

1. Fails to notify the applicable board, or the department if there is no board, of any adverse actions taken against his or her license as required under paragraph (d).

2. Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction.

862704

3. Violates any of the requirements of this section.

(5) VENUE.—For the purposes of this section, any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed. Venue for a civil or administrative action initiated by the department, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider may be located in the patient's county of residence or in Leon County.

(6) EXEMPTIONS.—A health care professional who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another state or jurisdiction, and who provides health care services using telehealth to a patient located in this state, is not subject to the registration requirement under this section if the services are provided:

(a) In response to an emergency medical condition as defined in s. 395.002; or

(b) In consultation with a health care professional licensed in this state who has ultimate authority over the diagnosis and care of the patient.

(7) RULEMAKING.—The applicable board, or the department if there is no board, may adopt rules to administer this section.

Section 2. For fiscal year 2019-2020, the sums of $261,389 in recurring funds and $15,020 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health, and four full-time equivalent positions with associated salary rate of 145,870 are authorized for the purpose of implementing s. 456.47, Florida Statutes, as created

862704

by this act.

Section 3. This act shall take effect July 1, 2019.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to telehealth; creating s. 456.47, F.S.; defining terms; establishing standards of practice for telehealth providers; authorizing telehealth providers to use telehealth to perform patient evaluations; providing that telehealth providers, under certain circumstances, are not required to research a patient's history or to conduct physical examinations before providing services through telehealth; authorizing certain telehealth providers to use telehealth to prescribe certain controlled substances under specified circumstances; providing that a nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice is not deemed to be practicing medicine without a license; providing recordkeeping requirements for telehealth providers; providing registration requirements for out-of-state telehealth providers; requiring the Department of Health to publish certain information on its website; authorizing a board, or the department if there is no board, to revoke a telehealth provider's registration


862704

under certain circumstances; providing venue; providing exemptions from telehealth registration requirements; authorizing the applicable board, or the department if there is no board, to adopt rules; providing an appropriation; authorizing positions; providing an effective date.

By Senator Harrell

25-01317B-19 20191526__

A bill to be entitled

An act relating to telehealth; amending s. 409.967, F.S.; prohibiting Medicaid managed care plans from using providers who exclusively provide services through telehealth to achieve network adequacy; deleting obsolete language; creating s. 456.4501, F.S.; defining the terms "telehealth" and "telehealth provider"; establishing certain practice standards for telehealth providers; prohibiting a telehealth provider from using telehealth to prescribe a controlled substance; providing exceptions; clarifying that prescribing medications based solely on answers to an electronic medical questionnaire constitutes a certain failure to practice medicine; specifying equipment and technology requirements for telehealth providers; providing recordkeeping requirements; providing applicability; defining the terms "emergency medical services" and "emergency medical condition"; authorizing the applicable board or the Department of Health to adopt rules; creating s. 627.42393, F.S.; providing reimbursement requirements for health insurers relating to telehealth services; amending s. 641.31, F.S.; prohibiting a health maintenance organization from requiring a subscriber to receive services via telehealth; creating s. 641.31093, F.S.; providing reimbursement requirements for health maintenance organizations relating to telehealth services; providing an effective date.

25-01317B-19 20191526__

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

Section 1. 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. A plan may not use providers who exclusively provide services through telehealth, as defined in s. 456.4501, to meet this requirement. 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.

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 2. Section 456.4501, Florida Statutes, is created to read:

456.4501 Use of telehealth to provide services.—

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

(a) "Telehealth" means the practice of a Florida-licensed telehealth provider's profession in which patient care, treatment, or services are provided through the use of medical information exchanged between one physical location and another through electronic communications. The term does not include audio-only telephone calls, e-mail messages, text messages, U.S. mail or other parcel service, facsimile transmissions, or any combination thereof.

(b) "Telehealth provider" means an individual who provides health care and related services using telehealth and who holds a Florida license under chapter 458 or chapter 459, including

providers who become Florida-licensed by way of the Interstate Medical Licensure Compact.

(2) PRACTICE STANDARD.—

(a) The standard of practice for telehealth providers who provide health care services is the same as the standard of practice for health care professionals who provide in-person health care services to patients in this state. If the standard of practice does not require an in-person physical examination, a telehealth provider may use telehealth to perform a patient evaluation and to provide services to the patient within the provider's scope of practice.

(b) A telehealth provider may not use telehealth to prescribe a controlled substance unless the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

(c) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to a patient.

(d) Prescribing medications solely based on answers to an electronic medical questionnaire constitutes a failure to practice medicine with the level of care, skill, and treatment that a reasonably prudent physician recognizes as being acceptable under similar conditions and circumstances.

(e) Telehealth providers are responsible for the quality of the equipment and technology employed and for the safe use of such equipment and technology. Telehealth equipment and technology must be able to provide, at a minimum, the same information to the physician or physician assistant which will enable them to meet or exceed the standard of practice for the telehealth provider's profession.

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standards used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing telehealth services, are confidential under ss. 395.3025(4) and 456.057. Patient access to personal health information created by telehealth services is granted under ss. 395.3025 and 456.057.

(4) APPLICABILITY.—

(a) This section does not prohibit consultations between practitioners, to the extent that the practitioners are acting within their scope of practice, or the transmission and review of digital images, pathology specimens, test results, or other medical data related to the care of patients in this state.

(b) This section does not apply to emergency medical services provided by emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers. For the purposes of this section, the term "emergency medical services" includes those activities or services designed to prevent or treat a sudden critical illness or injury and to provide emergency medical care and pre-hospital emergency medical transportation to sick, injured, or otherwise incapacitated

persons in this state.

(c) This section does not apply to a health care provider who is treating a patient with an emergency medical condition that requires immediate medical care. For the purposes of this section, the term "emergency medical condition" means a medical condition characterized by acute symptoms of sufficient severity that the absence of immediate medical attention will result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.

(d) To the extent that a health care provider is acting within his or her scope of practice, this section does not prohibit:

1. A practitioner caring for a patient in consultation with another practitioner who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment, including the use of any prescribed medications; or

2. The health care provider from caring for a patient in on-call or cross-coverage situations in which another practitioner has access to patient records.

(5) RULEMAKING.—The applicable board, or the department if there is no board, may adopt rules to administer this section.

Section 3. Section 627.42393, Florida Statutes, is created to read:

627.42393 Requirements for insurer reimbursement of telehealth services.—

(1) An individual, group, blanket, or franchise health insurance policy delivered or issued for delivery to any insured person in this state on or after January 1, 2020, may not deny coverage for a covered service on the basis of the service being

provided through telehealth if the same service would be covered if provided through an in-person encounter.

(2) A health insurer may not exclude an otherwise covered service from coverage solely because the service is provided through telehealth rather than through an in-person encounter between a health care provider and a patient.

(3) A health insurer is not required to reimburse a telehealth provider for originating site fees or costs for the provision of telehealth services. However, a health insurer shall reimburse a telehealth provider for the diagnosis, consultation, or treatment of any insured individual provided through telehealth on the same basis that the health insurer would reimburse the provider if the covered service were delivered through an in-person encounter.

(4) A covered service provided through telehealth may not be subject to a greater deductible, copayment, or coinsurance amount than would apply if the same service were provided through an in-person encounter.

(5) A health insurer may not impose upon any insured receiving benefits under this section any copayment, coinsurance, or deductible amount or any policy-year, calendar-year, lifetime, or other durational benefit limitation or maximum for benefits or services provided via telehealth which is not equally imposed upon all terms and services covered under the policy.

(6) This section does not preclude a health insurer from conducting a utilization review to determine the appropriateness of telehealth as a means of delivering a covered service if such determination is made in the same manner as would be made for

the same service provided through an in-person encounter.

(7) A health insurer may limit the covered services that are provided via telehealth to providers who are in a network approved by the insurer.

Section 4. Subsection (45) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(45) A health maintenance organization may not require a subscriber to consult with, seek approval from, or obtain any type of referral or authorization by way of telehealth from a telehealth provider, as defined in s. 456.4501.

Section 5. Section 641.31093, Florida Statutes, is created to read:

641.31093 Requirements for reimbursement by health maintenance organization for telehealth services.—

(1) Each health maintenance organization that offers, issues, or renews a major medical or similar comprehensive contract in this state on or after January 1, 2020, may not deny coverage for a covered service on the basis of the covered service being provided through telehealth if the same covered service would be covered if provided through an in-person encounter.

(2) A health maintenance organization may not exclude an otherwise covered service from coverage solely because the service is provided through telehealth rather than through an in-person encounter between a health care provider and a subscriber.

(3) A health maintenance organization is not required to reimburse a telehealth provider for originating site fees or

costs for the provision of telehealth services. However, a health maintenance organization shall reimburse a telehealth provider for the diagnosis, consultation, or treatment of any subscriber provided through telehealth on the same basis that the health maintenance organization would reimburse the provider if the service were provided through an in-person encounter.

(4) A covered service provided through telehealth may not be subject to a greater deductible, copayment, or coinsurance amount than would apply if the same service were provided through an in-person encounter.

(5) A health maintenance organization may not impose upon any subscriber receiving benefits under this section any copayment, coinsurance, or deductible amount or any contract-year, calendar-year, lifetime, or other durational benefit limitation or maximum for benefits or services provided via telehealth which is not equally imposed upon all services covered under the contract.

(6) This section does not preclude a health maintenance organization from conducting a utilization review to determine the appropriateness of telehealth as a means of delivering a covered service if such determination is made in the same manner as would be made for the same service provided through an in-person encounter.

(7) A health maintenance organization may limit covered services that are provided via telehealth to providers who are in a network approved by the health maintenance organization.

