

Tab 1	SB 714 by Garcia; (Compare to CS/H 00899) Comprehensive Transitional Education Programs				
346524	A	S	AHS, Garcia	Delete L.47 - 75:	04/12 03:44 PM
Tab 2	SB 1050 by Simmons; (Similar to H 00883) Memory Disorder Clinics				
Tab 3	SB 1056 by Garcia; (Identical to H 06021) Home Health Care Agency Licenses				
Tab 4	CS/SB 1406 by HP, Powell (CO-INTRODUCERS) Passidomo, Baxley; (Similar to CS/CS/CS/H 00785) Stroke Centers				
374610	A	S	AHS, Powell	Delete L.68 - 96:	04/12 04:24 PM
Tab 5	CS/SB 28 by JU, Simmons; (Similar to CS/H 06501) Relief of J.D.S. by the Agency for Persons with Disabilities				
Tab 6	CS/SB 34 by JU, Braynon; (Similar to CS/CS/H 06525) Relief of C.M.H. by the Department of Children and Families				
Tab 7	CS/SB 38 by JU, Benacquisto; (Similar to CS/CS/H 06511) Relief of L.T. by the State of Florida				
Tab 8	CS/SB 50 by JU, Gibson (CO-INTRODUCERS) Bracy; (Similar to CS/H 06539) Relief of Eddie Weekley and Charlotte Williams by the Agency for Persons with Disabilities				
Tab 9	CS/SB 406 by HP, Bradley (CO-INTRODUCERS) Young, Hutson; (Compare to H 01177) Compassionate Use of Low-THC Cannabis and Marijuana				
700186	A	S	AHS, Powell	btw L.702 - 703:	04/17 06:42 PM
593180	A	S L	AHS, Artiles	Delete L.635 - 640:	04/17 06:42 PM
504066	A	S L	AHS, Artiles	btw L.834 - 835:	04/17 06:42 PM
Tab 10	CS/SB 510 by HP, Gainer (CO-INTRODUCERS) Montford; (Similar to CS/H 00429) Grant Program for Rural Hospitals				
Tab 11	CS/SB 732 by HP, Steube; (Compare to CS/H 01307) Physician Assistant Workforce Surveys				
Tab 12	CS/SB 780 by ED, Stargel; (Similar to CS/H 00749) Adoption Benefits				
Tab 13	CS/SB 804 by HP, Brandes; (Similar to H 01371) Electronic Health Records				
218290	A	S	AHS, Brandes	btw L.312 - 313:	04/17 06:45 PM
Tab 14	CS/SB 876 by HP, Young (CO-INTRODUCERS) Bean, Rouson; (Similar to CS/CS/H 00229) Programs for Impaired Health Care Practitioners				
862134	A	S	AHS, Young	btw L.73 - 74:	04/17 06:50 PM
419466	A	S	AHS, Young	Delete L.266 - 313:	04/17 06:50 PM
794312	A	S	AHS, Young	Delete L.618 - 664:	04/17 06:51 PM
Tab 15	SB 888 by Bean; (Identical to H 00589) Prescription Drug Price Transparency				
Tab 16	CS/SB 1130 by HP, Bean (CO-INTRODUCERS) Mayfield, Stargel; (Similar to CS/CS/H 00969) Pregnancy Support Services				
698954	A	S	AHS, Book	btw L.95 - 96:	04/17 06:53 PM

Tab 17	CS/SB 1144 by HP, Montford ; (Similar to CS/H 01041) Laboratory Screening				
Tab 18	CS/SB 1318 by CF, Garcia, Broxson ; (Identical to CS/H 01269) Child Protection				
Tab 19	CS/SB 1756 by CF, Garcia ; (Compare to H 00645) Examination and Treatment of Individuals with Mental Illness				
289774	A	S L	AHS, Garcia	btw L.3495 - 3496:	04/17 06:57 PM
Tab 20	SB 1760 by Grimsley (CO-INTRODUCERS) Campbell ; (Similar to CS/H 01195) Health Care Facility Regulation				
286602	D	S	AHS, Grimsley	Delete everything after	04/17 06:59 PM

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA
 APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND
 HUMAN SERVICES
 Senator Flores, Chair
 Senator Stargel, Vice Chair

MEETING DATE: Tuesday, April 18, 2017

TIME: 4:00—6:00 p.m.

PLACE: James E. "Jim" King, Jr. Committee Room, 401 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Stargel, Vice Chair; Senators Artiles, Baxley, Book, Passidomo, Powell, and Rader

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 714 Garcia (Compare CS/H 899)	Comprehensive Transitional Education Programs; Authorizing the Agency for Persons with Disabilities to petition a court for the appointment of a receiver for a comprehensive transitional education program under certain circumstances; providing that no new comprehensive transitional education programs may be licensed after a specified date, etc. CF 03/06/2017 Favorable AHS 04/13/2017 Not Considered AHS 04/18/2017 AP	
2	SB 1050 Simmons (Similar H 883)	Memory Disorder Clinics; Establishing a memory disorder clinic at Florida Hospital in Orange County, etc. HP 03/14/2017 Favorable AHS 04/13/2017 Not Considered AHS 04/18/2017 AP	
3	SB 1056 Garcia (Identical H 6021)	Home Health Care Agency Licenses; Removing a prohibition against the issuance of an initial home health agency license to an applicant who shares common controlling interests with another licensed home health agency located within 10 miles of the applicant and in the same county, etc. HP 04/03/2017 Favorable AHS 04/13/2017 Not Considered AHS 04/18/2017 AP	
4	CS/SB 1406 Health Policy / Powell (Similar CS/CS/CS/H 785)	Stroke Centers; Directing the Agency for Health Care Administration to include hospitals that meet the criteria for acute stroke ready centers on a list of stroke centers; requiring the Department of Health to establish a statewide stroke registry, etc. HP 03/27/2017 Fav/CS AHS 04/13/2017 Not Considered AHS 04/18/2017 AP	

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services
Tuesday, April 18, 2017, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	CS/SB 28 Judiciary / Simmons (Similar CS/H 6501)	Relief of J.D.S. by the Agency for Persons with Disabilities; Providing for the relief of J.D.S.; providing an appropriation from the General Revenue Fund to compensate J.D.S. for injuries and damages sustained as a result of the negligence of the Agency for Persons with Disabilities, as successor agency of the Department of Children and Family Services; providing that certain payments and the appropriation satisfy all present and future claims related to the negligent act, etc. SM JU 02/21/2017 Fav/CS AHS 04/18/2017 AP	
6	CS/SB 34 Judiciary / Braynon (Similar CS/CS/H 6525)	Relief of C.M.H. by the Department of Children and Families; Providing for the relief of C.M.H.; providing an appropriation to compensate C.M.H. for injuries and damages sustained as a result of the negligence of the Department of Children and Families, formerly known as the Department of Children and Family Services; requiring certain funds to be placed into an irrevocable trust, etc. SM JU 03/14/2017 Fav/CS AHS 04/18/2017 AP	
7	CS/SB 38 Judiciary / Benacquisto (Similar CS/CS/H 6511)	Relief of L.T. by the State of Florida; Providing for the relief of L.T.; providing an appropriation to compensate L.T. for injuries and damages sustained as a result of the negligence of employees of the Department of Children and Families, formerly known as the Department of Children and Family Services, etc. SM JU 02/21/2017 Fav/CS AHS 04/18/2017 AP	

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services
Tuesday, April 18, 2017, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	CS/SB 50 Judiciary / Gibson (Similar CS/H 6539)	Relief of Eddie Weekley and Charlotte Williams by the Agency for Persons with Disabilities; Providing for the relief of Eddie Weekley and Charlotte Williams, individually and as co-personal representatives of the Estate of Franklin Weekley, their deceased son, for the disappearance and death of their son while he was in the care of the Marianna Sunland Center, currently operated by the Agency for Persons with Disabilities; providing an appropriation to compensate them for the disappearance and death of Franklin Weekley, which were due to the negligence of the Department of Children and Families, etc. SM JU 02/21/2017 Fav/CS AHS 04/18/2017 AP	
9	CS/SB 406 Health Policy / Bradley (Compare H 1177, H 1397, S 614, S 1388, S 1472, S 1666, S 1758, Linked S 1844)	Compassionate Use of Low-THC Cannabis and Marijuana; Authorizing physicians to issue physician certifications to specified patients who meet certain conditions; requiring the Department of Health to register caregivers meeting certain requirements on the compassionate use registry; requiring the department to establish a quality control program that requires medical marijuana treatment centers to submit samples from each batch or lot of marijuana to an independent testing laboratory; creating the "Medical Marijuana Research and Education Act"; establishing the Coalition for Medical Marijuana Research and Education within the H. Lee Moffitt Cancer Center and Research Institute, Inc., etc. HP 04/03/2017 Fav/CS AHS 04/18/2017 AP	
10	CS/SB 510 Health Policy / Gainer (Similar CS/H 429)	Grant Program for Rural Hospitals; Requiring the Department of Health to establish and administer the Florida Rural Hospital Capital Improvement Competitive Grant Program for certain rural hospitals; deleting requirements for certain information in grant applications, etc. HP 02/21/2017 Fav/CS AHS 04/18/2017 AP	

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services

Tuesday, April 18, 2017, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
11	CS/SB 732 Health Policy / Steube (Compare CS/H 1307)	Physician Assistant Workforce Surveys; Requiring that a physician assistant license renewal include the submission of a physician assistant workforce survey; requiring the Department of Health to report the data collected from such surveys to the boards, etc. HP 04/03/2017 Fav/CS AHS 04/18/2017 AP	
12	CS/SB 780 Education / Stargel (Similar CS/H 749)	Adoption Benefits; Revising the definition of the term "qualifying adoptive employee" to include persons employed by charter schools and the Florida Virtual School for the purpose of extending adoption benefits to those employees; authorizing such employees of charter schools and the Florida Virtual School to apply retroactively for the adoption benefit in certain circumstances, etc. ED 03/21/2017 Fav/CS AHS 04/18/2017 AP	
13	CS/SB 804 Health Policy / Brandes (Similar H 1371)	Electronic Health Records; Authorizing a person to donate his or her electronic health records, subject to certain requirements; authorizing electronic health records and qualified electronic health records to be donated to specified entities for specified purposes; requiring the Agency for Health Care Administration and the Department of Highway Safety and Motor Vehicles to develop and implement a program that encourages and authorizes persons to donate electronic health records and qualified electronic health records as part of a process of issuing and renewing identification cards and driver licenses, etc. HP 03/14/2017 Fav/CS TR 03/28/2017 Favorable AHS 04/18/2017 AP	

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services
Tuesday, April 18, 2017, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
14	CS/SB 876 Health Policy / Young (Similar CS/CS/H 229)	Programs for Impaired Health Care Practitioners; Revising provisions related to impaired practitioner programs; deleting a requirement authorizing the department to adopt by rule the manner in which consultants work with the department in intervention, in evaluating and treating professionals, in providing and monitoring continued care of impaired professionals, and in expelling professionals from the program; providing that, under certain circumstances, a board or, if there is no board, the department, is not required to refuse to admit certain candidates to an examination, to issue a license, certificate, or registration to certain applicants, or to renew a license, certificate, or registration of certain applicants if they have successfully completed a pretrial diversion program, etc. HP 03/14/2017 Fav/CS AHS 04/18/2017 AP	
15	SB 888 Bean (Identical H 589)	Prescription Drug Price Transparency; Requiring the Agency for Health Care Administration to collect data on the retail prices charged by pharmacies for the 300 most frequently prescribed medicines, etc. HP 03/14/2017 Favorable AHS 04/18/2017 AP	
16	CS/SB 1130 Health Policy / Bean (Similar CS/CS/H 969)	Pregnancy Support Services; Requiring the Department of Health to contract with a not-for-profit statewide alliance of organizations to provide pregnancy support services through subcontractors; providing for subcontractor background screenings under certain circumstances; requiring services to be provided in a noncoercive manner and forbidding the inclusion of religious content, etc. HP 03/14/2017 Fav/CS AHS 04/18/2017 AP	

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services
Tuesday, April 18, 2017, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
17	CS/SB 1144 Health Policy / Montford (Similar CS/H 1041, Compare S 1074)	Laboratory Screening; Clarifying that certain requirements related to the reporting of positive HIV test results to county health departments apply only to testing performed in a nonhealth care setting; revising requirements of a public information initiative on lead-based-paint hazards; revising requirements on the distribution of information on childhood lead poisoning developed by the State Surgeon General or his or her designee; clarifying that the membership of the Genetics and Newborn Screening Advisory Council must include one member each from four of the medical schools in this state, etc. HP 03/27/2017 Fav/CS AHS 04/18/2017 AP	
18	CS/SB's 1318 & 1454 Children, Families, and Elder Affairs / Garcia / Broxson (Identical CS/H 1269)	Child Protection; (THIS BILL COMBINES S1318 & 1454) Revising the entities responsible for screening, employing, and terminating child protection team medical directors to include the Statewide Medical Director for Child Protection; requiring the Department of Health, in consultation with the Department of Children and Families, to adopt rules regarding sexual abuse treatment programs; revising provisions regarding expert testimony provided by certain entities to include criminal cases involving child abuse and neglect, dependency cases, and cases involving sexual abuse of a child, etc. CF 03/27/2017 Fav/CS Combined - Lead AHS 04/18/2017 AP	
19	CS/SB 1756 Children, Families, and Elder Affairs / Garcia (Compare H 645, H 1327, H 7011, S 634)	Examination and Treatment of Individuals with Mental Illness; Providing responsibilities of the Department of Children and Families for a comprehensive statewide mental health and substance abuse program; revising rights of individuals receiving mental health treatment and services to provide for the use of health care surrogates or proxies to make decisions; designated receiving facilities to permit access authority to an agency designated by the Governor to serve as the federally mandated protection and advocacy system for individuals with disabilities, etc. CF 04/03/2017 Fav/CS AHS 04/18/2017 AP	

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Health and Human Services
Tuesday, April 18, 2017, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
20	SB 1760 Grimsley (Similar CS/H 1195, Compare CS/CS/H 7, S 676)	Health Care Facility Regulation; Eliminating state licensure requirements for clinical laboratories; authorizing the Agency for Health Care Administration to adopt rules establishing criteria for alternate-site laboratory testing; requiring the manager of a hospital or ambulatory surgical center internal risk management program to demonstrate competence in certain administrative and health care service areas; repealing provisions relating to the purpose and establishment of the Health Care Risk Manager Advisory Council; repealing provisions relating to the Subscriber Assistance Program and Statewide Managed Care Ombudsman Committee; authorizing law enforcement personnel to conduct drug tests on certain inmates and releasees, etc. HP 03/27/2017 Favorable AHS 04/18/2017 AP RC	

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: SB 714

INTRODUCER: Senator Garcia

SUBJECT: Comprehensive Transitional Education Programs

DATE: April 12, 2017

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Crosier	Hendon	CF	Favorable
2. Loe	Williams	AHS	Pre-meeting
3. _____	_____	AP	_____

I. Summary:

SB 714 authorizes the Agency for Persons with Disabilities (APD) to petition a court for the appointment of a receiver for a comprehensive transitional education program under certain circumstances. The bill also prohibits a new comprehensive transitional education program license from being granted after July 1, 2017, under s. 393.18, F.S., and prohibits a license from being renewed for an existing comprehensive transitional education program after December 31, 2019.

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

The bill has an effective date of July 1, 2017.

II. Present Situation:

A comprehensive transitional education program (CTEP) serves individuals with developmental disabilities who also have moderate to severe maladaptive behaviors. There are two CTEPs licensed in Florida. CTEP licenses are issued for a 12-month period. No fees are charged for the initial application or subsequent licensure renewal.

In s. 393.062, F.S., the legislature has expressed its intent that community-based programs and services for individuals with developmental disabilities are preferred to programs operated directly by the state.¹ Pursuant to the recently issued federal Medicaid waiver guidelines, there has been a shift to provide person-centered care and for care to be provided in home and

¹ Agency for Persons with Disabilities legislative analysis dated February 23, 2017.

community-based settings, moving away from institutionalized settings as currently utilized.² The new Medicaid waiver guidelines become effective March 2019.³

Receivership

A receiver is “[an] indifferent person between the parties appointed by a court to collect and receive the rents, issues and profits of land, or the produce or person estate, or other things which it does not seem reasonable to the court that either party should do; or where a party is incompetent to do so.”⁴ Pursuant to s. 393.0678, F.S., APD may petition a court for the appointment of a receiver for a residential habilitation center or a group home facility owned and operated by a corporation or partnership when certain conditions exist:

- A person is operating a facility without a license and refuses to make an application for a license;
- The licensee is closing the facility or has informed the department that it intends to close the facility, and adequate arrangements have not been made for relocation of the residents within seven days, exclusive of weekends and holidays, of the closing of the facility;
- The agency determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or which present a substantial probability that death or serious physical harm will result; or
- The licensee cannot meet its financial obligations to provide food, shelter, care, and utilities.⁵

III. Effect of Proposed Changes:

Section 1 amends s. 393.0678(1), F.S., to add Comprehensive Transitional Education Programs to the list of entities for which APD can initiate receivership proceedings.

Section 2 amends s. 393.18, F.S., to provide that new CTEPs may not be licensed in Florida after July 1, 2017, and existing licenses may not be renewed after December 31, 2019. Currently, CTEP licenses are renewed at the end of each calendar year. This will allow APD to comply with the federal guidelines, effective March 2019, related to the provision of Medicaid home and community-based services in residential settings.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

² *Id.*

³ Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule 79 Fed. Reg. 2948 (Jan. 16, 2014). The effective date of the final regulations was March 14, 2014, and the regulations allow each state up to five years to bring its home and community-based programs into compliance with the home and community-based settings requirements.

⁴ *Black’s Law Dictionary* (Online Dictionary 2nd Ed.)

⁵ Section 393.0678(1)(a)-(d), F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

The transition from the current comprehensive transitional education program in Lake Nona, Florida, to smaller residential group homes will require all clients, including those with private insurance, to move into a new residential group home. The location and expense of the smaller residential group homes are not known at this time.

C. Government Sector Impact:

The bill has no direct impact on state revenues or expenditures. However, in the event a receiver is appointed, APD will be required to provide assessments and transition plans to current residents residing at the comprehensive transitional education program in Lake Nona, Florida. APD will also be required to provide the licensing and oversight of the smaller group homes. These requirements will increase workload for agency staff, and can be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 393.0678 and 393.18.

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:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



346524

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete lines 47 - 75

and insert:

Section 2. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete lines 7 - 12

and insert:



346524

11 under certain circumstances; providing an effective
12 date.

By Senator Garcia

36-01178-17

2017714__

A bill to be entitled

An act relating to comprehensive transitional education programs; amending s. 393.0678, F.S.; authorizing the Agency for Persons with Disabilities to petition a court for the appointment of a receiver for a comprehensive transitional education program under certain circumstances; amending s. 393.18, F.S.; providing that no new comprehensive transitional education programs may be licensed after a specified date; providing that no licenses may be renewed for comprehensive transitional education programs after a certain specified date; providing an effective date.

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

Section 1. Subsection (1) of section 393.0678, Florida Statutes, is amended to read:

393.0678 Receivership proceedings.—

(1) The agency may petition a court of competent jurisdiction for the appointment of a receiver for a comprehensive transitional education program, a residential habilitation center, or a group home facility owned and operated by a corporation or partnership when any of the following conditions exist:

(a) Any person is operating a facility or program without a license and refuses to make application for a license as required by s. 393.067.

(b) The licensee is closing the facility or has informed the department that it intends to close the facility; and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility.

36-01178-17

2017714__

(c) The agency determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or which present a substantial probability that death or serious physical harm would result therefrom. Whenever possible, the agency shall facilitate the continued operation of the program.

(d) The licensee cannot meet its financial obligations to provide food, shelter, care, and utilities. Evidence such as the issuance of bad checks or the accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities constitutes prima facie evidence that the ownership of the facility lacks the financial ability to operate the home in accordance with the requirements of this chapter and all rules promulgated thereunder.

Section 2. Subsection (7) is added to section 393.18, Florida Statutes, to read:

393.18 Comprehensive transitional education program.—A comprehensive transitional education program serves individuals who have developmental disabilities, severe maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of developmental disability and mental illness. Services provided by the program must be temporary in nature and delivered in a manner designed to achieve the primary goal of incorporating the principles of self-determination and person-centered planning to transition individuals to the most appropriate, least restrictive community living option of their choice which is not operated as a comprehensive transitional education program. The supervisor of the clinical director of the program licensee must hold a

36-01178-17

2017714

62 doctorate degree with a primary focus in behavior analysis from
63 an accredited university, be a certified behavior analyst
64 pursuant to s. 393.17, and have at least 1 year of experience in
65 providing behavior analysis services for individuals in
66 developmental disabilities. The staff must include behavior
67 analysts and teachers, as appropriate, who must be available to
68 provide services in each component center or unit of the
69 program. A behavior analyst must be certified pursuant to s.
70 393.17.

71 (7) After July 1, 2017, a license may not be granted under
72 this section to a new comprehensive transitional education
73 program. After December 31, 2019, a license may not be renewed
74 for an existing comprehensive transitional education program.

75 Section 3. This act shall take effect July 1, 2017.

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 1050

INTRODUCER: Senator Simmons

SUBJECT: Memory Disorder Clinics

DATE: April 12, 2017

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Lloyd	Stovall	HP	Favorable
2. Forbes	Williams	AHS	Pre-meeting
3. _____	_____	AP	_____

I. Summary:

SB 1050 establishes a memory disorder clinic at Florida Hospital in Orange County.

This bill does not impact state revenues or expenditures

The bill is effective July 1, 2017.

II. Present Situation:

Alzheimer's Disease

Alzheimer's disease is a degenerative brain disease and the most common cause of dementia.¹ It accounts for 60 to 80 percent of dementia cases.² An estimated 5.5 million Americans are living with the disease in 2017, including 1 in 10 people aged 65 and older. For Florida, the number is estimated to be 520,000 for 2017 and it is projected to grow to 720,000 by 2025, a growth rate of 38.5 percent.³

Dementia is a syndrome of the disease and is actually a group of symptoms that has a number of causes that include difficulties with memory, language, problem-solving, and other cognitive skills that affect a person's ability to perform everyday activities.⁴ In Alzheimer's patients, these difficulties occur because of brain abnormalities. The nerve cells or neurons that are involved with cognitive brain function have been damaged or destroyed causing a loss of connection

¹ Alzheimer's Association, *2017 Alzheimer's Disease Facts and Figures*, http://www.alz.org/documents_custom/2017-facts-and-figures.pdf, p. 5, (last visited Mar. 8, 2017).

² Alzheimer's Association, *About Alzheimer's and Dementia*, http://www.alz.org/research/science/alzheimers_research.asp (last visited Mar. 9, 2017).

³ *Id.* at 21.

⁴ *Id.* at 5.

among brain cells.⁵ Eventually, those with Alzheimer's disease become bed bound and require around the clock care. The disease is fatal and there is currently no cure.

The brains of individuals with Alzheimer's show inflammation, dramatic shrinkage from cell loss, and widespread debris from dead and dying neurons.⁶ Other changes associated with Alzheimer's and other dementias include:

- Memory loss that disrupts daily life;
- Challenges in planning or solving problems;
- Difficulty completing familiar tasks;
- Confusion with time or place;
- Trouble understanding visual images and spatial relationships;
- New problems with words in speaking or writing;
- Misplacing things and losing the ability to retrace steps;
- Decreased or poor judgement;
- Withdrawal from work or social activities; or
- Change in mood and personality.⁷

For those living with Alzheimer's, management of the disease can lead to an improved quality of life. Active management of the disease may include:

- Appropriate use of available treatment options;
- Effective management of coexisting conditions;
- Coordination of care among physicians, other health care providers and lay caregivers;
- Participation in activities that are meaningful and bring purpose to one's life; and
- Have opportunities to connect with others living with dementia; support groups and supportive services.⁸

Florida Alzheimer's Disease Initiatives

Florida's Alzheimer's Disease Initiative (ADI) was created by the 1985 Legislature to meet the changing needs of individuals with Alzheimer's and similar memory disorders and their families. The Florida Department of Elder Affairs (department) coordinates and develops policy in conjunction with a 10-member advisory committee appointed by the Governor for the initiative. The program includes four components:

- Supportive services which include counseling, consumable medical supplies, and respite caregiver relief;
- Memory Disorder Clinics that provide diagnosis, research, treatment, education, and referrals;
- Model day care programs to test new care alternatives; and
- A brain bank to support research.⁹

⁵ *Id.*

⁶ *Id.*

⁷ *Id.* at 9.