Section 6. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR GAYLE HARRELL
25th District

March 26, 2019

Senator Aaron Bean
405 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Bean,

I respectfully request that **SB 1526 – Telehealth** be placed on the next available agenda for the Appropriations Subcommittee on Health and Human Services Meeting. **SB 1526** passed its last committee stop unanimously.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

McKnight, Brooke

From: Kotas, James <James.Kotas@ahca.myflorida.com>
Sent: Sunday, April 14, 2019 3:39 PM
To: McKnight, Brooke
Subject: Fwd: PRIORITY REVIEW REQUEST: Updated Summary Analysis - SB 1526 Telehealth

Please see below

From: Harris, Shevaun <shevaun.harris@ahca.myflorida.com>
Sent: Sunday, April 14, 2019 3:11 PM
To: Kotas, James; Kidder, Beth; Sokoloski, Kristin
Cc: Keenan, Lauren
Subject: Re: PRIORITY REVIEW REQUEST: Updated Summary Analysis - SB 1526 Telehealth

Hi James - in our original reading of the bill, we did not interpret it to limit our ability to pay for telehealth services beyond those specified in the bill. If that is in the intent, then we do have concerns, as it would limit our health plan's ability to pay for behavioral health services via telehealth in parts of the state where it may be needed most (rural areas) and in after hour situations where the goal is to avoid an ED visit.

Shevaun Harris
Agency for Health Care Administration

From: Kotas, James <james.kotas@ahca.myflorida.com>
Sent: Sunday, April 14, 2019 2:05 PM
To: Harris, Shevaun; Kidder, Beth; Sokoloski, Kristin
Cc: Keenan, Lauren
Subject: PRIORITY REVIEW REQUEST: Updated Summary Analysis - SB 1526 Telehealth

Good afternoon - Brooke needs a quick response to the below question regarding telemedicine.

Can you let me know your thoughts please

James

From: McKnight, Brooke <brooke.mcknight@laspbs.state.fl.us>
Sent: Sunday, April 14, 2019 1:55 PM
To: Kotas, James
Cc: Keenan, Lauren
Subject: RE: Updated Summary Analysis - SB 1526 Telehealth

Afternoon, James –

The Health Policy post-meeting bill analysis states the following for Government Sector Impact:

The bill restricts the use of telehealth to only those licensed under ch. 458 (medical) and ch. 459 (osteopathic) in Florida with some limited exceptions for emergency medical care, hospice, and nursing homes. With committee testimony from previous years of telehealth bills, provisions in other state statutes, and current practices ongoing in the community,

other non-physician health care professionals are already providing telehealth services. It is unclear what would happen to their ability to continue to practice this modality should this bill pass, especially in the Medicaid program which allows its Medicaid managed care plans to use telehealth beyond permitted in this bill. Medicaid also authorizes the use of telehealth services in its fee for service component. The definition restriction may especially impact access to mental health and substance abuse disorder practitioners where the statutes currently specifically allow for non-physician health care professionals to participate through telehealth options.

Can you please share what the government impact would be to prohibit an MMA provider from exclusively providing services through telehealth.

From: Kotas, James <James.Kotas@ahca.myflorida.com>
Sent: Sunday, March 31, 2019 8:45 PM
To: McKnight, Brooke <Brooke.McKnight@LASPBS.STATE.FL.US>
Cc: Keenan, Lauren <lauren.keenan@ahca.myflorida.com>
Subject: Updated Summary Analysis - SB 1526 Telehealth

Brooke – please find below the updated and approved analysis for SB 1526. Please let me know if you have any questions.

James

Medicaid Comments:

SB 1526 (Telehealth) amends and creates sections of Florida Statutes to related to the use of telehealth by health care providers.

The bill creates and amends the following statutes:

- Amends §409.967, F.S., related to Medicaid managed care plan accountability. Specifically, the bill states that a plan may not use providers who exclusively provide services through telehealth, as defined in s. 456.4501, F.S., to meet network adequacy requirements. The bill further amends s. 409.967, F.S., to delete obsolete language relating to hospital contracting that expired with the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014.
    - The Agency already prohibits SMMC plans from using providers that exclusively provide telehealth services to meet network adequacy requirements. Therefore, this change has no operational or fiscal impact on the Medicaid program.

- Creates §456.4501, F.S., related to the use of telehealth to provide services. The bill includes definitions for the terms telehealth and telehealth provider and provides practice standards in the delivery of telehealth services, by a licensed practitioner, including prohibitions.
    - The Agency already has a rule (Rule 59G-1.057, F.A.C.) that governs Medicaid coverage and payment of services provided via telemedicine. The rule allows for Medicaid payment for telemedicine services to the extent that the practitioner's scope of practice allows such. The Agency's rule is consistent with the proposed requirements in this section, but some technical updates may be needed to the rule for clean-up purposes (e.g., ensuring consistency in the definition of terms to avoid provider confusion).

- Creates §627.42393, F.S., related to requirements for insurer reimbursement of telehealth services. The bill requires insurers regulated under Chapter 627 to institute coverage parity for telehealth services to the same extent the service can be delivered in an in-person encounter. The bill specifies that the insurer is not required to pay for the origination site fees or other administrative fees associated with telehealth, but is required to pay for the diagnosis, consultation, and treatment of the insured on the same basis that the health insurer would reimburse the provider if the service were delivered through an in-person encounter ("payment parity"). It appears as if the sponsor intends to require payment parity where the health insurer reimburses the provider**the same amount** for the telehealth service as an in-person encounter.
    - This change does not apply to the Medicaid program as it does not explicitly state that the provisions apply to health insurers regulated under Chapter 641, F.S. or to the SMMC program governed under Chapter 409, F.S.

- Adds subsection (45) to §641.31, F.S., related to health maintenance contracts. The bill prohibits a health maintenance organization (HMO) from requiring subscribers to have to received consultative, referral, or authorization services via telehealth. Essentially, it prohibits the HMO from requiring its member to use telehealth services.
    - The bill does not specifically make this provision applicable to plans operating under the SMMC program, but even it did, the SMMC contract already prohibits the plans from requiring its members to receive services via telehealth/telemedicine. Medicaid recipients enrolled in a health plan always have a choice whether to receive a service via an in-person encounter or via telehealth.

- Creates §641.31093, F.S., related to requirements for reimbursement by health maintenance organization for telehealth services. The bill requires HMOs to institute coverage parity for telehealth services to the same extent the service can be delivered in an in-person encounter. The bill specifies that the HMO is not required to pay for the origination site fees or other administrative fees associated with telehealth, but is required to pay for the diagnosis, consultation, and treatment of the subscriber on the same basis that the HMO would reimburse the provider if the service were delivered through an in-person encounter. It appears as if the sponsor intends to require payment parity where the HMO reimburses the provider **the same amount** for the telehealth service as an in-person encounter.
    - The bill does not specifically make this provision applicable to plans operating under the SMMC program, and coverage and payment requirements for services provided under the SMMC program are governed by Part IV of Chapter 409, F.S., unless Chapter 409 specifically references a subsection of Chapter 641, F.S. If it is the intent of the sponsor that these changes apply to Medicaid (as reported to the Health Policy Committee on 3/25/2019), there is an indeterminate fiscal impact to the Medicaid program. While the Agency already requires coverage parity for services delivered via telemedicine to the extent the same service is covered via an in-person encounter, the Agency has not required payment parity, and the plans still have the flexibility to negotiate mutually agreed upon rates for telehealth services. This may mean that the rates paid by plans differ from the rates paid for an in-person encounter.

      To the extent the plans are able to negotiate better rates for telehealth services, requiring the plan to pay the same amount as an in-person encounter could increase costs to the Medicaid managed care plans, which would have to be accounted for in the capitation rates. In addition, the plans are increasingly using value-based purchasing agreements with providers to incentivize higher quality and increasingly efficient delivery

of care. Payment mandates such as this are difficult to reconcile under those types of arrangements, which can allow providers to share in savings and take on financial risk if quality or other performance goals are not met.

The fiscal impact is indeterminate at this time as the Agency does not at this time have comprehensive data on whether plans are paying differently for telehealth.

James Kotas
Deputy Chief of Staff
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Florida Agency for Health Care Administration
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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/18
Meeting Date

1526
Bill Number (if applicable)

#763358
Amendment Barcode (if applicable)

Topic Telehealth

Name Aimee Diaz Lyon

Job Title

Address 119 South Monroe Street Suite 200
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-205-9000

Email aimee.diazlyon@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Florida Chapter of the American Academy of Pediatrics

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Alison Dudley

Job Title President AB Dudley & Assoc

Address P.O. Box 428
Street
Tall FL
City *State* *Zip*

Phone 850/559-1139

Email alisondudley@dudleyandassociates.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Radiological Society

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

76 3358
Amendment Barcode (if applicable)

Topic Telehealth

Name Alison Dudley

Job Title President AB Dudley · ABCS

Address P.O Box 420
Street
Tall, Fl
City *State* *Zip*

Phone 850/559-1139

Email alisondudley@dudleyandassociates.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Radiological Society

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16
Meeting Date

1526
Bill Number (if applicable)

763358
Amendment Barcode (if applicable)

Topic Telehealth

Name Chris Hansen

Job Title Ballard Partners

Address 201 E. Park Ave
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 577-0444

Email Chansen@ballardfl.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Podiatric Medical Assoc. (Podiatry)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

763358
Amendment Barcode (if applicable)

Topic The Amendment Only

Name Chris Mand

Job Title

Address 1000 Riverside Ave #240
Street

Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email mylandlaw@aol.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

648844
Amendment Barcode (if applicable)

Topic Telehealth

Name Cynthia Henderson

Job Title

Address 108 E. Jefferson
Street

Tallahassee
City *State* *Zip*

Phone 850 559 0855

Email cyhenderson@me.com

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Luxottica

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

SB 1526
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Dorene Barker

Job Title Associate State Director

Address 200 W. College Ave, Ste 304A
Street

Phone 850-228-6387

Tallahassee FL 32301
City *State* *Zip*

Email dobarker@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/18/19
Meeting Date

1526
Bill Number (if applicable)

Topic TELEHEALTH

809042
Amendment Barcode (if applicable)

Name DAVID RAMBA

Job Title ATTORNEY

Address _____ Phone 850.727.7087
Street

Email davide rambalaw.com

City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA OPTOMETRIC ASSOCIATION

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/18/19
Meeting Date

1526
Bill Number (if applicable)

648844
Amendment Barcode (if applicable)

Topic TELEHEALTH

Name DAVID RAMBA

Job Title ATTORNEY

Address 120 S. MONROE ST
Street

TALLAHASSEE, FL 32301
City *State* *Zip*

Phone 850 727 7087

Email david@rambalaw.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA OPTOMETRIC ASSOCIATION

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

16 April 2019
Meeting Date

SB 1526
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Diego Echeverri "Dee yay Goh Etch-uh-vay-ree

Job Title Director of Coalitions

Address 200 West College ave
Street

Phone 813-767-2084

TLH FL
City *State* *Zip*

Email decheverri@cv4a.c

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Concerned Veterans For America

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-16-2019
Meeting Date

SB 1526
Bill Number (if applicable)

Topic TELEHEALTH

Amendment Barcode (if applicable)

Name JACK HEBERT

Job Title GOVT. Affairs Dir.