⁸ *Id.* at 14.

⁹ Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, <http://elderaffairs.state.fl.us/doea/alz.php> (last visited Mar. 9, 2017).

The ADI includes in-home, facility-based (usually at adult day care centers), emergency, and extended care (up to 30 days) for caregivers who serve patients with memory disorders.¹⁰ During FY 2014-2015, 2,652 individuals received respite and support services, including case management, specialized medical equipment, services, and supplies, and caregiver counseling, support groups, and training.¹¹

The 2016-2017 General Appropriations Act includes \$22,139,517 from the General Revenue Fund for the ADI services.¹² The appropriated funds are allocated to each of the Area Agencies on Aging to fund providers of model day care and respite care programs based on each county's population age 75 and older and probable number of Alzheimer's cases. Additional Alzheimer disease services are administered through contracts with designated Memory Disorder Clinics and the Florida Brain Banks. Remaining funds are allocated to local funding initiatives based on legislative direction in the General Appropriations Act.¹³

Participants in the ADI program are assessed co-payments and other partial payment amounts based on their ability pay and in accordance with Rule 58C-1.007, F.A.C. The co-pay schedule is set on a sliding scale, not to exceed 3 percent of an individual's monthly income in 2016.¹⁴ Provider agencies are responsible for the collection of fees for ADI services and report their collections annually to the department.¹⁵

Respite for Caregiver Relief

Respite care programs for caregivers are established in all 67 of Florida's counties.¹⁶ Many Alzheimer's patients require around the clock care, especially in the late stages of the disease. Caregivers may also receive supportive services such as training and support groups, counseling, consumable medical supplies, and nutritional supplements.

Memory Disorder Clinics

There are 15 state-funded Memory Disorder Clinics in the state of Florida that provide comprehensive assessments, diagnostic services, and treatment to individuals who show signs of Alzheimer's disease and related memory disorders. The Memory Disorder Clinics are also required to conduct specific research in coordination with the department. The clinics are established at medical schools, teaching hospitals, and public and private, not-for-profit hospitals.¹⁷ From July 1, 2015 through June 30, 2016, the Memory Disorder Clinics completed

¹⁰ Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, <http://elderaffairs.state.fl.us/doea/alz.php>, (last visited Mar. 9, 2017).

¹¹ *Id.*

¹² Specific Appropriations 410 of chapter 2016-66, Laws of Fla. (General Appropriations Act for the 2016-2017 fiscal year).

¹³ Dep't of Elder Affairs, *2016 Summary of Programs and Services - Section D*, p. 94, http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2016/2016_SOPS_D.pdf (last visited Mar. 9, 2017).

¹⁴ Dep't of Elder Affairs, *Department of Elder Affairs Programs and Services Handbook, Appendix B - Co-Payment for Service Guidelines (ADI and CCE Programs), Attachment 2: 2016 Co-Pay Schedule for Individual*, http://elderaffairs.state.fl.us/doea/notices/July16/2016_Appendix_B_Co-Payment_for_Service_Guidelines.pdf, (last visited Mar. 9, 2017).

¹⁵ *Id.* at B-34.

¹⁶ *Id.*

¹⁷ *Id.* The 15 Memory Disorder Clinics are: West Florida Hospital, Tallahassee Memorial Hospital, Mayo Clinic Jacksonville, University of Florida, Orlando Health Center for Aging, East Central Florida, Madonna Ptak Center for Memory Disorders at Morton Plant Mease, University of South Florida, St. Mary's Medical Center, Florida Atlantic University Louis and Anne

9,810 medical memory evaluations, saw 4,745 new patients, with 16,569 office visits made by patients and their caregivers.¹⁸ Over 7,000 family caregivers also received educational training from the clinics on how to care for a loved one with dementia during this same time period.¹⁹ For the 2016-2017 state fiscal year, the clinics used \$3,464,683 in state funding to serve almost 7,000 unduplicated clients.²⁰

The law currently provides that memory disorder clinics funded as of June 30, 1995, shall not receive decreased funding due solely to subsequent additions of memory disorder clinics. As of June 30, 1995, the following clinics were included in the statute:

A memory disorder at each of the three medical schools in the state;

A memory disorder clinic at a major non-profit research-oriented teaching hospital, and may fund a memory disorder clinic at any of the other affiliated teaching hospitals;

- A memory disorder clinic at the Mayo clinic in Jacksonville;
- A memory disorder clinic at the West Florida Regional Medical Center;
- The Central Florida Memory Disorder Clinic at the Joint Center for Advanced Therapeutics and Biomedical Research at the Florida Institute of Technology and Holmes Regional Medical Center, Inc.; and
- A memory disorder clinic located at a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000.²¹

Florida Hospital in Central Florida opened a self-funded memory disorder program in 2012. The Florida Hospital Maturing Minds Clinic serves patients with Alzheimer's disease and related disorders in Orange, Seminole, and Osceola counties. It is estimated that 30,000 people with Alzheimer's disease live in these three counties.²² The clinic conducts over 360 new patient memory loss evaluations each year and provides services and referrals to other local organizations.²³ The clinic does not plan to request state funding at this time, but will seek national and local grants and the state designation will assist the clinic in that process, according to local representatives.²⁴

Model Day Care

Model day care programs provide a safe environment where Alzheimer's patients can meet and socialize during the day as well as receive therapeutic interventions which improve their

Green Memory and Wellness Center, Sarasota Memorial Hospital, Lee Memorial Health System, Broward Health North, The Wien Center for Alzheimer's Disease and Memory Disorders Mt. Sinai Medical Center, and University of Miami Memory Disorders Center, Center on Aging Mental Health Hospital Center.

¹⁸ Dep't of Elder Affairs, *2015-2016 Year End Summary - Alzheimer Disease Initiative*, p. 3, http://elderaffairs.state.fl.us/doea/alz/MDC_Year_End_Summary_2015-2016.pdf (last visited: Mar. 9, 2017).

¹⁹ *Id.*

²⁰ Dep't of Elder Affairs, *2016 Summary of Programs and Services - Section D, Memory Disorder Clinics Appropriation History and Numbers Served*, p. 97, http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2016/2016_SOPS_D.pdf (last visited: Mar. 9, 2017).

²¹ Chapter Law 1995-253, s. 1, Laws of Fla.

²² Fla. Hospital, *Memory Disorder Clinics Handout - Support HB 883/SB 1050* (on file with the Senate Committee on Health Policy).

²³ Fla. Hospital, *Memory Disorder Clinics Handout - Support HB 883/SB 1050* (on file with the Senate Committee on Health Policy).

²⁴ Conversation with Jean Van Smith, Florida Hospital Representative (March 9, 2017).

cognitive functioning. Model day care programs have been established in Gainesville, Tampa, and Miami.²⁵

Florida Brain Bank

The Florida Brain Bank was created in 1987, is administered by Mount Sinai Medical Center, and facilitated by an additional four regional centers. The Florida Brain Bank conducts research related to Alzheimer's disease and other degenerative disorders of the brain. Participants elect to "bank" their brain making the patient's brain tissue available to researchers upon the patient's death.²⁶ Upon the patient's death, a final pathology report would also be made available to the patient's family and physicians. Currently, the only way to get an accurate diagnosis of Alzheimer's disease or related dementia disorders is a brain autopsy at the time of death.²⁷ The Brain Bank's 2016-2017 State General Revenue appropriation was \$117,535 and the bank registered 87 individuals and conducted 79 autopsies during that fiscal year.²⁸

The Alzheimer's Disease Advisory Committee is statutorily created under s. 430.501(2), F.S., and includes 10 members appointed by the Governor. The members advise the department on legislative, programmatic, and administrative matters that relate to individuals with Alzheimer's disease and their caregivers. Members serve 4-year, staggered terms and select one of its own members to serve as chair of the committee for a 1 year term.²⁹

III. Effect of Proposed Changes:

Section 1 republishes and amends s. 430.502, F.S., relating to the establishment of the Alzheimer Disease Initiative program's memory disorder clinics and adds a memory disorder clinic at Florida Hospital in Orange County. The memory disorder clinics conduct research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders.

Current statute provides that any memory disorder clinic funded as of June 30, 1995, shall not receive decreased funding due solely to the subsequent additions of memory disorder clinics. The addition of Florida Hospital in Orange County makes 16 total memory disorder clinics created under the statute, of which at least seven have been added since June 30, 2015.

Section 2 reenacts s. 1004.445, F.S., relating to the Johnnie S. Byrd, Sr., Alzheimer Center and Research Institute, for the purpose of incorporating the amendment made to the underlying act, s. 430.502, F.S.

Section 3 provides an effective date of July 1, 2017.

²⁵ Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, <http://elderaffairs.state.fl.us/doea/alz.php> (last visited Mar. 9, 2017).

²⁶ Dep't of Elder Affairs, *The Florida Brain Bank*, <http://elderaffairs.state.fl.us/doea/BrainBank/howto.php> (last visited Mar. 9, 2017).

²⁷ *Id.*

²⁸ Department of Elder Affairs, *2016 Summary of Programs and Services - Section D, Brain Bank Appropriation History and Client Served*, p. 98, http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2016/2016_SOPS_D.pdf (last visited Mar. 9, 2017)

²⁹ Dep't of Elder Affairs, *Alzheimer's Disease Advisory Committee*, http://elderaffairs.state.fl.us/doea/advisory_alz.php (last visited Mar. 9, 2017).

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

The costs associated with the Memory Disorder Clinic at Florida Hospital in Orange County will be funded through Florida Hospital. The hospital anticipates competing for several local, state, and national grants which may bring additional funds and resources to the state for Alzheimer's research. Receiving a statutory designation as a state Memory Disorder Clinic may help the hospital in its efforts to receive those grant and research dollars.

C. Government Sector Impact:

The bill does not impact state revenues or expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 430.502 and 1004.445.

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:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Simmons

9-00495-17

20171050__

A bill to be entitled

An act relating to memory disorder clinics; amending s. 430.502, F.S.; establishing a memory disorder clinic at Florida Hospital in Orange County; reenacting s. 1004.445(3), F.S., relating to providing assistance to memory disorder clinics, to incorporate the amendment made to s. 430.502, F.S., in a reference thereto; providing an effective date.

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

Section 1. Subsection (1) of section 430.502, Florida Statutes, is amended, and subsection (2) is republished, to read:

430.502 Alzheimer's disease; memory disorder clinics and day care and respite care programs.—

(1) There is established:

(a) A memory disorder clinic at each of the three medical schools in this state;

(b) A memory disorder clinic at a major private nonprofit research-oriented teaching hospital, and may fund a memory disorder clinic at any of the other affiliated teaching hospitals;

(c) A memory disorder clinic at the Mayo Clinic in Jacksonville;

(d) A memory disorder clinic at the West Florida Regional Medical Center;

(e) A memory disorder clinic operated by Health First in Brevard County;

Page 1 of 4

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

9-00495-17

20171050__

(f) A memory disorder clinic at the Orlando Regional Healthcare System, Inc.;

(g) A memory disorder center located in a public hospital that is operated by an independent special hospital taxing district that governs multiple hospitals and is located in a county with a population greater than 800,000 persons;

(h) A memory disorder clinic at St. Mary's Medical Center in Palm Beach County;

(i) A memory disorder clinic at Tallahassee Memorial Healthcare;

(j) A memory disorder clinic at Lee Memorial Hospital created by chapter 63-1552, Laws of Florida, as amended;

(k) A memory disorder clinic at Sarasota Memorial Hospital in Sarasota County;

(l) A memory disorder clinic at Morton Plant Hospital, Clearwater, in Pinellas County; ~~and~~

(m) A memory disorder clinic at Florida Atlantic University, Boca Raton, in Palm Beach County; and

(n) A memory disorder clinic at Florida Hospital in Orange County,

for the purpose of conducting research and training in a diagnostic and therapeutic setting for persons suffering from Alzheimer's disease and related memory disorders. However, memory disorder clinics funded as of June 30, 1995, shall not receive decreased funding due solely to subsequent additions of memory disorder clinics in this subsection.