Address 2861 EXEC DR. SUITE 100
Street

Clearwater FL 33762
City *State* *Zip*

Phone 727-560-3323

Email JACK@FCACHIRO.ORG

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chiropractic Assn.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/10/19
Meeting Date

SB 1526
Bill Number (if applicable)

Topic Amendment Only

763358
Amendment Barcode (if applicable)

Name Jeff Scott

Job Title

Address 1430 Piedmont Dr. E.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850 224-6496

Email jscott@flmedical.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/18
Meeting Date

1526
Bill Number (if applicable)

#763358
Amendment Barcode (if applicable)

Topic Telehealth

Name Jim Daughton

Job Title

Address 119 South Monroe Street Suite 200
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-205-9000

Email jim.daughton@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Florida Academy of Family Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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4/16/19
Meeting Date

SB 1526
Bill Number (if applicable)

→ 648844
Amendment Barcode (if applicable)

Topic Telehealth

Name Joe Anne Hart

Job Title Chief Legislative Officer

Address 118 E. Jefferson St.
Street

Tall, FL 32301
City *State* *Zip*

Phone 850.224.1089

Email jahart@floridadental.org

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Matthew Choy

Job Title Director

Address 136 S. Bronough St.
Street

Phone 561-386-3451

Tallahassee FL 32301
City *State* *Zip*

Email MChoy@FlChamber.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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4/16/19
Meeting Date

1526
Bill Number (if applicable)

763358
Amendment Barcode (if applicable)

Topic Telehealth

Name Matthew Choy

Job Title Director

Address 136 S° Bronough St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 561-386-3451

Email MChoy@FlChamber.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Phillip Suderman

Job Title Policy Director

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Americans for Prosperity

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-16 — *Meeting Date*

1526 — *Bill Number (if applicable)*

Topic Telemed

6489444 — *Amendment Barcode (if applicable)*

Name Rhett O'Doski

Job Title

Address 115 E Park Ave — *Street*

Tallahassee — *City* FL — *State* 32301 — *Zip*

Phone 850 322 8746

Email rodoski@mwdlc.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing 1-800-Contacts

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

763358
Amendment Barcode (if applicable)

Topic Telehealth

Name Stephen Winn

Job Title Exec. Director

Address 2544 Blairstone Pines Dr
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 878-7364

Email winnsr@earthlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1526
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name VICTORIA ZEPP

Job Title Chief Research & Policy Ofcr.

Address 411 E. College Ave.
Street

Phone 850/561-1102

32301
City *State* *Zip*

Email VICTORIA@FLCHILDREN.ORG

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 1592
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Harrell
SUBJECT:	Assisted Living Facilities
DATE:	April 15, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hendon	Hendon	CF	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1592 makes a number of changes relating to assisted living facilities (ALFs). The bill authorizes and encourages the use of safety devices to protect residents in ALFs. The bill updates the fire safety code that all ALFs must meet. The bill clarifies the administration of the core training requirements for ALF staff and administrators and provides requirements for the medical examination that residents must undergo to determine appropriate placement in an ALF. Additionally, the bill requires ALFs to provide information in writing on the Long-Term Care Ombudsman Program when providing a notice for eviction.

The bill does not have a fiscal impact on state revenues or expenditures.

The bill takes effect on July 1, 2019.

II. Present Situation:

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.[1] A personal service is direct physical assistance with, or supervision of, the activities of daily living

[1] Section 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.

and the self-administration of medication.[2] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[3]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[4] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on a number of criteria.[5] If, as determined by the facility administrator or health care provider, a resident no longer meets the criteria for continued residency or the facility is unable to meet the resident's needs, the resident must be discharged in accordance with the Resident Bill of Rights.[6]

There are 3,081 licensed ALFs in Florida having a total of 106,016 beds.[7] An ALF must have a standard license issued by the Agency for Health Care Administration (AHCA) under part I of ch. 429, F.S., and part II of ch. 408, F.S. In addition to a standard license, an ALF may have one or more specialty licenses that allow an ALF to provide additional care. These specialty licenses include limited nursing services (LNS),[8] limited mental health services (LMH),[9] and extended congregate care services (ECC).[10]

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established in rule by the Department of Elder Affairs (DOEA),[11] that are intended to assist ALFs in appropriately responding to the needs of residents, maintaining resident care and facility standards, and meeting licensure requirements.[12]

The current ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within three months after becoming an ALF administrator or manager. The minimum passing score for the competency test is 75 percent.[13]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every two years.[14] A newly-hired administrator or manager, who has

[2] Section 429.02(17), F.S.
[3] Section 429.02(1), F.S.
[4] *See* Rule 58A-5.0182, F.A.C., for specific minimum standards.
[5] Section 429.26, F.S., and Rule 58A-5.0181, F.A.C.
[6] Section 429.28, F.S.
[7] Agency for Health Care Administration, Health Care Finder see http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx, (last visited April 3, 2019).
[8] Section 429.07(3)(c), F.S.
[9] Section 429.075, F.S.
[10] Section 429.07(3)(b), F.S.
[11] Rule 58A-5.0191, F.A.C.
[12] Section 429.52(1), F.S.
[13] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with part II of chapter 468, F.S., are exempt from this requirement.
[14] Rule 58A-5.0191(1)(c), F.A.C.

successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements, must retake the ALF core training and retake the competency test.[15]

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for six hours of in-service training for facility staff who provide direct care to residents.[16] Staff training requirements must generally be met within 30 days after staff begin employment at the facility; however, staff must have at least one hour of infection control training before providing direct care to residents. Nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard six hours of in-service training, staff must complete one hour of elopement training and one hour of training on "do not resuscitate" orders. The staff may be required to complete training on special topics such as self-administration of medication and Alzheimer's disease, if applicable.

Inspections and Surveys

The AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:
- Prior to the issuance of a license;
- Prior to biennial renewal of a license;
- When there is a change of ownership;
- To monitor ALFs licensed to provide Limited Nursing Services or Extended Congregate Care services;
- To monitor ALFs cited in the previous year for a class I or class II violation or for four or more uncorrected class III violations;
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents;
- If the AHCA has reason to believe an ALF is violating a provision of part III of ch. 429, F.S., relating to adult day care centers or an administrative rule;
- To determine if cited deficiencies have been corrected; or
- To determine if an ALF is operating without a license.[17]

An applicant for licensure renewal is eligible for an abbreviated biennial survey by the AHCA if the applicant does not have any:
- Class I, class II, or uncorrected class III violations;
- Confirmed complaints from the long-term care ombudsman council which were reported to the AHCA by the council; or
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[18]

[15] Rule 58A-5.0191, F.A.C.
[16] *Id.*
[17] Section 429.34, F.S.
[18] Rule 58A-5.033(1), F.A.C.

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items the AHCA must inspect.[19] The AHCA must expand an abbreviated survey or conduct a full survey if violations that threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[20]

III. Effect of Proposed Changes:

Section 1 amends s. 429.02, F.S., providing definitions which govern ALFs to add a definition of "assistive device." The term is defined as any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer, but does not include lifts such as a total body lift or a chair lift. The bill revises the definition of a "physical restraint" to exclude devices that the resident is able to remove themselves.

Section 2 amends s. 429.11, F.S., relating to obtaining an initial ALF license, to update the term occupational license with the term "business tax receipt" to reflect the current terminology used by local governments.

Section 3 amends s. 429.176, F.S., relating to a change of administrators in an ALF to require new administrators to provide documentation that they meet educational requirements (GED or high school diploma) and have completed the core training and passed the core competency test.

Section 4 amends s. 429.23, F.S., relating to risk management and quality assurance for ALFs. The bill clarifies the requirement that ALFs investigate an adverse incident in the facility within 24 hours of the incident and provide a report to the AHCA within 15 days of the incident.

Section 5 amends s. 429.255, F.S., relating to use of ALF staff and emergency care. The bill clarifies that a resident or resident's representative, designee, surrogate, guardian, or attorney in fact may contract with a third party for services to be provided at the ALF. The third party must coordinate care with the ALF and the ALF must document such services.

Section 6 amends s. 429.256, F.S., relating to assistance with self-administration of medication. The bill requires that the ALF confirm that the medication is for the resident and advise the resident of the medication name and purpose.

Section 7 amends s. 429.26, F.S., relating to the appropriate placements and examinations of residents in an ALF. The bill:

- Provides an alternative option for residents by authorizing a medical examination to be performed 30 days after admission to an ALF. Residents are currently limited to having a medical examination performed within 60 days prior to admission.
- Specifies the information required on the medical examination form.
- Establishes the criteria applied to the determination and appropriateness for an individual's residency and continued residency in an ALF, allowing an ALF to admit or retain a resident that receives health care services from a third party provider; who requires the use of assistive devices; and receives hospice services if the arrangement is agreed to by the ALF

[19] *Id.*
[20] *Id.*

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.

- Provides for the placement of a resident who is bed ridden for seven or less consecutive days in an ALF. For ALFs with a specialty license for Extended Congregate Care, the bill allows an ALF to retain a resident who is bed ridden for 14 or less consecutive days. These changes would allow ALF residents needing more acute care to be served in an ALF rather than a nursing home. Currently persons who require 24-hour nursing care would need to be placed in a nursing home.
- Requires an ALF to notify a licensed physician in writing when a resident exhibits signs of dementia or cognitive impairment or has a change in condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment, and to notify the resident's representative or designee in writing of the need for health care services and assist in making appointments for the necessary care and services to treat the condition.
- Revises provisions relating to the placement of residents by the DOEA and the Department of Children and Families.

Section 8 amends s. 429.28, F.S., relating to the ALF resident bill of rights. The bill requires ALFs to provide information in writing on the Long-Term Care Ombudsman Program when providing a notice for eviction.

Section 9 amends s. 429.41, F.S., relating to rules establishing standards. The bill:

- Revises the legislative intent that licensure standards "promote" rather than "ensure" quality care for residents and to allow for technological advances, including the use of devices, equipment and other security measures, in the provision of care, safety, and security of residents, staff, and the facility.
- Removes references to national fire safety standards. Instead, section 10 of the bill requires an ALF to meet the uniform fire safety standards in s. 633.206, F.S.
- Requires the AHCA to use an abbreviated inspection under certain circumstances. Current law provides discretion to the AHCA on when to use an abbreviated inspection. The bill also changes the criteria for using an abbreviated inspection from having no confirmed complaints to the long-term care ombudsman to having no confirmed complaints that led to a licensure violation.
- Deletes an outdated requirement for the DOEA to provide copies of proposed rules to the Legislature.
- Requires the AHCA to adopt by rule key quality-of-care standards.

Section 10 creates s. 429.435, F.S., to establish uniform fire safety standards for ALFs. The bill:

- Requires the State Fire Marshal to establish uniform fire safety standards for ALFs and provides certain requirements. A fire safety evacuation test must be made by the fire marshal within six months after the date of initial licensure.
- Requires the National Fire Protection Association, Life Safety Code to be used in determining the uniform ALF fire safety standards.
- Prohibits a local government from charging a fee beyond that which would cover the cost for an inspection of an ALF sprinkler system.

- Requires local fire marshals to annually inspect ALFs for compliance with fire safety standards.
- Authorizes ALFs operating before July 1, 2016, to continue being subject by the previous fire safety standards.

Section 11 amends s. 429.52, F.S., relating to ALF staff training and educational requirements. The bill:

- Clarifies the educational requirements and core training requirements for ALF administrators. The current DOEA rule requires a GED or high school diploma.[21] The bill establishes core training requirements for administrators consisting of core training learning objectives and successful passage of the core competency test.
- Revises the training and continuing education requirements for facility staff who assist resident with the self-administration of medications, requiring a minimum of six completed hours of training before providing assistance and thereafter, two hours annually.
- Requires the DOEA to contract with another entity to administer the competency test.
- Requires the DOEA to develop rules regarding the administration of the training competency test and an outline of the training curriculum, as well as rules to establish core trainer removal requirements.

Section 12 amends s. 429.07, F.S., related to establishing license fees for ALFs. The bill corrects a cross-reference for the required medical examination of ALF residents.

Section 13 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[21] Agency for Health Care Administration bill analysis, dated March 11, 2019. On file with the Committee on Children, Families and Elder Affairs.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 429.02, 429.07, 429.11, 429.176, 429.23, 429.255, 429.256, 429.26, 429.28, 429.41, and 429.52.

This bill creates section 429.435 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on April 8, 2019:

- The CS removes changes to s. 429.19, F.S., relating to ALF violations of licensure standards and fines, to clarify that ALFs are not to be fined under parts II, III, and IV of chapter 400. Part II of that chapter governs nursing homes, part III governs home health agencies, and part IV governs hospice providers.
- The CS amends s. 429.02, providing definitions for part I of chapter 429, F.S., governing ALFs to add a definition of "assistive device." The term is defined as any device to help a resident perform an activity of daily living, but does not include lifts such as a total body lift or a chair lift. The bill revises the definition of a "physical restraint" to exclude devices that the resident is able to remove themselves.
- The CS amends s. 429.176, F.S., relating to change of administrators in an ALF to require new administrators provide documentation that they meet educational requirements (GED or high school diploma) and has completed the core competency training and passed the test.

- The CS removes language that would have eliminated the educational requirements of ALF administrators.
- The bill requires that the written notice to residents who are to be evicted include information on obtaining assistance from the Long-Term Care Ombudsman Program.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and Senator Harrell

586-04036A-19 20191592c1

A bill to be entitled

An act relating to assisted living facilities; amending s. 429.02, F.S.; defining and redefining terms; amending s. 429.11, F.S.; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to an assisted living facility under certain circumstances; amending s. 429.176, F.S.; amending educational requirements for an administrator who is replacing another administrator; amending s. 429.23, F.S.; requiring a facility to initiate an investigation of an adverse incident within 24 hours and provide a report of such investigation to the Agency for Health Care Administration within 15 days; amending s. 429.255, F.S.; authorizing a facility resident or his or her representative to contract with a third party under certain circumstances; amending s. 429.256, F.S.; 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 purpose; 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 and continued residency at an assisted living facility; defining the term "bedridden"; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility;

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requiring that such examination be recorded on a specified form; providing minimum requirements for such form; revising provisions relating to the placement of residents by the Department of Elderly Affairs or 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; removing provisions relating to the retention of certain residents in a facility; amending s. 429.28, F.S.; revising residents' rights relating to a safe and secure living environment; amending s. 429.41, F.S.; removing provisions relating to firesafety requirements; removing an obsolete provision; requiring, rather than authorizing, the Agency for Health Care Administration to use an abbreviated biennial standard licensure inspection; revising the criteria under which a facility must be fully inspected; revising provisions requiring the agency to develop key quality-of-care standards; creating s. 429.435, F.S.; revising uniform firesafety standards for assisted living facilities, which are relocated to this section; amending s. 429.52, F.S.; revising provisions relating to facility staff training requirements; requiring the Department of Elderly Affairs 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 Department of Elderly Affairs and the Agency for Health Care Administration; requiring the Department of Elderly Affairs to contract with another entity to administer the competency test; requiring the department to adopt a curriculum outline to be used by core trainers; amending s. 429.07, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Present subsections (6) through (27) of section 429.02, Florida Statutes, are redesignated as subsections (7) through (28), respectively, present subsections (13), (18), and (27) of that section are amended, and a new subsection (6) is added to that section, to read:

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

(6) "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.

(14) ~~(13)~~ "Limited nursing services" means acts that may be performed by a person licensed under part I of chapter 464. Limited nursing services shall be for persons who meet the admission criteria ~~established by the department~~ for assisted

living facilities and shall not be 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.

(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.

(27) "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services shall be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or the disease state or stage.

Section 2. 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 3. 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 and core competency test 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 training and core competency test ~~educational~~ requirements.

Section 4. Subsections (3) through (9) 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 initiate an investigation ~~provide~~ within 24 hours after ~~1 business day after~~ the occurrence of an adverse incident~~, by electronic mail, facsimile, or United States mail, a preliminary report to the~~

~~agency on all adverse incidents specified under this section~~. The facility must complete the investigation and submit a report to the agency within 15 days after the occurrence of the adverse incident. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the result ~~status~~ of the facility's investigation of the incident.

~~(4) Licensed facilities shall provide within 15 days, 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) 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.~~

(4) ~~(6)~~ Abuse, neglect, or exploitation must be reported to the Department of Children and Families as required under chapter 415.

(5) ~~(7)~~ The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may

investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.

(6) ~~(8)~~ If the agency, through its receipt of the adverse incident report ~~reports~~ prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.

(7) ~~(9)~~ The adverse incident report ~~reports and preliminary adverse incident reports~~ required under this section is ~~are~~ confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.

Section 5. Paragraphs (a) and (b) of subsection (1) of section 429.255, Florida Statutes, are amended, and paragraph (d) is added to that subsection, to read:

429.255 Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician, observe

residents, document observations on the appropriate resident's record, and report observations to the resident's physician~~, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26~~. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician.

(b) All staff of ~~in~~ facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility.

(d) A resident or a resident's representative, designee, surrogate, guardian, or attorney in fact may contract for services with a third party, provided the resident meets the criteria for continued residency as provided in s. 429.26. The third party must communicate with the facility regarding the resident's condition and the services being provided. The facility must document that it received such communication.

Section 6. 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 and topical skin, ophthalmic, otic, and nasal dosage forms, including patches, 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 purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(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 the ~~at the request of a competent~~ resident requesting the medication is aware of his or her need for the medication and understands the purpose of taking the medication.

Section 7. 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 residency 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. A facility may not retain a resident who requires 24-hour nursing supervision, except for a resident who is enrolled in hospice services pursuant to part IV of chapter 400. The resident must have a plan of care that delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident.

(d)1. Except as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden. For purposes of this paragraph, the term "bedridden" means that a resident is confined to 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;

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 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 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 stay in the facility. The medical examination form 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.

(6) The medical examination form submitted under subsection (5) must include the following information relating to the resident:

(a) Height, weight, and known allergies.

(b) Significant medical history and diagnoses.

(c) Physical or sensory limitations, including the need for fall precautions or recommended use of assistive devices.

(d) Cognitive or behavioral status and a brief description of any behavioral issues known or ascertained by the examining practitioner, including any known history of wandering or elopement.

(e) Nursing, treatment, or therapy service requirements.

(f) Whether assistance is needed for ambulating, eating, and transferring.

(g) Special dietary instructions.

(h) Whether he or she has any communicable diseases, including necessary precautions.

(i) Whether he or she is bedridden and the status of any pressure sores that he or she has.

(j) Whether the resident needs 24-hour nursing or psychiatric care.

(k) A list of current prescribed medications as known or ascertained by the examining practitioner and whether the resident can self-administer medications, needs assistance, or needs medication administration.

~~(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.~~

(7) ~~(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 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.

(8) ~~(7)~~ The facility shall ~~must~~ notify a licensed physician in writing 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 in writing 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.

(9) ~~(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.~~

(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 8. Paragraphs (a) and (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:

(a) Live in a safe and decent living environment, free from abuse, exploitation, and neglect.

(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 written notice must contain the following disclosure in 12-point uppercase type:

THE STATE LONG-TERM CARE OMBUDSMAN PROGRAM PROVIDES SERVICES THAT ASSIST IN PROTECTING THE HEALTH, SAFETY, WELFARE, AND RIGHTS OF RESIDENTS. FOR ASSISTANCE, CONTACT THE OMBUDSMAN PROGRAM TOLL-FREE AT 1-888-831-0404 OR VIA E-MAIL AT LTCOPInformer@elderaffairs.org.