(2) It is the intent of the Legislature that research conducted by a memory disorder clinic and supported by state

Page 2 of 4

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

9-00495-17

20171050__

59 funds pursuant to subsection (1) be applied research, be
 60 service-related, and be selected in conjunction with the
 61 department. Such research may address, but is not limited to,
 62 diagnostic technique, therapeutic interventions, and supportive
 63 services for persons suffering from Alzheimer's disease and
 64 related memory disorders and their caregivers. A memory disorder
 65 clinic shall conduct such research in accordance with a research
 66 plan developed by the clinic which establishes research
 67 objectives that are in accordance with this legislative intent.
 68 A memory disorder clinic shall also complete and submit to the
 69 department a report of the findings, conclusions, and
 70 recommendations of completed research. This subsection does not
 71 apply to those memory disorder clinics at the three medical
 72 schools in the state or at the major private nonprofit research-
 73 oriented teaching hospital or other affiliated teaching
 74 hospital.

75 Section 2. For the purpose of incorporating the amendment
 76 made by this act to section 430.502, Florida Statutes, in a
 77 reference thereto, subsection (3) of section 1004.445, Florida
 78 Statutes, is reenacted to read:

79 1004.445 Johnnie B. Byrd, Sr., Alzheimer's Center and
 80 Research Institute.—

81 (3) BUDGET.—The institute's budget shall include the moneys
 82 appropriated in the General Appropriations Act, donated, or
 83 otherwise provided to the institute from private, local, state,
 84 and federal sources, as well as technical and professional
 85 income generated or derived from practice activities at the
 86 institute. Any appropriation to the institute shall be expended
 87 for the purposes specified in this section, including conducting

9-00495-17

20171050__

88 and supporting research and related clinical services, awarding
 89 institutional grants and investigator-initiated research grants
 90 to other persons within the state through a peer-reviewed
 91 competitive process, developing and operating integrated data
 92 projects, providing assistance to the memory disorder clinics
 93 established in s. 430.502, and providing for the operation of
 94 the institute.

95 Section 3. This act shall take effect July 1, 2017.

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 1056

INTRODUCER: Senator Garcia

SUBJECT: Home Health Care Agency Licenses

DATE: April 12, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	Favorable
2.	Forbes	Williams	AHS	Pre-meeting
3.			AP	

I. Summary:

SB 1056 removes a prohibition on the Agency for Health Care Administration (AHCA) from issuing an initial home health agency license to an applicant that shares common controlling interests with another licensed home health agency that is located in the same county and within 10 miles of the applicant.

There is no fiscal impact on any state revenues or expenditures.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Home Health Agencies (HHA)

An HHA is an organization that provides home health services and staffing services.¹ Home health services provided by an HHA include health and medical services and medical supplies provided to an individual in his or her home, such as nursing care, physical and occupational therapy, and home health aide services.^{2,3}

¹ Section 400.462(12), F.S.

² Section 400.462(14), F.S. Additional services may include dietetics and nutrition practice and nutrition counseling.

³ Home health aide services may include hands-on personal care, simple procedures as an extension of therapy or nursing services, assisting in ambulation or exercises, and assisting with the self-administration of medication. *See* s. 400.462(15), F.S.

Home health agencies are regulated by the AHCA pursuant to part III of ch. 400, F.S., and the general licensing provisions in part II of ch. 408, F.S. As of March 31, 2017, there are 1950 licensed HHAs in the state.⁴

A license is required to operate as an HHA unless an exemption applies.⁵ Numerous exemptions exist and the most common exemptions apply to an HHA operated by the federal government or home health services provided by a state agency, licensed health care practitioner operating under his or her professional license, or other licensed health care facility.⁶

An HHA must designate a geographic service area (one or more counties within an AHCA district) in which the HHA will operate. These counties are identified on the license. An HHA may apply to amend the geographic service area to expand within the AHCA district under the same license.⁷

A licensed HHA may also operate satellite offices under the main HHA license. A satellite office must be located in the same geographic service area as the HHA's main office and share administration, fiscal management, supervision, and service provision with the main office. Supplies and records may be stored at a satellite office and signs and advertisements can notify the public of the satellite office location. If an HHA wants to open an office outside of the geographic services area where the main licensed office is located, it must obtain a separate license.⁸

Section 400.471(7), F.S., prohibits the AHCA from issuing an initial license to an applicant for an HHA license if the applicant shares common controlling interest with another licensed HHA that is located within 10 miles of the applicant and is in the same county. This restriction was enacted in ch. 2008-246, Laws of Fla.

“Controlling interest” means:⁹

- The applicant or licensee or
- A person or entity that serves as an officer of, is on the board of directors of, or has a five percent or greater ownership interest in the
 - Applicant or licensee or
 - Management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider.

⁴ Agency for Health Care Administration, FloridaHealthFinder.gov, search on home health agencies, available at: <http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx> (last visited March 31, 2017),

⁵ Section 400.464, F.S.

⁶ Section 400.464(5), F.S.

⁷ Rule 59A-8.007, F.A.C. The AHCA reviews the HHA's previous history of survey results and administrative action to assess the HHA's ability to provide quality services within the requested expanded area.

⁸ Rule 59A-8.003(7), F.A.C.

⁹ Section 408.803(7), F.S.

Medicare and Medicaid Fraud

The HHA industry in Florida has been marred with years of uncontrolled growth and health care fraud. The Florida Senate studied HHAs in Florida in 2007, issuing an interim report¹⁰ that outlined unusually rapid growth in licensed HHAs, particularly in South Florida, and indications of possible quality-of-care problems and Medicaid fraud. Numerous regulatory reforms were enacted in 2008 and 2009 which focused on fraud and abuse prevention in the HHA industry.¹¹

Ongoing monitoring and Medicare and Medicaid fraud enforcement action continues. Most recently, in fiscal year 2015-2016, 24 HHAs were terminated from participation in the Medicaid program as a result of fraud and abuse,¹² and 26 HHAs were denied enrollment or reenrollment in the Medicaid program because of suspected fraud and abuse.¹³

In addition, the Centers for Medicare and Medicaid Services (CMS) has imposed a federal moratoria on new HHAs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) in order to target fraud in Florida.¹⁴

- In July 2013, CMS implemented a moratorium on the enrollment of new HHAs in the Miami area.
- CMS extended the moratorium in 2014 to the metropolitan areas of Fort Lauderdale. The moratoria have since been extended at 6-month intervals and remain in place in both Miami and Ft. Lauderdale.
- Effective July 29, 2016, CMS expanded the moratoria statewide and made it applicable to Medicare, Medicaid, and the CHIP.¹⁵

There is no indication at this point as to the duration of the CMS imposed moratoria. The CMS has created a Provider Enrollment Moratoria Access Waiver Demonstration (PEWD) which is designed to provide exceptions to the moratoria to ensure that beneficiary access to care is not adversely impacted.¹⁶

III. Effect of Proposed Changes:

The bill removes a prohibition on the agency from issuing an initial home health agency license to an applicant that shares common controlling interests with another licensed home health

¹⁰ The Florida Senate, *Review Regulatory Requirements for Home Health Agencies*, November 2007, http://archive.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf (last viewed March 30, 2017)

¹¹ See chs. 2008-246, 2009-193, and 2009-223, Laws of Fla.

¹² Joint Report by the AHCA and the Medicaid Fraud Control Unit with the Office of the Attorney General, *The State's Efforts to Control Medicaid Fraud and Abuse FY 2015-16*, December 16, 2016, page 57, available at: http://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2015-16_MedicaidFraudandAbuseAnnualReport.pdf (last viewed March 30, 2017).

¹³ *Id.* at page 58.

¹⁴ CMS *Provider Enrollment Moratorium*, available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentMoratorium.html> (last viewed March 30, 2017).

¹⁵ The moratoria was imposed statewide to address problems in the effectiveness of the earlier moratorium because those did not prevent providers outside the moratoria area from billing for servicing beneficiaries within that area.

¹⁶ *Supra*, note 13.

agency that is located in the same county and within 10 miles of the applicant. The bill also removes the directive for the agency to return the application and fees to the applicant.

The effective date of the bill is July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Applicants for an initial HHA license with common controlling interests with a currently licensed HHA will be able to obtain a new license within close proximity to the currently licensed HHA. A new license will enable the HHA to do business under a different license authority.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 400.471 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.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Garcia

36-00455A-17

20171056__

A bill to be entitled

An act relating to home health care agency licenses;
amending s. 400.471, F.S.; removing a prohibition
against the issuance of an initial home health agency
license to an applicant who shares common controlling
interests with another licensed home health agency
located within 10 miles of the applicant and in the
same county; providing an effective date.

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

Section 1. Subsection (7) of section 400.471, Florida
Statutes, is amended to read:

400.471 Application for license; fee.—

~~(7) The agency may not issue an initial license to an
applicant for a home health agency license if the applicant
shares common controlling interests with another licensed home
health agency that is located within 10 miles of the applicant
and is in the same county. The agency must return the
application and fees to the applicant.~~

Section 2. This act shall take effect July 1, 2017.

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 1406

INTRODUCER: Health Policy Committee and Senator Powell and others

SUBJECT: Stroke Centers

DATE: April 12, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	Fav/CS
2.	Forbes	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1406 requires the Agency for Health Care Administration (ACHA) to add acute stroke ready centers to the list of primary stroke centers and comprehensive stroke centers made available to emergency medical services providers. All three levels of stroke centers are treated similarly for purposes of being added to, or removed from, the list. The bill removes language instructing the ACHA to base stroke center rules on criteria established solely by the Joint Commission; and expands rule criteria to be substantially similar to any nationally recognized accrediting organization.

The Department of Health (DOH) is directed to develop a statewide stroke registry to house data submitted by stroke centers which will include patient care quality assurance proceedings, records, or reports associated with the treatment or service provided to a person suffering a stroke. The data will be used to:

- Evaluate stroke care effectiveness;
- Ensure compliance with stroke center standards; and
- Monitor patient outcomes.

The AHCA must adopt by rule electronic standardized forms for stroke centers to report the data to the DOH.

The DOH may choose to establish and maintain the registry or contract it out. The bill provides protection from liability for any entity that provides information required by the registry.

The cost to create and maintain the statewide stroke registry required by this legislation is unknown. The DOH and AHCA will incur costs associated with rulemaking, but such costs should be absorbed within current resources.

The bill provides an effective date of July 1, 2017.

II. Present Situation:

What is a Stroke?

A stroke is a serious medical condition that occurs when the blood supply to the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.¹ The brain needs a constant supply of oxygen and nutrients in order to function.² Even a brief interruption in blood supply from a stroke can cause significant problems.

During a stroke, brain cells begin to die after just a few minutes without blood or oxygen.³ Brain cell death causes loss of brain function, including impaired ability with movement, speech, thinking and memory, bowel and bladder, eating, emotional control, and other vital bodily functions. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death.⁴ A stroke is one of the leading causes of death in the United States.⁵

There are two main types of strokes: an ischemic stroke and a hemorrhagic stroke. The former, is the most common type, and occurs when an artery in the brain becomes blocked. The latter occurs when a brain artery leaks blood or ruptures.⁶

There are two types of ischemic strokes: thrombotic and embolic.⁷ In a thrombotic stroke, a blood clot (thrombus) forms in an artery that supplies blood to the brain.⁸ In an embolic stroke, a blood clot, or other substance such as plaque or fatty material, travels through the bloodstream to an artery in the brain.⁹ With both types of ischemic stroke, the blood clot or other substance blocks the flow of oxygenated blood to a portion of the brain.¹⁰

¹ The Mayo Clinic, *Stroke*, available at <http://www.mayoclinic.org/diseases-conditions/stroke/home/ovc-20117264>, (last visited Mar. 22, 2017).

² UCLA Health, *What is a Stroke?* available at <http://stroke.ucla.edu/what-is-a-stroke>, (last visited Mar. 23, 2017).

³ Id.

⁴ Id.