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 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 9. Section 429.41, Florida Statutes, is 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, in consultation with the department, may adopt rules to administer the requirements of 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 department, in consultation with the agency, 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 or chapter 381, relating to

furnishings for resident bedrooms or sleeping areas, locking devices, linens, laundry services ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and similar physical plant standards ~~other housing conditions~~, 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 department 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 local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, 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 local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(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) ~~(c)~~ 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; and

9. The requirements for using medical diagnostic testing equipment that is designed for a residential setting and is used

at the point of care delivery, including equipment to test cholesterol, blood glucose level, and blood pressure.

(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 geriatric chairs or 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. 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 ~~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 department, in conjunction with 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 department 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 department, in conjunction with 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 department and the agency relative to the physical characteristics of facilities and the types of care offered.

(3) ~~The department shall submit a copy of proposed rules to the Speaker of the House of Representatives, the President of the Senate, and appropriate committees of substance for review and comment prior to the promulgation thereof.~~ Rules promulgated by the department must ~~shall~~ encourage the development of homelike facilities which promote the dignity, individuality, personal strengths, and decisionmaking ability of residents.

(4) The agency, in consultation with the department, may waive rules promulgated pursuant to this part in order to demonstrate and evaluate innovative or cost-effective congregate care alternatives which enable individuals to age in place. Such waivers may be granted only in instances where there is reasonable assurance that the health, safety, or welfare of residents will not be endangered. To apply for a waiver, the licensee shall submit to the agency a written description of the concept to be demonstrated, including goals, objectives, and anticipated benefits; the number and types of residents who will be affected, if applicable; a brief description of how the demonstration will be evaluated; and any other information deemed appropriate by the agency. Any facility granted a waiver

shall submit a report of findings to the agency and the department within 12 months. At such time, the agency may renew or revoke the waiver or pursue any regulatory or statutory changes necessary to allow other facilities to adopt the same practices. The department may by rule clarify terms and establish waiver application procedures, criteria for reviewing waiver proposals, and procedures for reporting findings, as necessary to implement this subsection.

(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 violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program to a regulatory agency ~~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~~, in consultation with the department,~~ 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 10. Section 429.435, Florida Statutes, is created to read:

429.435 Uniform firesafety standards.-Uniform firesafety standards for assisted living facilities and a residential board and care occupancy 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, 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 11. 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 Department of Elderly Affairs 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 department shall establish 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 competency test must be developed by the department in conjunction with the agency ~~and providers~~. 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 department 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 department staff~~. Two hours of continuing education is required annually thereafter. The department shall establish by rule the minimum requirements of this ~~additional~~ training.

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

(8) If ~~the department or~~ the agency determines that there are problems in a facility that could be reduced through specific staff training ~~or education~~ beyond that already required under this section, ~~the department or~~ 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 department 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 department 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 department 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 department as having the requisite experience and credentials to conduct the training. A person seeking to register as a core trainer must provide the department 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 department; or

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

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

Section 12. Paragraph (b) of subsection (3) of section 429.07, Florida Statutes, is 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 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 services 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).

Section 13. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1592
Bill Number (if applicable)

Topic ALF

Amendment Barcode (if applicable)

Name Cynthia Henderson

Job Title

Address 108 E Jefferson
Street
Tallahassee
City *State* *Zip*

Phone 8505590855

Email cthenderson

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Atria Senior Living

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-16-19
Meeting Date

1592
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Senior Living Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1592
Bill Number (if applicable)

Topic ALFs

Amendment Barcode (if applicable)

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Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Health Care Assoc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

SB 1592
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

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Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Leading Age Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/19
Meeting Date

1592
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

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Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Long-Term Care Ombudsman Program

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/CS/SB 1620 (903010)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Gainer and others
SUBJECT:	Health Care Licensing Requirements
DATE:	April 18, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.	Gerbrandt	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1620 creates s. 456.0231, F.S., to grant physicians who are employees of the U.S. Department of Veterans Affairs (VA) an exemption from Florida's physician licensure requirements when providing medical treatment to veterans in a Florida-licensed hospital, if such physicians meet certain criteria and furnish specified documentation to the Florida Department of Health (DOH).

The bill provides for an expiration of that exemption, allows for a renewal process, and creates conditions under which an exemption can be revoked or invalidated by the DOH.

The bill has no fiscal impact on state expenditures. The bill has an effective date of July 1, 2019.

II. Present Situation:

Regulation of Health Care Practitioners in Florida

The Department of Health (DOH) is responsible for the regulation of health care practitioners and certain health care facilities in Florida for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA), working in conjunction with 22 boards and six councils, licenses and regulates seven types of health care facilities, and more

than 200 license types, in over 40 health care professions.[1] Any person desiring to be a licensed health care professional in Florida must apply to the MQA in writing.[2] Most health care professions are regulated by a board or council in conjunction with the DOH, and all professions have different requirements for initial licensure and licensure renewal.[3]

Licensing of Florida Physicians

The regulation of the practices of medicine and osteopathic medicine fall under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[4] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[5]

The current licensure application fee for a medical doctor is $350 and is non-refundable.[6] Applications must be completed within one year. If a license is approved, the initial license fee is $355.[7] The entire process may take from two to six months from the time the application is received.[8]

For osteopathic physicians, the current application fee is non-refundable $200, and if approved, the initial licensure fee is $305.[9] Applications must be completed within one year. The entire process may take from two to six months from the time the application is received.[10] If an applicant is licensed in another state, the applicant may request that Florida "endorse" the exam scores of the others states licensing exam. The applicant must demonstrate that the out of state license was issued based on those exam scores. The applicant must also show that the exam was substantially similar to any exam that Florida allows for licensure.[11]

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[1] Florida Department of Health, Medical Quality Assurance, *Annual Report and Long Range Plan, 2017-2018*, p. 6, available at: http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1718.pdf (last visited Apr. 4, 2019).
[2] Section 456.013, F.S.
[3] *See* chs. 401, 456-468, 478, 480, 483, 484, 486, 490, and 491, F.S.
[4] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[5] *Id.*
[6] Florida Board of Medicine, *Medical Doctor - Fees*, available at: *https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted /*(Last visited Mar. 8, 2019).
[7] A change to Rule 64B-3.002, F.A.C., is effective March 11, 2019 which modifies the fee schedule for licensure applications. The fee for licensure by examination will increase to $500 and the fee for licensure by endorsement will increase also to $500. The time to complete an initial applications is also reduced from one year to six months.
[8] Florida Board of Medicine, *Medical Doctor Unrestricted – Process*, available at: *https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/* (last visited Mar. 8, 2019).
[9] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees*, available at: *https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/* (last visited: Mar. 8, 2019).
[10] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process*, available at: *https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/* (last visited Mar. 8, 2019).
[11] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure – Requirements*, available at: *https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/* (last visited Mar. 8, 2019).

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. However, the practice acts are not identical in their licensure offerings as shown in the table below which compares some of the contents of the two practice acts. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:

- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education.
- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to the DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.
- Demonstrate that she or he has successfully completed a resident internship (osteopathic medicine) or supervised clinical training (medical) of not less than 12 months in a hospital approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.[12]

Statutory References for Practice Acts - Licensure Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.		
Issue	**Medical Physicians**	**Osteopathic Physicians**
Regulatory Board	Board of Medicine s. 458.307, F.S.	Board of Osteopathic Medicine s. 459.004, F.S.
Rulemaking Authority	s. 458.309., F.S.	s. 459.005, F.S.
General Requirements for Licensure	s. 458.311, F.S.	s. 459.0055, F.S.
Licensure Types		
Restricted License	s. 458.310, F.S.	No provision
Restricted License Certain foreign physicians	s. 458.3115, F.S.	No provision
Licensure by Endorsement	s. 458.313, F.S.	No provision
Temporary Certificate	s. 458.3135, F.S.	No provision

[12] *See* ss. 458.311, F.S. and 459.0055, F.S.

Statutory References for Practice Acts - Licensure Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.		
Issue	**Medical Physicians**	**Osteopathic Physicians**
(Approved Cancer Centers)		
Temporary Certificate (Training Programs)	s. 458.3137, F.S.	No provision
Medical Faculty Certificate	s. 458.3145, F.S.	s. 459.0077, F.S.
Temporary Certificate Areas of Critical Need	s. 458.315, F.S.	s. 459.0076, F.S.
Temporary Certificate Areas of Critical Need – Active Duty Military & Veterans	s. 458.3151, F.S.	s. 459.00761, F.S.
Public Health Certificate	s. 458.316, F.S.	No provision
Public Psychiatry Certificate	s. 458.3165, F.S.	No provision
Limited Licenses	s. 458.317, F.S.	s. 459.0075, F.S.
Expert Witness	s. 458.3175, F.S.	s. 459.0066, F.S.
License Renewal	s. 458.319, F.S. $500/max/biennal renewal	s. 459.008, F.S.
Financial Responsibility *Condition of Licensure*	s. 458.320, F.S.	s. 459.0085, F.S.
Penalty for Violations	s. 458.327, F.S.	s. 459.013, F.S.

In Florida, to practice medicine an individual must become a licensed medical doctor through licensure by examination[13] or licensure by endorsement.[14] Florida does not recognize automatically another state's medical license or provide licensure reciprocity. Licensure by endorsement requires the medical physician to meet the following requirements:

- Be a graduate of an allopathic United States Medical School recognized and approved by the United States Office of Education (AMG) and completed at least one year of residency training;
- Be a graduate of an allopathic international medical school (IMG) and have a valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate and completed an approved residency of at least two years in one specialty area; or
- Be a graduate who has completed the formal requirements of an international medical school except the internship or social service requirements, passed parts I and II of the National Board of Medical Examiners (NBME) or ECFMG equivalent examination, and completed an academic year of supervised clinical training (5th pathway) and completed an approved residency of at least two years in one specialty area.
- And both of the following:
  - Passed all parts of a national examination (the NBME; the Federation Licensing Examination offered by the Federation of State Medical Boards of the United States, Inc.; or the United States Medical Licensing Exam); and

[13] Section 458.311, F.S.
[14] Section 458.313, F.S.