⁵ National Institutes of Health, National Heart, Lung and Blood Institute, *What Is a Stroke?* (updated Jan. 27, 2017) available at <https://www.nhlbi.nih.gov/health/health-topics/topics/stroke>, (last visited Mar. 23, 2017).

⁶ Id.

⁷ Id.

⁸ Id.

⁹ Id. The blood clot or other substance traveling through the bloodstream is called an embolus.

¹⁰ Id.

The two types of hemorrhagic stroke are intracerebral and subarachnoid.¹¹ In an intracerebral hemorrhage, a blood vessel inside the brain leaks blood or ruptures.¹² In a subarachnoid hemorrhage, a blood vessel on the surface of the brain leaks blood or ruptures, and bleeding occurs between the inner and middle layers of the membrane that covers the brain.¹³ In both types of hemorrhagic stroke, the leaked blood causes swelling of the brain and increased pressure in the skull. This swelling and pressure causes brain damage.¹⁴

Signs and Symptoms of a Stroke

The signs and symptoms of a stroke often develop quickly. However, they can develop over hours or even days as well. Signs and symptoms of a stroke may include:

- Sudden weakness;
- Paralysis (an inability to move) or numbness of the face, arms, or legs, especially on one side of the body;
- Confusion;
- Trouble speaking or understanding speech;
- Trouble seeing in one or both eyes;
- Problems breathing;
- Dizziness, trouble walking, loss of balance or coordination, and unexplained falls;
- Loss of consciousness; and
- Sudden and severe headache.¹⁵

Stroke Treatment

Time is of the essence in the treatment of a stroke. Medical personnel begin treatment in the ambulance on the way to the hospital.¹⁶ Treatment for a stroke depends on how much time has elapsed since the symptoms began to appear; and whether the stroke is ischemic or hemorrhagic.¹⁷

Treatment for an ischemic stroke may include medicines,¹⁸ such as antiplatelet medicines and blood thinners, and medical procedures, but a hemorrhagic stroke may require surgery to find and stop the bleeding.¹⁹ In addition to emergency care to treat a stroke, an individual may also receive treatment to prevent another stroke and rehabilitation to treat the side effects of the stroke.²⁰ According to the Centers for Disease Control and Prevention (CDC), research indicates

¹¹ Id.

¹² Id.

¹³ Id.

¹⁴ Id.

¹⁵ Id.

¹⁶ Center for Disease Control and Prevention, *Stroke Treatment* (updated Feb. 10, 2017) available at <https://www.cdc.gov/stroke/treatments.htm>, (last visited Mar. 23, 2017).

¹⁷ National Institutes of Health, National Heart, Lung and Blood Institute, *How Is a Stroke Treated?* (updated Jan. 27, 2017) available at <https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/treatment> (last visited Mar. 23, 2017).

¹⁸ Id. Such medication includes a tissue plasminogen activator (TPA), which dissolves, or breaks up the clot. TPA is an injection which must be given within 4 hours of stroke symptoms onset.

¹⁹ Id.

²⁰ *Supra* note 16.

that patients receiving care at primary stroke centers have a higher incidence of survival and recovery than those treated in hospitals without this type of specialized care.²¹

Stroke Centers in Florida

Florida first enacted legislation relating to primary and comprehensive stroke centers in 2004.²² The AHCA establishes the criteria for both the primary and comprehensive stroke centers.²³ There are 118 Florida hospitals designated as primary stroke centers in 37 counties, and 41 comprehensive stroke centers in 16 counties.²⁴

Primary Stroke Centers

A primary stroke center certification recognizes hospitals that meet standards to support better outcomes for stroke care.²⁵ Such hospitals must have a dedicated stroke-focused program, be staffed by qualified medical professionals trained in stroke care, and provide individualized care to meet stroke patients' needs based on recommendations of the Brain Attack Coalition and guidelines published by the American Heart Association/American Stroke Association or equivalent guidelines.²⁶ These hospitals must also collect and utilize performance data to improve quality of care for stroke patients.²⁷

In order for the AHCA to designate a hospital program as a primary stroke center, the hospital program must be certified by the Joint Commission as a primary stroke center, or meet the certification criteria applicable to primary stroke centers as outlined in the Joint Commission Disease-Specific Care Certification Manual, 2nd Edition.²⁸ The manual requires a primary stroke center to:²⁹

- Use a standardized method of delivering care;
- Support patient self-management activities;
- Tailor treatment and intervention to individual needs;
- Promote the flow of patient information across settings and providers, while protecting patient rights, security and privacy;

²¹ Centers for Disease Control and Prevention, *A Summary Of Primary Stroke Center Policy In The United States* (2011), available at https://www.cdc.gov/dhds/pubs/docs/primary_stroke_center_report.pdf, (last visited Mar. 23, 2017)

²² Section 3, ch. 2004-325, Laws of Fla.

²³ Section 395.3038, F.S.

²⁴ Agency for Health Care Administration, *Senate Bill 1406 Analysis* (Feb. 17, 2017) (on file with the Senate Committee on Health Policy). Although stroke services is dependent upon the availability of qualified health care professionals, the majority of primary stroke centers have fewer than 300 inpatient beds and the majority of comprehensive stroke centers have more than 300 beds.

²⁵ American Heart Association, *Primary Stroke Center Certification*, available at https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/PrimaryStrokeCenterCertification/Primary-Stroke-Center-Certification_UCM_439155_SubHomePage.jsp, (last visited Mar. 23, 2017).

²⁶ Id.

²⁷ Id.

²⁸ Rule 59A-3.2085(15)(a) F.A.C.

²⁹ The standards are published in the Comprehensive Certification Manual for Disease-Specific Care. They incorporate the "Recommendations for the Establishment of Primary Stroke Centers" developed by the Brain Attack Coalition. The chapters address program management, delivering or facilitating clinical care, supporting self-management, clinical information management, and performance improvement and measurement.

- Analyze and use standardized performance measure data to continually improve treatment plans; and
- Demonstrate their application of and compliance with clinical practice guidelines published by the American Heart Association/American Stroke Association or equivalent evidence-based guidelines.³⁰

Comprehensive Stroke Centers

A comprehensive stroke center certification recognizes hospitals that meet standards to treat the most complex stroke cases.³¹ These hospitals must meet all the criteria of a primary stroke center; they must also have advanced imaging techniques and personnel trained in vascular neurology, neurosurgery and endovascular procedures available 24 hours a day, seven days a week, as well as neuroscience intensive care unit (ICU) and experience and expertise treating patients with large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.

In order for the AHCA to designate a hospital program as a comprehensive stroke center, the hospital program must have received primary stroke center designation and also have the following:

- Personnel with clinical expertise in specified disciplines available;³²
- Advanced diagnostic capabilities;³³
- Neurosurgical and endovascular interventions available;³⁴
- Specialized infrastructure;³⁵ and
- Quality improvement and clinical outcomes measurements.³⁶

The specialized infrastructure includes extensive requirements that the emergency medical services (EMS) and comprehensive stroke center leadership are linked to ensure:

- EMS use a stroke triage assessment tool;
- EMS patient assessment and management at the scene is consistent with evidence-based practice;
- Inter-facility transfers; and
- On-going communication with EMS providers regarding availability of services; and
- A comprehensive stroke center maintains:
 - An acute stroke team available 24 hours per day, 7 days per week;
 - A system for facilitating inter-facility transfers;
 - Defined access telephone numbers in a system for accepting appropriate transfer;

³⁰ The Joint Commission, *Facts about Primary Stroke Center Certification* (Jan. 6, 2015), available at https://www.jointcommission.org/facts_about_primary_stroke_center_certification/ (last visited Mar. 23, 2017).

³¹ The American Heart Association, *Comprehensive Stroke Center Certification*, available at https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/ComprehensiveStrokeCenterCertification/Comprehensive-Stroke-Center-Certification_UCM_455446_SubHomePage.jsp, (last visited Mar. 23, 2017).

³² See Fla. Admin. Code R. 59A-3.2085(15)(b), for specific qualifications. Medical personnel with neurosurgical expertise must be available in a CSC on a 24 hours per day, seven days per week basis and in-house within two hours, and neurologist(s) with special expertise in the management of stroke patients should be available 24 hours per day, seven days per week.

³³ Id.

³⁴ Id.

³⁵ Id.

³⁶ Id.

- Specialized inpatient units including an ICU with medical and nursing personnel who have special training, skills and knowledge in the management of patients with all forms of neurological or neurosurgical conditions that require intensive care;
- An acute stroke unit with medical and nursing personnel who have training, skills and knowledge sufficient to care for patients with neurological conditions, particularly acute stroke patients, and who are appropriately trained in neurological assessment and management;
- Inpatient post-stroke rehabilitation and ensure continuing arrangements post-discharge for rehabilitation needs and medical management;
- Its medical and paramedical professionals education by offering ongoing professional education for all disciplines; and provide education to the public and inpatients and families on risk factor reduction or management, primary and secondary prevention, the warning signs and symptoms of stroke, and medical management and rehabilitation for stroke patients;
- Provide a career development track to develop neuroscience nursing, particularly in the area of cerebrovascular disease; and
- Professional and administrative infrastructure necessary to conduct clinical trials and should have participated in stroke clinical trials within the last year and actively participate in ongoing clinical stroke trials.³⁷

Stroke Patient Transportation

The DOH has also developed a stroke assessment tool.³⁸ The tool is available on the DOH's website and is provided to emergency medical services providers.³⁹ Each licensed emergency medical services provider must use a stroke-triage assessment tool that is substantially similar to the DOH's stroke-triage assessment tool.⁴⁰ Annually, by June 1, each year the DOH sends the list of primary stroke centers and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in Florida.⁴¹

Stroke Center Inventory

The AHCA maintains an inventory of hospitals offering stroke services.⁴² A listing of hospitals meeting the criteria as either a primary stroke center or comprehensive stroke center is published on the AHCA's website.^{43,44}

Currently, there are no data reporting requirements for stroke centers related to quality measures.⁴⁵ There are 274 emergency medical service providers, 222 acute care hospitals and 25 medical examiner districts that report patient data to the DOH.⁴⁶ However, the data is not

³⁷ Id.

³⁸ Section 395.3041(2), F.S.

³⁹ Section 395.3041(2), F.S.

⁴⁰ Id.

⁴¹ Section 395.3041(1), F.S.

⁴² Section 395.3038, F.S.

⁴³ *Supra* note 24.

⁴⁴ Id. A list of hospitals with a stroke center designation is also available through the facility locator tool on www.floridahealthfinder.gov, (last visited Mar. 23, 2017).

⁴⁵ Id.

⁴⁶ *Supra* note 24.

standardized and much of the data that the DOH currently collects comes from voluntary participation in the DOH's EMS Tracking and Reporting System (EMSTARS) program⁴⁷ and only includes data on response, provider impression, procedures and medication, and destination.⁴⁸

Acute Stroke Ready Centers

Many patients with an acute stroke live in areas without ready access to a primary or comprehensive stroke center; more than half the U.S. population lives more than an hour away from a stroke center.⁴⁹ Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke.⁵⁰ In such settings, there is a need to distinguish between those that offer enhanced care and expertise for acute stroke versus those with only basic or no organized abilities and expertise.⁵¹

A recent study by the American Stroke Association proposed a new designation for hospitals that are not primary stroke centers, but can provide timely, evidence-based care to most patients with an acute stroke; these acute stroke-ready hospitals provide initial diagnostic services, stabilization, emergent care and therapies to patients with an acute stroke who are seen in their emergency department, and would then transfer these patients to a primary or comprehensive stroke center.⁵²

Accrediting Organizations

The Joint Commission, the Healthcare Facilities Accreditation Program, and the DNV GL (formerly known as Det Norske Veritas) offer certification as an acute stroke ready centers, as well as primary and comprehensive stroke centers.⁵³

III. Effect of Proposed Changes:

Acute Stroke Ready Centers

Section 1 amends s. 395.3038, F.S., to recognize a new level of stroke services: an acute stroke ready center. A hospital could receive an acute stroke ready center designation by attesting to the ACHA on the appropriate form that, among other things, it is accredited by a nationally recognized accrediting organization or meets the criteria for accreditation. A hospital with an acute stroke ready center designation is required to notify the ACHA if it no longer meets the criteria.

⁴⁷ The EMSTARS program allows emergency medical providers to capture incident level patient care records for every emergency activation.

⁴⁸ *Supra* note 46.

⁴⁹ Mark J. Alberts, et al, *Formation and Function of Acute Stroke-Ready Hospitals Within a Stroke System of Care Recommendations From the Brain Attack Coalition*, *Stroke*, Vol. 44, Issue 12 (Nov. 25, 2013), available at <http://stroke.ahajournals.org/content/44/12/3382.full>, (last visited Mar. 23, 2017).

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Supra* note 24.

The bill removes language instructing the ACHA to base stroke center rules on criteria established solely by the Joint Commission; and expands criteria to be substantially similar to any nationally recognized accreditation organization's criteria for the level of stroke center.

Acute stroke ready centers must be added to the list of stroke centers the DOH supplies to emergency medical services providers in the state. The bill requires the AHCA to develop and adopt by rule electronic standardized forms for stroke centers to report data to the DOH, including patient care quality assurance proceedings, records, or reports associated with any treatment or service provided to a person suffering a stroke.

Currently, there are approximately 60 acute care hospitals that do not have primary or comprehensive stroke center designation and may be eligible for an acute stroke ready center designation. The majority of these hospitals have less than 100 beds.⁵⁴

Statewide Stroke Registry

Section 2 creates s. 395.30381, F.S., to require the DOH to develop a statewide stroke registry. All stroke centers must submit data, including patient care quality assurance proceedings, records, or reports associated with the treatment or service provided to a person suffering a stroke to the registry. The DOH is required to use this information to:

- Evaluate stroke care effectiveness;
- Ensure compliance with stroke center standards established pursuant to s. 395.3038, F.S.; and
- Monitor patient outcomes.

The DOH may choose to establish and maintain the registry, or contract it out to a private entity. The bill provides protection from liability for any entity that provides information required by the registry. The DOH is required to adopt rules to implement the registry.

Stroke centers that do not comply with the reporting requirements to the registry will be subject to licensure denial, modification, suspension, or revocation by the AHCA.⁵⁵

Section 3 amends s. 395.3041, F.S., to removes obsolete deadlines for the DOH to implement the stroke-triage assessment tool. This section also directs the DOH to include the acute stroke ready centers on the list of stroke-related facilities to the licensed emergency medical services providers in the state.

⁵⁴See The Joint Commission, *Certification for Primary Stroke Centers*, available at https://www.jointcommission.org/certification/primary_stroke_centers.aspx, and

Certification Comprehensive Stroke Centers, available at

https://www.jointcommission.org/certification/advanced_certification_comprehensive_stroke_centers.aspx (last visited Mar. 28, 2017); DNV-GL, *Healthcare*, available at <http://dnvglhealthcare.com/search?q=stroke+centers&s=rank>; and Healthcare Facilities Accreditation Program, available at <http://www.hfap.org/AccreditationPrograms/stroke.aspx>, (last visited Mar. 28, 2017).

⁵⁵ Section 395.003(7)(a), F.S., authorizes the AHCA to deny, modify, suspend, and revoke a license for the substantial failure to comply with any requirements of part I of ch. 395, F.S., which is where the statute establishing the stroke registry is located.

The bill provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Public hospitals that are required to submit data to the DOH under the bill, may be required to purchase new software and incur labor costs to collect, maintain and send the required data to the DOH. The estimated cost of this is unknown at this time.

C. Government Sector Impact:

The DOH will incur rulemaking costs to implement the registry. The DOH may also incur costs to develop and maintain the registry or to contract with a private entity to establish and maintain the registry. There is no appropriation provided in the bill to establish the registry.

The AHCA will incur rulemaking costs related to updating criteria for acute stroke ready centers and comprehensive stroke centers. According to the AHCA, current resources can absorb these costs.⁵⁶

VI. Technical Deficiencies:

None.

VII. Related Issues:

A public records exemption (separate bill) may be necessary to protect the confidentiality of information in the statewide stroke registry.

⁵⁶ *Supra* note 24.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.3038 and 395.3041.

This bill creates the following section 395.30381, of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 27, 2017:

Deletes emergency medical services providers and medical examiners from the list of entities required to submit to the DOH patient care quality assurance proceedings, records, or reports associated with any treatment or services provided to a person suffering a stroke.

- B. **Amendments:**

None.



374610

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete lines 68 - 96
and insert:

Section 2. Section 395.30381, Florida Statutes, is created
to read:

395.30381 Statewide stroke registry.-

(1) Subject to a specific appropriation, the department
shall contract with a private entity to establish and maintain a
statewide stroke registry to ensure that the stroke performance



374610

measures required to be submitted under subsection (2) are maintained and available for use to improve or modify the stroke care system, ensure compliance with standards, and monitor stroke patient outcomes.

(2) Each acute ready stroke center, primary stroke center, and comprehensive stroke center shall regularly report to the statewide stroke registry information specified by the department, including nationally recognized stroke performance measures.

(3) The department shall require the contracted entity to use a nationally recognized platform to collect data from each stroke center on the stroke performance measures required in subsection (2). The contracted entity shall provide regular reports to the department on the data collected.

(4) No liability of any kind or character for damages or other relief shall arise or be enforced against any acute ready stroke center, primary stroke center, or comprehensive stroke center by reason of having provided such information to the statewide stroke registry.

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

And the title is amended as follows:

Delete lines 6 - 14

and insert:

stroke centers; creating s. 395.30381, F.S.; requiring the department to contract with a private entity to establish and maintain a statewide stroke registry, subject to an appropriation; requiring stroke centers to provide certain information to the statewide stroke



374610

40 registry; requiring the contracted entity to use a
41 nationally recognized platform to collect data;
42 requiring the contracted entity to provide reports to
43 the department on stroke performance measures;
44 providing immunity from liability under certain
45 circumstances; amending s. 395.3041, F.S.;

By the Committee on Health Policy; and Senators Powell,
Passidomo, and Baxley

588-02959A-17

20171406c1

A bill to be entitled

An act relating to stroke centers; amending s. 395.3038, F.S.; directing the Agency for Health Care Administration to include hospitals that meet the criteria for acute stroke ready centers on a list of stroke centers; directing the agency to adopt rules governing such criteria and the development of certain electronic forms to provide reports to the Department of Health; creating s. 395.30381, F.S.; requiring stroke centers to provide certain information to the department; requiring the department to establish a statewide stroke registry; providing immunity from liability under certain circumstances; requiring the department to adopt rules; amending s. 395.3041, F.S.; conforming a provision and deleting obsolete dates; providing an effective date.

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

Section 1. Section 395.3038, Florida Statutes, is amended to read:

395.3038 State-listed ~~primary stroke centers and comprehensive~~ stroke centers; notification of hospitals.-

(1) The agency shall make available on its website and to the department a list of the name and address of each hospital that meets the criteria for an acute stroke ready center, a primary stroke center, ~~or and the name and address of each hospital that meets the criteria for~~ a comprehensive stroke center. The list of ~~primary and comprehensive~~ stroke centers

Page 1 of 4

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

588-02959A-17

20171406c1

must include only those hospitals that attest in an affidavit submitted to the agency that the hospital meets the named criteria, or those hospitals that attest in an affidavit submitted to the agency that the hospital is certified as an acute stroke ready center, a primary stroke center, or a comprehensive stroke center by a nationally recognized ~~an~~ accrediting organization.

(2) (a) If a hospital no longer chooses to meet the criteria for an acute stroke ready center, a primary stroke center, or a comprehensive stroke center, the hospital shall notify the agency and the agency shall immediately remove the hospital from the list of stroke centers.

(b) 1. This subsection does not apply if the hospital is unable to provide stroke treatment services for a period of time not to exceed 2 months. The hospital shall immediately notify all local emergency medical services providers when the temporary unavailability of stroke treatment services begins and when the services resume.

2. If stroke treatment services are unavailable for more than 2 months, the agency shall remove the hospital from the list of ~~primary or comprehensive~~ stroke centers until the hospital notifies the agency that stroke treatment services have been resumed.

(3) The agency shall adopt by rule criteria for an acute stroke ready center, a primary stroke center, and a comprehensive stroke center which are substantially similar to the certification standards for the same categories of ~~primary~~ stroke centers of a nationally recognized accrediting organization ~~the Joint Commission~~.

Page 2 of 4

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

588-02959A-17

20171406c1

~~(4) The agency shall adopt by rule criteria for a comprehensive stroke center. However, if the Joint Commission establishes criteria for a comprehensive stroke center, agency rules shall be substantially similar.~~

~~(4)(5)~~ This act is not a medical practice guideline and may not be used to restrict the authority of a hospital to provide services for which it is licensed under chapter 395. The Legislature intends that all patients be treated individually based on each patient's needs and circumstances.

(5) The agency shall adopt by rule standardized electronic forms for each acute stroke ready center, primary stroke center, and comprehensive stroke center to report to the department such information as required in s. 395.30381.

Section 2. Section 395.30381, Florida Statutes, is created to read:

395.30381 Statewide stroke registry.—

(1) Each acute ready stroke center, primary stroke center, and comprehensive stroke center shall submit to the department patient care quality assurance proceedings, records, or reports associated with any treatment or service provided to a person suffering a stroke. Such information shall be used to evaluate stroke care system effectiveness, ensure compliance with standards established pursuant to s. 395.3038, and monitor patient outcomes.

(2) The department shall establish a statewide stroke registry to ensure that patient care quality assurance proceedings, records, and reports required to be submitted under subsection (1) are maintained and available for use to improve or modify the stroke care system, ensure compliance with

588-02959A-17

20171406c1

standards, and monitor stroke patient outcomes. The department may contract with a private entity to establish and maintain the registry. No liability of any kind or character for damages or other relief shall arise or be enforced against any acute ready stroke center, primary stroke center, or comprehensive stroke center by reason of having provided such information to the department.

(3) The department shall adopt rules to administer this section.

Section 3. Subsections (1), (2), and (4) of section 395.3041, Florida Statutes, are amended to read:

395.3041 Emergency medical services providers; triage and transportation of stroke victims to a stroke center.—

(1) By June 1 of each year, the department shall send the list of acute stroke ready centers, primary stroke centers, and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in this state.

(2) The department shall develop a sample stroke-triage assessment tool. The department must post this sample assessment tool on its website and provide a copy of the assessment tool to each licensed emergency medical services provider ~~no later than June 1, 2005~~. Each licensed emergency medical services provider must use a stroke-triage assessment tool that is substantially similar to the sample stroke-triage assessment tool provided by the department.

(4) Each emergency medical services provider licensed under chapter 401 must comply with all sections of this act ~~by July 1, 2005~~.

Section 4. This act shall take effect July 1, 2017.



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

302 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
1/30/17	SM	Favorable
2/22/17	JU	Fav/CS
4/17/17	AHS	Pre-meeting
	AP	

January 30, 2017

The Honorable Joe Negrón
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 28** – Judiciary Committee and Senator David Simmons
HB 6501 – Representative Scott Plakon
Relief of J.D.S.

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR \$950,000 PAYABLE TO THE AGED POOLED SPECIAL NEEDS TRUST ON BEHALF OF J.D.S., BASED ON A SETTLEMENT AGREEMENT BETWEEN PATTI R. JARRELL, AS PLENARY GUARDIAN OF J.D.S., AND THE STATE OF FLORIDA, AGENCY FOR PERSONS WITH DISABILITIES. THE CLAIM AROSE FROM THE NEGLIGENT SUPERVISION OF A GROUP HOME BY THE AGENCY.

FINDINGS OF FACT:

In 1980, J.D.S. was born with severe disabilities, including cerebral palsy, autism, and mental retardation. J.D.S. has a 31 IQ and has been nonverbal her entire life. J.D.S. was placed in the custody of the State of Florida, Department of Children and Families (DCF) and considered to be a "ward" of DCF. Due to her condition, J.D.S. was dependent upon DCF for the provision of her care, treatment, and daily needs.