- Be licensed in another jurisdiction and actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years; or passed a board-approved clinical competency examination within the year preceding filing of the application or; successfully completed a board approved postgraduate training program within 2 years preceding filing of the application.[15]

Financial Responsibility

As a condition of licensure all Florida-licensed allopathic physicians are required to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.[16] Physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim.[17] Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim.[18] Certain physicians who are exempt from the requirement to carry professional liability insurance or other financial responsibility must provide notice to their patients.[19]

Florida-licensed osteopathic physicians have similar financial responsibility requirements as allopathic physicians[20]. With specified exceptions, the DOH must suspend, on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.[21]

Disciplinary Process: Fines and Sanctions

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in the DOH. Section 456.072, F.S., specifies 40 acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 458.331, F.S., identifies 43 acts that constitute grounds for which disciplinary actions may be taken against a medical physician and s. 459.015, F.S., identifies those acts which are specific to an osteopathic physician. Some parts of the review process are public and some are confidential.[22]

Complaints and allegations are received by the MQA unit for determination of legal sufficiency and investigation. A determination of legal sufficiency is made if the ultimate facts show that a

[15] Florida Board of Medicine, *Medical Doctor-Unrestricted; Licensure by Endorsement*, available at: https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Apr. 1, 2019).
[16] *Section* 458.320, F.S.
[17] Section 458.320(2), F.S.
[18] Section 458.320(1), F.S.
[19] Section 458.320(5)(f) and (g), F.S.
[20] Section 459.0085, F.S
[21] Sections 458.320(8) and 459.0085(9), F.S.
[22] Fla. Department of Health, Division of Medical Quality Assurance, *Enforcement Process*, available at: http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/enforcement-process-chart.pdf (last updated Mar. 11, 2019).

violation has occurred.[23] The complainant is notified by letter as to the whether the complaint will be investigated and if any additional information is needed. Complaints which involve an immediate threat to public safety are given the highest priority.

The DOH is responsible for reviewing each report to determine if discipline against the provider is warranted.[24] Authorization for the discipline of allopathic and osteopathic physicians can be found in state law and administrative rule.[25] If held liable for one of the offenses, the fines and sanctions by category and by offense are based on whether it is the physician's first, second, or third offense.[26] The boards may issue a written notice of noncompliance for the first occurrence of a single minor violation.[27] The amount of fines assessed can vary depending on the severity of the situation, such as improper use of a substance to concealment of a material fact. A penalty may come in the form of a reprimand, a licensure suspension, or revocation followed by some designated period of probation if there is an opportunity for licensure reinstatement. Other sanctions may include supplemental continuing education requirements which require proof of completion before the license can be reinstated.

Disciplinary Process: Emergency Procedures

When a third report of a professional liability claim has been submitted, within a 5-year period, against a licensed physician, the DOH is required to initiate an emergency investigation and the BOM or BOOM must conduct an emergency probable cause hearing to determine if a physician should be disciplined for committing medical malpractice, gross medical malpractice, or repeated medical malpractice.[28]

Disciplinary Process: Physician's Consent

During an investigation of a complaint, every Florida-licensed physician is deemed to have given his or her consent to the following:[29]

- To render a handwriting sample to an agent of the DOH and waive any objections to its use as evidence;
- To waive the confidentiality and authorize the preparation and release of medical reports, including symptoms, diagnosis, treatment prescribed, relevant history, and progress, pertaining to his or her mental or physical condition; and
- To waive any objection to the admissibility of the reports as constituting privileged communications.

[23] Fla. Department of Health, *Consumer Services – Administrative Complaint Process,* available at: http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited Mar. 11, 2019).
[24] *See* ss. 458.351(5) and 459.026(5), F.S.
[25] *See s*s. 458.307 and 459.004, F.S., for the regulatory boards, and ss. 64B8-8 and 64B15-19, F.A.C., for administrative rules relating to disciplinary procedures.
[26] *Id.*
[27] Sections 64B8-8.011 and 64B15-19.0065, F.A.C. A minor violation is deemed to not endanger the public health, safety, and welfare and does not demonstrate a serious inability to practice.
[28] *See* ss. 458.3311 and 459.0151, F.S.
[29] *See* ss. 458.339 and 459.017, F.S.

The DOH may issue subpoenas duces tecum, requiring the names and addresses of some or all of the patients of a licensed physician against whom a complaint has been filed pursuant to s. 456.073, F.S.[30]

Itemized Patient Billing

All licensed allopathic and osteopathic physicians are required, upon request, to provide to a patient an itemized statement of the specific services rendered and the charge for each service.[31]

Florida Background Checks

Effective January 1, 2013, all applicants for initial physician licensure must undergo a Level 2 background screening[32] and use a *Livescan* provider[33] to submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to applicant. The results of the search are returned to the Care Provider Background Screening Clearinghouse and made available to the DOH for consideration during the licensure process. The fingerprints submitted by the applicant are retained by FDLE and the Clearinghouse. All costs for conducting a criminal history background screening are borne by the applicant.[34]

Applicants for physician licensure can use any FDLE-approved Livescan provider to submit their fingerprints. The applicant is fully responsible for selecting the service provider and ensuring the results are reported to the DOH. An applicant must use a DOH form available on its website and take it to the Livescan provider.[35]

A physician licensed in Florida must undergo a Level 2 background screening every five years. Effective January 1, 2019, the fee to retain fingerprints within the Clearinghouse is $43.25, plus minimal service fee. Once fingerprints have been retained by the Clearinghouse, they are good for five years. Clearinghouse renewals can only be requested within a specific timeframe that is based on the retained print expiration date.

VA Practitioners in Florida

Health care practitioners practicing in VA facilities in Florida are not required to be licensed in Florida. In order for a practitioner to practice at any VA facility, the VA requires the practitioner to have an active, unrestricted license from any state.[36] Thus, a VA health care practitioner may treat any veteran in a VA facility located in Florida, regardless of the state of licensure. However, a VA practitioner may not provide medical services to any patient, veteran or otherwise, outside of a VA facility unless he or she holds a Florida license. If a VA practitioner

[30] *See* ss. 458.343 and 459.019, F.S.
[31] *See* ss. 458.323 and 459.012, F.S.
[32] Sections 435.04 and 458.311(1) (g), FS.
[33] Section 435.12, F.S.
[34] Florida Department of Health, *Board of Medicine, Medical Doctor – Licensure Requirements*, available at: https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Apr. 11, 2019).
[35] *Id.*
[36] U.S. Department of Veterans Affairs, *Navigating the Hiring Process*, (updated January 06, 2019) available at: https://www.vacareers.va.gov/ApplicationProcess/NavigatingHiringProcess (last visited April 8, 2019).

is not licensed in Florida and provides such services outside a VA facility, the practitioner could be prosecuted for the unlicensed practice of a health care practitioner.

VA Background Checks

All VA employees are subject to an evaluation process for the purpose of determining their suitability for work through a background investigation process. The level of investigation is determined by the sensitivity of the position in question, which is then rated as low, moderate, or high risk. At a minimum, VA employees should receive a Tier 1 investigation to verify that the individual is suitable for employment. Most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians, are required to receive this type of investigation.[37]

In March 2018, the VA Office of Inspector General published the findings of an investigation conducted to evaluate controls over the adjudication of background investigations at VA medical facilities for the five-year period ending September 30, 2016. The report included the following:[38]

- The VA did not provide effective governance of the personnel suitability program necessary to ensure that background investigation requirements were met at medical facilities nationwide;
- While background investigations were required for most medical facility staff, about 6,200 employees who were working at the facilities did not have a background investigation initiated, including health care practitioners who were employed to provide direct patient care to veterans;39
- VA adjudicators had not been reviewing background investigations timely, and suitability program staff were not maintaining official personnel records as required;
- The VA office responsible for evaluating compliance with personnel suitability program requirements, including the background investigation process, lacked sufficient staff to conduct regular oversight;
- The VA personnel suitability program was allowed to operate unmonitored and without assurance that background investigations were properly initiated and adjudicated; and
- The VA could not reliably attest to the suitability of its largest workforce, thereby exposing veterans and employees to individuals who have not been properly vetted.

Military Health Care Practitioners

Florida offers an expedited licensure process to facilitate veterans seeking licensure in a health care profession in Florida through its Veterans Application for Licensure Online Response System (VALOR).[40] In order to qualify, a veteran must apply for the license within 6 months before, or 6 months after, he or she is honorably discharged from the Armed Forces. There is no application fee, licensure fee, or unlicensed activity fee for such expedited licensure.[41]

[37] VA Office of Inspector General, *Veterans Health Administration, Audit of Personnel Suitability Program,* p. 1, available at: https://www.va.gov/oig/pubs/VAOIG-17-00753-78.pdf (last visited April 11, 2019).
[38] *Id.* pp. i-ii
[39] *Id.* p. 4
[40] Florida Dep't of Health, Veterans, http://www.flhealthsource.gov/valor#Veterans, (last visited April 4, 2019).
[41] *Id.*

Section 456.024, F.S., provides that any member of the U.S. Armed Forces is eligible for licensure as a health care practitioner in Florida if he or she:

- Serves, or has served, as a health care practitioner in the U.S. Armed Forces, the U.S. Reserve Forces, or the National Guard;
- Serves, or has served, on active duty with the U.S. Armed Forces as a health care practitioner in the United States Public Health Service; or
- Is the spouse of a person serving on active duty with the U.S. Armed States Armed Forces and is a health care practitioner in another state, the District of Columbia, or a possession or territory of the U.S.[42]

The DOH is required to waive fees and issue a license if such individuals submit a completed application and proof of the following:

- An honorable discharge within 6 months before or after the date of submission of the application;[43]
- One of the following:
  - An active, unencumbered license from another state, the District of Columbia, or U.S. possession or territory, with no disciplinary action taken within the 5 years preceding the application; or
  - That he or she is a military health care practitioner in a profession that does not require licensure in a state or jurisdiction to practice in the U.S. Armed Forces, if he or she submits to the DOH evidence of :
    - Military training or experience substantially equivalent to the requirements for licensure; and
    - Evidence of a passing score on an examination from a national or regional standards organization, if such exam is required in this state; or
  - That he or she is the spouse of a person serving on active duty in the U.S. Armed Forces and is a health care practitioner in a profession that licensure is not required in another state or jurisdiction, if he or she submits to the DOH evidence of:
    - Training or experience substantially equivalent to the requirements for licensure in this state; and
    - Evidence of a passing score on an examination from a national or regional standards organization, if such exam is required in this state.
- An affidavit that he or she is not the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the U. S. Department of Defense for reasons related to the practice of the profession; and
- Active practice in the profession for the 3 years preceding the application.