At the age of 4, J.D.S., as a developmentally-disabled dependent ward of the State of Florida, was placed in the Strong Group Home. J.D.S. was totally dependent on the Strong Group Home to provide the care for her needs. She was incapable of performing even the most basic functions of life. The Strong Group Home was licensed by DCF to operate

the group home, and the home was monitored through face to face visits on a monthly basis with the exception of a short interval when, due to budget cuts, visits occurred either every other month or quarterly. The Strong Group Home was also visited monthly by the Medicaid Waiver Support Coordinator who had the responsibility of ensuring J.D.S. was receiving her care plan services. Hester Strong was the administrator/owner of the Strong Group Home and was assisted by her husband, Phillip Strong. In addition to caring for 4 - 6 developmentally disabled persons, Ms. Strong cared for her elderly parents who also resided in the home.

Beginning in late 2001 and into 2002, J.D.S.'s behavior became more aggressive. She began to resist getting into a car which had not been an exhibited behavior in the past. And, although she was previously toilet trained, she began exhibiting regular incontinence. Ms. Strong did not report these changes in J.D.S.'s behaviors, and the DCF monitoring reports of the Strong Group Home did not contain any reference to them.

In December 2002, J.D.S. became pregnant while a resident in the Strong Group Home. J.D.S. was 5 months pregnant when her doctor discovered her pregnancy.

Upon the discovery of J.D.S.'s pregnancy, DCF revoked the Strong Group Home's license and J.D.S. was moved to another group home. J.D.S. gave birth to a baby girl on August 30, 2003. The newborn was immediately removed from J.D.S. and placed for adoption. Following the birth, the Florida Department of Law Enforcement took DNA samples from Phillip Strong and the newborn. The results of the DNA testing confirmed that Phillip Strong was the biological father of the infant.

DCF was responsible for the oversight of the Strong Group Home and providing care to J.D.S. when the events related to the claim bill occurred. However, in 2004, the responsibility to oversee group homes for the disabled was transferred to the Agency for Persons with Disabilities along with DCF's related liabilities.

Based on the foregoing, the State of Florida, Agency for Persons with Disabilities, stipulated to the entry of a judgment in the amount of \$1,150,000. The Agency for Persons' with

Disabilities paid \$200,000 to the AGED Pooled Special Needs Trust on behalf of J.D.S., leaving \$950,000, which is the amount sought through this claim bill.

CLAIMANT'S POSITION:

The Agency for Persons with Disabilities is directly and vicariously liable for the rape and subsequent pregnancy of J.D.S. The claimant also alleges that the rape of J.D.S. was foreseeable by the agency. It should be noted that Mr. Strong was determined incompetent and never charged with the rape of J.D.S.

RESPONDENT'S POSITION:

The Agency for Persons with Disabilities settled this claim before a jury trial and is neutral in this proceeding and will take no action adverse to the passage of a claim bill.

CONCLUSIONS OF LAW:

As provided in s. 768.28, F.S. (2002), sovereign immunity shields the State of Florida and its agencies against tort liability in excess of \$200,000 per occurrence. The parties settled the case for \$1.15 million, and the Agency for Persons with Disabilities paid \$200,000 to the AGED Pooled Special Needs Trust on behalf of J.D.S. The claimant alleged APD is liable for the sexual molestation of J.D.S. under two separate legal precepts: vicarious liability and direct liability. The claimant alleged APD had a "non-delegable" duty to protect J.D.S. from harm and sexual assault. At all times material to this matter J.D.S. was a resident of the Strong Group Home.

APD is a governmental agency that licenses, monitors, and places clients in residential living facilities. APD does not undertake to provide direct services to any particular client. Instead, the Florida Legislature, in s. 393.066, F.S. (2002), has mandated that the day-to-day operational level duties of care and maintenance of a client are to be delegated by APD.

Duty

Whether there is a jury verdict or a settlement agreement, as there is in this case, every claim bill must be based on facts sufficient to meet the preponderance of evidence standard. DCF had a duty to protect and care for J.D.S. while she was in the care of the Strong Group Home. This duty included ensuring the administrator and staff of the Strong Group Home were properly trained to detect and prevent sexual abuse of the developmentally-disabled individuals placed in their care; adequate staffing was in place at all times and the staff met training requirements; the number of placements in

the home did not exceed the limit established by DCF; and the home complied with the Bill of Rights of Persons with Developmental Disabilities as set forth under s. 393.13, F.S. (2002). Such Bill of Rights guarantees that developmentally disabled individuals have the right to be free from sexual abuse in a residential facility, the right to be free from harm, and the right to receive prompt and appropriate medical care and treatment.

The Strong Group Home administrator and staff did not meet the educational and training requirements set forth in Rule 65G-2.012, F.A.C., and s. 393.067, F.S. (2002). There was no evidence presented that the administrator met the educational requirements for licensing or that she or any staff member had received any training on how to detect, report, or prevent sexual abuse of the group home's residents and clients.

The Strong Group Home was licensed for and housed 4 - 6 developmentally disabled clients. Nevertheless, at one point while J.D.S. was in the home, DCF placed two foster children in the home. As a result of the placement of additional clients, not enough bedrooms were available and the dining room was converted into J.D.S.'s bedroom. The placement of her bed in the dining room area did not provide J.D.S. the privacy she was entitled to under the Bill of Rights of Persons with Developmental Disabilities set out in s. 393.13, F.S.

Additionally, the Strong Group Home had a duty to exercise reasonable care to protect J.D.S. from abuse and neglect, including sexual abuse; to exercise reasonable care to discover abuse and neglect, to provide J.D.S. with a reasonable, safe living environment that afforded her with privacy, and to exercise reasonable care to ensure she received prompt and appropriate medical care and treatment.

Breach

A preponderance of the evidence establishes that The Strong Group Home did not meet the educational and training requirements to be licensed as a group home initially by DCF and subsequently by APD. APD and the Strong Group Home as licensed by APD, breached their duty to properly care for and protect J.D.S. Further, APD and the Strong Group Home breached their duty to J.D.S. with respect to compliance with the rights and privileges afforded the developmentally

disabled pursuant to the Bill of Rights of the Developmentally Disabled.

Causation

The failure of the Department of Children and Families and subsequently the Agency for Persons with Disabilities to ensure the staff of the Strong Group Home was properly trained, possessed the required levels of education and credentials likely led to the rape of J.D.S.

Damages

The claim bill awards \$950,000 for the benefit of J.D.S. No evidence was presented or available indicating that the damages authorized by the settlement are excessive or inappropriate.

ATTORNEYS FEES:

Section 768.28(8), F.S., provides that “[n]o attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement.” The claimant’s attorneys have agreed to limit their fees to 25 percent of any amount awarded in compliance with the statutes. Lobbyists’ fees are included with the attorneys’ fees.

RECOMMENDATIONS:

For the reasons set forth above, I recommend that Senate Bill 28 be reported FAVORABLY.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

cc: Secretary of the Senate

CS by Judiciary:

The committee substitute, in conformity with a recent opinion of the Florida Supreme Court, does not include the limits on costs, lobbying fees, and other similar expenses, which were included in the original bill.

By the Committee on Judiciary; and Senator Simmons

590-01949-17

201728c1

A bill to be entitled

An act for the relief of J.D.S.; providing an appropriation from the General Revenue Fund to compensate J.D.S. for injuries and damages sustained as a result of the negligence of the Agency for Persons with Disabilities, as successor agency of the Department of Children and Family Services; providing that certain payments and the appropriation satisfy all present and future claims related to the negligent act; providing a limitation on the payment of attorney fees; providing an effective date.

WHEREAS, in December 2002, J.D.S., a 22-year-old developmentally disabled woman with autism, cerebral palsy, and mental retardation, was living at the Strong Group Home, which was owned and operated by Hester Strong and licensed and supervised by the Department of Children and Family Services, and

WHEREAS, in December 2002, J.D.S. was raped and impregnated by Philip Strong, husband of the owner and operator of the Strong Group Home, and

WHEREAS, on April 24, 2003, J.D.S.'s pregnancy was discovered by her physician, and on August 30, 2003, J.D.S. gave birth to a baby girl, known as G.V.S., who was immediately taken from J.D.S. and placed for adoption, and

WHEREAS, as a result of her rape and impregnation, J.D.S. sustained mental anguish and a further diminution in the quality of her life, and

WHEREAS, J.D.S. filed a claim in Orange County Circuit

Page 1 of 4

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

590-01949-17

201728c1

Court alleging that the department negligently supervised the Strong Group Home and that the Strong Group Home was negligently operated, thereby allowing Philip Strong to rape J.D.S., which resulted in her impregnation, and

WHEREAS, J.D.S.'s claims against the department, the Strong Group Home, and other parties were based upon negligence, violations of chapter 393, Florida Statutes, and violations of the Bill of Rights of Persons with Developmental Disabilities, as set forth in s. 393.13, Florida Statutes, and

WHEREAS, as a client of the department, as the term "client" is defined in s. 393.063, Florida Statutes, J.D.S. had a right under s. 393.13, Florida Statutes, to "dignity, privacy, and humane care, including the right to be free from abuse, including sexual abuse, neglect, and exploitation," and

WHEREAS, J.D.S. alleged that the department had a nondelegable duty to protect her from foreseeable harm, including sexual abuse, and

WHEREAS, J.D.S. alleged that the department was liable for direct negligence relating to its oversight of the Strong Group Home and that it was vicariously liable for the negligence of the Strong Group Home under the doctrine of respondeat superior established under s. 768.28(9)(a), Florida Statutes, and

WHEREAS, before the jury trial was scheduled to commence on February 6, 2012, the parties agreed to settle the case titled *Patti R. Jarrell, as plenary guardian of J.D.S., an incapacitated person, Plaintiff, v. State of Florida, Agency for Persons With Disabilities, as successor agency of the Department of Children and Family Services*, for the sum of \$1.15 million, and

Page 2 of 4

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

590-01949-17

201728c1

WHEREAS, under the terms of the settlement agreement consented to by the parties, the Agency for Persons with Disabilities agreed to pay \$200,000 to J.D.S., with the remaining \$950,000 to be paid pursuant to a stipulated claim bill, and

WHEREAS, the agency has agreed to request an appropriation from the Legislature in the amount of \$950,000, and

WHEREAS, the \$950,000 stipulated settlement is sought through the submission of a claim bill to the Legislature, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. The sum of \$950,000 is appropriated from the General Revenue Fund to the Agency for Persons with Disabilities for the relief of J.D.S. as compensation for the injuries and damages she sustained.

Section 3. The Chief Financial Officer shall draw a warrant upon funds of the Agency for Persons with Disabilities in the sum of \$950,000 and shall pay such amount out of funds in the State Treasury to the AGED Pooled Special Needs Trust, which shall be managed and administered on behalf of J.D.S. by AGED, Inc., a nonprofit trust company.

Section 4. The amount paid by the Agency for Persons with Disabilities pursuant to s. 768.28, Florida Statutes, and the amount awarded under this act are intended to provide the sole compensation for all present and future claims arising out of

590-01949-17

201728c1

the factual situation described in this act which resulted in the injuries and damages to J.D.S. The total amount paid for attorney fees relating to this claim may not exceed 25 percent of the amount awarded under this act.

Section 5. This act shall take effect upon becoming a law.



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

302 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
1/31/17	SM	Favorable
3/15/17	JU	Fav/CS
4/17/17	AHS	Pre-meeting
	AP	

January 31, 2017

The Honorable Joe Negron
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 34** – Judiciary Committee and Senator Oscar Braynon
HB 6525 – Representative J.W. Grant
Relief of C.M.H.

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR \$5,000,000 PREDICATED ON THE ENTRY OF A JURY AWARD IN FAVOR OF CHRISTOPHER HANN AND THERESA HANN, INDIVIDUALLY, AND AS NAUTRAL GUARDIANS OF C.M.H., A MINOR CHILD, DUE TO THE NEGLIGENCE OF THE DEPARTMENT OF CHILDREN AND FAMILIES.

FINDINGS OF FACT:

The Department of Children and Families, placed J.W., a 10 year old foster child with a history of violence and sexual assaults against younger children, in the home of Christopher and Theresa Hann. The Hanns had young children of their own, and because the Hanns were not trained to handle a child with J.W.'s propensity for violence, the department should not have placed J.W. in the Hann's home. Making matters worse, the department concealed J.W.'s violent past from the Hanns when it had a duty to disclose it. Ultimately, the department's placement of J.W. in the Hann's home led to the emotional, physical, and sexual abuse of C.M.H., the Hann's 8 year old son, by J.W.