An applicant must also submit fingerprints for a background screening, if required for the profession for which the applicant is applying.[44]

The DOH must verify all information submitted by an applicant using the National Practitioner Data Bank; and an applicant under s. 456.024(3), F.S., for initial licensure as a physician or

[42] Section 456.024(3)(a), F.S.
[43] A form DD-214 or an NGB-22 is required as proof of honorable discharge. See Department of Health, Veterans, available at: http://www.flhealthsource.gov/valor (last visited Apr. 4, 2019).
[44] Section 456.024(3)(b), F.S.

advanced practice registered nurse (APRN) must submit all information required by ss. 456.039(1) and 456.0391(1), F.S., no later than 1 year after the license is issued.[45]

A board, or the DOH if there is no board, may also issue a temporary health care professional license to the spouse of an active duty member of the Armed Forces upon submission of an application form and fees. The applicant must hold a valid license for the profession issued by another state, the District of Columbia, or a possession or territory of the U.S. and may not be the subject of any disciplinary proceeding in any jurisdiction relating to the practice of a regulated health care profession in Florida.

III. Effect of Proposed Changes:

CS/SB 1620 creates s. 456.0231, F.S., to grant physicians who are employees of the VA an exemption from Florida's physician licensure requirements when providing medical treatment to veterans in a Florida-licensed hospital, if such physicians meet certain criteria and furnish specified documentation to the DOH.

The bill defines "physician" as a person who holds an active, unencumbered license to practice allopathic medicine or osteopathic medicine issued by another state; the District of Columbia; or a possession, commonwealth, or territory of the United States.

To be exempt from Florida licensure requirements pertaining to medical doctors under ch. 458, F.S., or osteopathic physicians under ch. 459, F.S., such a physician must submit the following to the DOH:

- Proof that the physician holds an active, unencumbered license to practice allopathic medicine or osteopathic medicine, as applicable, issued by another state; the District of Columbia; or a possession, commonwealth, or territory of the United States; and
- Proof of current employment with the VA;

As a condition of receiving the licensure exemption, the physician must submit a notarized attestation that he or she will provide only medical services to veterans:

- Pursuant to employment as a physician with the VA; and
- In Florida-licensed hospitals.

The exemption is contingent upon a physician's continued employment with the VA and requires that a physician notify the DOH within 15 business days after their employment with the VA is terminated. The DOH is required to revoke the exemption upon receipt of such notification. Exemptions granted under the bill expire after 24 months unless it has been revoked or is renewed. The bill allows for exemptions to be renewed upon the submission of certain information.

The bill requires the DOH to notify the physician within 15 business days after receipt of the documentation that the physician is exempt. The notification must include information related to

[45] Section 456.024, (3)(d), F.S. The information required by ss. 356.039(1) and 356.0391(1), F.S., includes: 1) school name where education and training received; 2) names of locations and hospitals where practice; 3) address of primary practice location; 4) year applicant began practice; 5) any certification or designation; 6) any faculty appointments; 7) any criminal record: and 8) Any professional disciplinary action.

the conditions under which the DOH may invalidate or revoke an exemption and exemption renewal requirements.

The bill authorizes the DOH to adopt rules to implement the exemption provisions.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

PCS/SB 1620 may provide an avenue for veterans who do not live near a VA facility and/or face transportation problems with getting to a VA facility, to receive medical services from VA physicians at a Florida-licensed hospital that is more accessible.

C. Government Sector Impact:

The bill may increase the workload on DOH staff due to the processing of exemptions, renewals, and revocations authorized under the bill, however, the additional costs can be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Under the bill, it appears that individuals exempt from the licensure requirements of chs. 458 and 459, F.S., are also exempt from the BOM and BOOM standards of practice. The BOM and BOOM have the authority to investigate and discipline licensed physicians. Individuals, under the bill, will not have a Florida license; Therefore, the boards would not have authority/jurisdiction to discipline the physicians that are exempt under the bill. If physicians exempt under this bill fail to meet the standard of care or cause patient harm, it does not appear that Florida has the authority to discipline these physicians and it is unknown if the state where they have an active license would have jurisdiction.

A physician may have a license in multiple states. Under the bill, as long as they have an active unencumbered license in one state, they would be able to practice, even if there were extensive disciplinary actions in other states. Checking previous disciplinary actions in other states is part of Florida's licensing process.

There are also a wide range of statutory and regulatory requirements throughout the Florida Statutes that only apply to physicians licensed under these chapters. Examples include provisions on kickbacks, required disclosures to patients, reporting of adverse incidents, and other reporting requirements. Since these practitioners would be unlicensed, it appears that they would not be subject to any of those provisions.

Each physician exempted from licensure under the bill will result in a deferral of criminal background checks and fingerprinting, which would normally occur before a physician is allowed to practice in the state outside of a VA facility. Therefore, a physician exempted under the bill who has committed a Florida-licensure disqualifying offense may still be able to practice in Florida-licensed hospitals under the bill.

On lines 34-36, the bill provides that as a condition of "receiving" the exemption, a physician must attest that he or she "will provide only medical services to veterans." However, after a physician "receives" the exemption, the physician could technically remain exempt under the bill from Florida's physician licensure requirements, regardless of whether he or she abides by the attestation.

Under the bill, physicians not licensed in Florida may provide medical services to "veterans" in Florida-licensed hospitals. According to the definition of "veterans" in s. 1.01(14), F.S., the bill does not authorize exempted physicians to provide medical services to active duty service members in such hospitals under the bill, even though the VA allows active duty service members to receive limited health benefits and health care services from the VA under certain circumstances.

VIII. Statutes Affected:

This bill creates section 456.0231 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on April 16, 2019:
The committee substitute:

- Requires a person seeking an exemption to submit to the DOH a *notarized* attestation that he or she will provide medical services to veterans exclusively under certain conditions, rather than an attestation alone.
- Removes one of the conditions of exemption, which requires a person seeking an exemption to provide medical services to veterans at a USDVA facility or outreach location. Currently, under federal law a health care practitioner practicing in a VA facility is not required to be licensed in Florida.
- Expands one of the conditions of exemption, which requires a person seeking an exemption to provide medical services to veterans at hospital licensed under ch. 395, to include, providing medical services to veterans at a hospital licensed under ch. 395 *while remaining employed as a physician by the VA.*
- Requires that an exemption is contingent upon a physician remaining employed by the VA and is otherwise invalid. The CS also requires a physician to notify the DOH within 15 business days of termination of VA employment and upon receipt, the DOH must revoke the exemption.
- Requires that an exemption expire after 24 months, unless the exemption is revoked or rendered invalid at an earlier time.
- Authorizes an exemption renewal process.
- When notifying a person that an exemption has been granted, the CS requires the DOH to include information related the conditions under which the DOH must invalidate or revoke an exemption and exemption renewal requirements.

CS by Health Policy on April 8, 2019
The CS:

- Removes the statement of legislative intent from the underlying bill;
- Provides that a person holding an unencumbered license to practice medicine as a physician in another state, D.C., or a U.S. possession or territory, is exempt from needing a Florida license to practice medicine in Florida if he or she submits to the DOH:
    - Proof that he or she holds such a license described above;
    - Proof of current employment with the VA; and,
    - An attestation that he or she will provide only medical services to veterans at a VA facility or outreach location, pursuant to his or her employment with the VA, and in Florida-licensed hospitals.
- Requires the DOH to notify such a physician that he or she is exempt within 15 business days after receiving the documentation required for the exemption;

- Limits the exemption of licensure to medical doctors and osteopaths only, instead of including other types of health care practitioners as provided in the underlying bill;
- Removes the allowance from the underlying bill that practitioners licensed in other countries could also be exempted from needing a Florida license;
- Removes the underlying bill's requirement for the executive director of the Florida Department of Veterans' Affairs to provide the state surgeon general with a list of all practitioners who are eligible for exemption under the bill;
- Removes from the underlying bill the provision for the bill to not be construed to preempt or supplant a medical facility's policies regarding the award of emergency privileges to medical personnel; and
- Provides authority for the DOH to adopt rules, as opposed to the underlying bill's *requirement* for the DOH to adopt rules.

B. Amendments:

None.

828958

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/16/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Gainer) recommended the following:

Senate Amendment (with title amendment)

Delete lines 25 - 46

and insert:

(2) The department may grant an exemption from the licensure requirements of chapters 458 and 459 to a physician who requests the exemption and who submits to the department all of the following:

(a) Proof that he or she holds an active, unencumbered license to practice allopathic medicine or osteopathic medicine

828958

issued by another state; the District of Columbia; or a possession, commonwealth, or territory of the United States.

(b) Proof of current employment as a physician with the United States Department of Veterans Affairs.

(c) A notarized attestation, on a form developed by the department, that under any exemption or renewal granted under this section, he or she will provide medical services to veterans exclusively, under one or more of the following conditions:

1. Pursuant to his or her employment as a physician with the United States Department of Veterans Affairs.

2. In a hospital licensed under chapter 395 while remaining employed as a physician by the United States Department of Veterans Affairs.

(3) The department shall notify a physician seeking exemption under this section within 15 business days after receipt of the documentation required under subsection (2) that the physician has been granted an exemption from the licensure requirements of chapters 458 and 459. The notification must include the conditions and requirements specified in subsection (4).

(4) An exemption granted under this section:

(a) Is contingent upon the physician remaining employed by the United States Department of Veterans Affairs and is otherwise invalid. A physician granted an exemption under this section shall notify the department within 15 business days after his or her employment with the United States Department of Veterans Affairs is terminated. Upon receipt of such notification, the department shall revoke the exemption.

828958

(b) Expires 24 months after being granted, unless the exemption is revoked or rendered invalid earlier under paragraph (a) or is renewed. An exempted physician may apply for exemption renewal by providing updated proof consistent with the proof required under paragraphs (2)(a) and (2)(b) within a timeframe determined by the department.

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

And the title is amended as follows:

Delete lines 4 - 10

and insert:

"physician"; authorizing the Department of Health to exempt certain physicians from specified licensing requirements when providing certain services to veterans in this state; requiring such physicians seeking the exemption to submit specified documentation to the department; requiring the department to notify such physicians within a specified timeframe that the exemption has been granted; specifying notice requirements; providing for revocation, expiration, or renewal of the exemption under certain

By the Committee on Health Policy; and Senators Gainer and Passidomo

588-04018-19 20191620c1

A bill to be entitled

An act relating to health care licensure requirements; creating s. 456.0231, F.S.; defining the term "physician"; exempting certain physicians from specified licensing requirements when providing certain services to veterans in this state; requiring such physicians to submit specified documentation to the Department of Health; requiring an exempted physician to attest that he or she will provide medical services only to veterans under certain conditions; authorizing the department to adopt rules; providing an effective date.

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

Section 1. Section 456.0231, Florida Statutes, is created to read:

456.0231 Exemption from health care licensure requirements for physicians who treat veterans.—

(1) As used in this section, the term "physician" means a person who holds an active, unencumbered license to practice allopathic medicine or osteopathic medicine issued by another state; the District of Columbia; or a possession, commonwealth, or territory of the United States.

(2) A physician must submit to the department all of the following to be exempt from the licensure requirements of chapters 458 and 459:

(a) Proof that he or she holds an active, unencumbered license to practice allopathic medicine or osteopathic medicine

588-04018-19 20191620c1

issued by another state; the District of Columbia; or a possession, commonwealth, or territory of the United States.

(b) Proof of current employment with the United States Department of Veterans Affairs.

(3) As a condition of receiving the health care licensure requirement exemption, the physician shall attest that he or she will provide only medical services to veterans:

(a) At United States Department of Veterans Affairs facilities or outreach locations;

(b) Pursuant to his or her employment with the United States Department of Veterans Affairs; and

(c) In hospitals licensed under chapter 395.

(4) The department shall notify the physician within 15 business days after receipt of the documentation of eligibility for the exemption required by subsection (2) that the physician is exempt from the licensure requirements of chapters 458 and 459.

(5) The department may adopt rules to administer this section.

Section 2. This act shall take effect July 1, 2019.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Finance and Tax, *Chair*
Agriculture, *Vice Chair*
Appropriations
Appropriations Subcommittee on Criminal and Civil Justice
Military and Veterans Affairs and Space

SENATOR GEORGE B. GAINER
2nd District

April 8, 2019

Re: SB 1620

Dear Chair Bean,

I am respectfully requesting Senate Bill 1620, related to Health Care Licensing Requirements, be placed on the agenda for the next meeting of the Appropriations Subcommittee on Health and Human Services.

I appreciate your consideration of this bill. If there are any questions or concerns, please do not hesitate to call my office at (850) 487-5002.

Thank you,

Senator George Gainer
District 2

Cc. Tonya Kidd, Robin Jackson, Dee Alexander, Chesten Goodman, Austin Nicklas

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 302 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002
❒ Northwest Florida State College, 100 East College Boulevard, Building 330, Rooms 105 and 112, Niceville, Florida 32578 (850) 747-5454

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/16/2019
Meeting Date

1620
Bill Number (if applicable)

Topic Health Care Licensing Requirements

Amendment Barcode (if applicable)

Name Allison Sitte ("City")

Job Title Legislative & Cabinet Affairs Director

Address The Capitol, Suite 2105
Street

Tallahassee FL 32399
City *State* *Zip*

Phone (850) 487-1533

Email Sittea@fdva.State.fl.US

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Florida Dept. of Veterans' Affairs

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 4/16/2019 1:01:39 PM
Ends: 4/16/2019 2:11:19 PM **Length: 01:09:41**

1:01:40 PM Sen. Bean (Chair)
1:02:02 PM Sen. Bean (Chair)
1:02:58 PM S. 884
1:03:30 PM Jim Akin, Executive Director, National Association of Social Worker Florida (waives in support)
1:03:35 PM Corinne Mixon, Lobbyist, Florida Mental Health Counselor Association (waives in support)
1:03:59 PM Sen. Baxley
1:04:58 PM Sen. Bean (Chair)
1:05:24 PM Patrick Thorson
1:05:52 PM Sen. Berman
1:06:04 PM Sen. Bean (Chair)
1:06:28 PM Am. 206192
1:07:08 PM S. 410
1:07:17 PM Ingrid Delgado, Associate for Social Concerns and Respect Life, Florida Conference of Catholic Bishops (waives in opposition)
1:07:17 PM Barbar Devane, Florida Now (waives in support)
1:07:54 PM S. 410
1:08:41 PM S. 1620
1:08:59 PM Sen. Passidomo
1:09:29 PM Am. 828958
1:10:21 PM Allison Sitte, Legislative and Cabinet Affairs Director, The Florida Department of Veterans Affairs (waives in support)
1:11:16 PM Sen. Bean (Chair)
1:11:44 PM S. 748
1:11:47 PM Sen. Harrell
1:14:15 PM Sen. Bean (Chair)
1:14:28 PM Sen. Harrell
1:14:34 PM S. 1592
1:16:26 PM Sen. Bean (Chair)
1:16:39 PM Susan C. Langston, VP of Advocacy, Leading Age Florida (waives in support)
1:16:45 PM James McFaddin, Florida Senior Living Association (waives in support)
1:16:53 PM Zaynab Salman, Legal Advocate, Long Term Care Ombudsman Program (waives in support)
1:17:08 PM Cynthia Henderson, Atria Senior Living (waives in support)
1:17:19 PM Melody Arnold, Associate Director of Government Affairs, Florida Health Care Association (waives in support)
1:18:14 PM Sen. Bean (Chair)
1:18:28 PM Sen. Rouson
1:18:56 PM S. 634
1:21:59 PM Sen. Bean (Chair)
1:22:14 PM Am. 524848
1:22:50 PM Jerry Paul, Sarasota/ Manatee/Desoto YMCA (waives in support)
1:23:10 PM Sen. Book
1:24:03 PM Sen. Rouson
1:24:56 PM Sen. Bean (Chair)
1:25:04 PM Sen. Harrell (Chair)
1:25:29 PM S. 1192
1:25:32 PM Sen. Bean
1:25:59 PM Am. 799536
1:26:28 PM Chris Nuland, Florida Chapter American College of Physician (waives in support)
1:26:35 PM John Bailey, Psychiatrist, Florida Osteopathic Medical Association
1:30:12 PM Sen. Bean
1:30:30 PM Am. 731540
1:30:49 PM Am. 483502

1:31:03 PM Sen. Bean
1:32:03 PM Chris Hansen, Ballard Partners, Walgreens (waives in support)
1:32:36 PM Sen. Harrell (Chair)
1:32:58 PM Sen. Flores
1:33:22 PM Sen. Bean
1:34:07 PM Jake Farmer, Director of Government Affairs, Florida Retail Federation
1:34:45 PM Chris Hansen, Ballard Partners, Walgreens (waives in support)
1:34:53 PM Brewster Bevis, Senior VP, Associated Industries of Florida (waives in support)
1:35:42 PM Sen. Bean (Chair)
1:35:57 PM S. 1526
1:36:08 PM Sen. Harrell
1:42:09 PM Am. 763358
1:42:17 PM Sen. Hooper
1:42:22 PM Am. 809042
1:43:16 PM Am. 809042 Withdrawn
1:43:21 PM David Ramba, Attorney, Florida Optometric Association (Waives time)
1:43:27 PM Am. 648844
1:43:35 PM Sen. Hooper
1:44:47 PM David Ramba, Attorney, Florida Optometric Association (Waives time)
1:44:57 PM Am. 277068
1:45:16 PM Sen. Harrell
1:45:54 PM Chris Nuland, Florida Chapter American College of Physician (waives in support)
1:45:57 PM Am. 763358
1:46:08 PM Matthew Choy, Director, Florida Chamber of Commerce (waives in support)
1:46:20 PM Stephen Winn, Executive Director, Florida Osteopathic Medical Association (waives in opposition)
1:46:32 PM Jeff Scott, Florida Medical Association
1:50:31 PM Sen. Rader
1:51:17 PM Alison Dudley, President, Florida Radiological Society
1:53:34 PM Chris Hansen, Ballard Partners, Walgreens (waives in support)
1:53:48 PM Jim Daughton, Florida Academy of Family Physicians (waives in opposition)
1:53:56 PM Aimee Diaz Lyon, Florida Chapter of the American Academy of Pediatrics (waives in opposition)
1:54:31 PM Joe Anne Hart, Chief Legislative Officer Florida Dental Association
1:57:23 PM Sen. Farmer
1:59:48 PM Phillip Suderman, Policy Director, Americans for Prosperity
2:01:41 PM Dorene Barker, Associate State Director, AARP Florida (waives in support)
2:01:50 PM Diego Echeverri, Director of Coalitions, Concerned Veterans for America
2:03:37 PM Jack Hebert, Government Affairs Director, Florida Chiropractic Association (waives in support)
2:03:47 PM Alison Dudley, President, Florida Radiological Society (waives in opposition)
2:03:57 PM Victoria Zepp, Chief Research Policy Officer, Florida Coalition for Children (waives in support)
2:04:11 PM Matthew Choy, Director, Florida Chamber of Commerce (waives in support)
2:04:30 PM Sen. Bean (Chair)
2:08:14 PM S. 1526
2:08:59 PM Sen. Book Favorably 884
2:09:11 PM Sen. Farmer Favorably 884
2:09:40 PM Sen. Rader
2:10:54 PM Sen. Bean (Chair)
2:10:56 PM Meeting Adjourned