The Department of Children and Families knew of J.W.'s propensity for violence toward other children.

J.W. was born January 23, 1992, in Florida, to a teenage mother who had a history of mental illness and homelessness. She did not receive prenatal care and attempted suicide during the third month of her pregnancy by inhaling butane. J.W.'s mother was living in a shelter for homeless and runaway youth at his birth. J.W.'s biological father had a history of drug abuse and played no major role in his life.

J.W. lived with his mother until the age of 4. During this time, he was subjected to extreme neglect, cruelty, and physical and sexual abuse by his mother, her boyfriends, and her extended family members. J.W., at age 1, was subjected to sexual abuse for approximately 2-3 years by males visiting his mother. He was severely beaten at age 2 while in the care of his mother's boyfriend.

As a result of his repeated abuse and neglect, J.W. began to exhibit symptoms of post-traumatic stress disorder. Due to aggressive behaviors, he was dismissed from two daycare centers. At age 3, he attempted suicide. He was subsequently diagnosed as having attention deficit hyperactivity disorder with psychotic behavior and suicidal tendencies and treated with anti-psychotic medication.

J.W. was returned to his mother's care at age 5. He was severely psychotic and began setting fires. In June 1997, J.W. was admitted to the Columbia Hospital Inpatient Psychiatric Program for a week due to self-mutilation, violent behavior, homicidal ideation, auditory hallucinations, and multiple suicide attempts. J.W. would continue receiving intensive outpatient psychiatric treatment for 7 months following his initial hospitalization.

After receiving a report that J.W. was again sexually molested by another of his mother's male friends, the department placed J.W. back into foster care where he resided on and off for approximately 5 years. He was involuntarily hospitalized at least two more times by age 9. One hospitalization was due to aggressive behavior, an attempt to stab his uncle and his babysitter with a knife. Later he was hospitalized for planning to bring a gun and knife to school to kill a teacher and himself.

In 2002, J.W. was living with his mother who had married several years earlier and had given birth to a daughter with her new husband. The department and the family entered into a voluntary case plan to address continuing allegations of abuse, neglect, and domestic violence in the home. During this time, J.W. began to exhibit sexually aggressive behavior towards other children. Multiple reports indicated that J.W. performed anal penetration on a neighborhood girl. He also continued to display severe psychotic behavior. On one occasion he attempted to cut his stepfather's throat while he slept.

On June 14, 2002, DCF family services counselor, Suzy Parchment, referred J.W. to Camelot Community Care, a DCF provider of child welfare and behavioral health services, for intensive therapeutic in-home services. Realizing the severity of J.W.'s behavior, in a communication with Camelot on June 24, Ms. Parchment noted that J.W. needed to be in a residential treatment facility as soon as possible.

As an emergency, temporary solution and noting that J.W. was a danger in the home, Camelot accepted the referral to provide mental health services to J.W. in his natural home while the department sought residential placement. Camelot noted on its admission form that J.W. was a sexual predator and engaged in sexually inappropriate behavior. It was also noted that J.W. suffered from non-specified psychosis, major depression with psychotic features, adjustment disorder and attention deficit hyperactivity disorder. The in-home counselor assigned to J.W.'s case did not have experience with sexual trauma, and Camelot's initial treatment plan did not include any specific goals or specialized treatment for sexual abuse.

J.W.'s mother informed Camelot and the department that J.W. was giving his 3 year old sister hickies, bouncing her on his lap in a sexual manner, and having her fondle his genitals. Camelot performed a child safety determination and found that based on J.W.'s history, a sibling was likely to be in immediate danger of moderate to severe harm if J.W. was not supervised. Camelot recommended that J.W.'s parents separate him from his younger sister at night and closely watch him when he interacts with his sister.

On or about August 2002, the department removed J.W. and his younger sister from their mother's care after she

abandoned them at a friend's house. J.W. was sheltered in the home of a family friend, Luz Cruz, a non-relative placement while his younger half-sister was placed with family members.

J.W. underwent a Comprehensive Behavioral Health Assessment on August 30, 2002, at the request of DCF. The assessment concluded that J.W. "should not have unsupervised access to [his younger sister], or to any younger, or smaller children wherever he resides." The Assessment also states: ***"J.W.'s caregiver must be informed about these issues and must be able to demonstrate that they can provide adequate levels of supervision in order to prevent further victimization. These issues should be strongly considered in terms of making decisions about both temporary and long term care and supervision of J.W."***

Based upon the findings and recommendations in the Assessment, J.W. was referred to Father Flanagan's Boys' Home d/b/s Girls and Boys Town, a DCF service provider, for case management services.

The Department of Children and Families knew that J.W., should not have been placed in a home with younger children.

Ms. Parchment removed J.W. from the Cruz home on September 6, 2002, due to allegations of sexual abuse by a member of the Cruz family; however, she did not report the abuse allegation as required by Florida law. It was also on September 6, 2002, that J.W. was placed with the Hanns.

Mr. and Mrs. Hann were former neighbors of J.W. and his natural family. The Hanns lived with their two children, a daughter, age 16, and a son, C.M.H., age 8. They were not licensed or trained foster parents. In the past, J.W. had often sought shelter in the Hann home when left alone by his mother. Theresa Hann had offered to care for J.W. and his mother lobbied Camelot and the department to have J.W. placed with the Hann family instead of Luz Cruz.

Ms. Parchment recalled her first impressions of the Hann family were of nice people who maintained a very organized and clean home. She believed Theresa Hann's main purpose was to care for J.W. and that she had no ulterior motives.

However, despite the willingness of the Hanns to care for J.W., the removal of J.W. from the Cruz home and placement in the Hann home violated DCF rules.

Under the department's rules, it is required to obtain prior court approval for all non-relative placements. This requirement eliminates non-relative placements for use in lieu of emergency shelter care. Ms. Parchment did not obtain the required court approval prior to placing J.W. in the Hann home. She also failed to notify the department's legal team, who is responsible for court filings, of the allegation of sexual abuse of J.W. in the Cruz home or his subsequent placement in the Hann home for two months.

Additionally, the placement directly conflicted with previous recommendations by department providers regarding placement for J.W. due to his sexually aggressive behaviors. J.W. was placed in a home with an 8 year old child even though 2 months earlier Camelot had warned that a sibling would be in danger in a home with J.W. One week prior to the placement, St. Mary's Medical Center had recommended that J.W. not have unsupervised access to younger children. The Hanns were not provided any information about J.W.'s ongoing inappropriate behavior with younger children and the Hanns allowed J.W. to share a bedroom with their son, C.M.H. Department rules expressly prohibit placing a sexually aggressive child in a bedroom with another child. Ms. Parchment knew of the planned sleeping arrangements prior to placing J.W. in the Hann home but did not tell them that the arrangement was prohibited under the department's rules.

The Department of Children and Families failed to inform the Hanns of J.W.'s background.

Christopher Hann specifically requested information about J.W., but the department failed to provide any information regarding J.W.'s troubled history of child-on-child sexual abuse or on his background generally. Florida law requires DCF to share psychological, psychiatric and behavioral histories, comprehensive behavioral assessments and other social assessments found in the child's resource record with caregivers. The department acknowledged during litigation that no evidence of a child resource record for J.W. was found. Additionally, for the purpose of preventing the reoccurrence of child-on-child sexual abuse, the department must provide caregivers of sexual abuse victims and aggressors with

written, complete, and detailed information and strategies related to such children, including the date of the sexual abuse incident(s), type of abuse, type of treatment received, and outcome of the treatment in order to “provide a safe living environment for all the children living in the home.”

Not only did the department fail to comply with its own requirements, Ms. Parchment told Mr. Hann that she was not allowed to give him such information about J.W. because the placement was temporary. Nevertheless, J.W. remained in the Hann home for approximately 3 years during which his behavioral problems continued and quickly escalated.

The Department of Children and Families knew it should have removed J.W. from the Hann home as his violent behaviors increased.

Within a few weeks after J.W.’s placement in the Hann home, Mrs. Hann reported to Camelot that J.W. was playing with matches in the presence of C.M.H.; exhibited extreme anger and hostility towards C.M.H., including yelling, screaming “shut up” at the smallest aggravation or noise, and kicking C.M.H. Among J.W.’s behavioral problems, he stabbed himself with a straightened paper clip after being grounded for leaving the neighborhood without permission; threatened to jump out of a window after it was discovered he stole a roll of felt from school; and attacked Ms. Hann, biting and scratching her when she grounded him for cursing.

Camelot recommended to Ms. Parchment that the Hanns place a one way monitor in the bedroom shared by J.W. and C.M.H. While Ms. Parchment agreed to pass the recommendation on to the Hanns, there is no evidence that the information was shared or that the Hanns ever obtained the monitor.

J.W.’s behavior further deteriorated and on October 24, 2002, after a physical altercation with C.M.H., he pulled a knife on the younger child but was stopped from further assaulting him by Mr. Hann. Camelot was immediately informed of the incident by Mr. Hann, and J.W. was again involuntarily committed into Columbia Hospital for a mental health assessment. Camelot’s notes indicate Ms. Parchment was informed of J.W.’s escalating behavior in the Hann home. Ms. Parchment later acknowledged that at this point she should

have considered removing J.W. from the Hann home due to the danger he posed to himself, the Hanns and their son.

A week after the mental health assessment was performed, J.W. sexually assaulted a 4 year old girl who was visiting the Hann home. The children were watching a movie when J.W. exposed his genitals and began “humping” the young girl. Ms. Hann reported the incident to DCF. During the course of the investigation, the department learned the children were not under the direct supervision of any adult at the time of the incident – a failure that DCF providers warned would lead to harm of other children when left alone with J.W. Again, DCF was required to give immediate consideration to the safety of C.M.H. Despite, the inability of the Hanns, who both worked outside the home, to adequately supervise J.W. and his continuing access to young children, DCF did not remove J.W. from the Hann home.

Camelot began pressuring Ms. Parchment to schedule a psychosexual evaluation of J.W. which she was required to do months earlier pursuant to DCF’s operating procedures. The evaluation had in fact been requested by Camelot when J.W. was placed with the Hanns and again just 2 days before he sexually assaulted the 4 year old girl visiting the Hann home. Camelot’s notes indicate that it told Ms. Parchment that “[J.W.] needed specific sexual counseling by a specialist in this area.” Ms. Parchment took no action so Camelot advised Mr. Hann that a new safety plan would be implemented which prohibited J.W. and C.M.H. from sharing a bedroom and requiring J.W. to be under close adult supervision when other children were present. Such recommendations had already been a complete failure at preventing J.W. from perpetuating sexual abuse on other children. Further, still without knowledge of J.W.’s extensive history of sexual abuse as a victim and aggressor, Mr. Hann informed Camelot that the family disagreed with and would not follow the safety plan.

The Department of Children and Families ignored repeated warnings from its service providers.

Beginning in November 2002, Girls and Boys Town began providing services to J.W. in conjunction with Camelot. The assessment of J.W.’s case and his current behaviors, which was performed by Girls and Boys Town, found that despite his escalating violence and suicidal and sexually aggressive

actions, no additional interventions or therapies had been put in place.

Camelot again requested a psychosexual evaluation of J.W. on November 6, 2002.

Additionally, in November 2002, C.M.H. began to exhibit behavioral problems which Camelot directly attributed to J.W. being in the home. C.M.H.'s grade dropped. In one school year he went from being an "A", "B", or "C" student to failing grades and was ultimately retained in the fourth grade.

In December 2002, the Hanns, overwhelmed with the number of providers involved in J.W.'s care and the disruption to their family, canceled the services of Camelot. Camelot recommended in its discharge form, signed by Ms. Parchment, that J.W. be placed in a residential treatment facility; however, DCF did not initiate a change in placement.

In June 2003, J.W. began expressing sexually inappropriate behavior towards C.M.H., asking him if he wanted to "see what sperm looks like" before masturbating to completion in front of him and attempting to hand him the semen. Due to this new escalation of J.W.'s behavior now directed at C.M.H., the department finally secured the psychosexual evaluation of J.W. but still did not remove him from the Hann home.

The department received the results of the psychosexual evaluation of J.W. performed by The Chrysalis Center on September 18, 2003. The Center found that J.W. "fit the profile of a sexually aggressive child due to the fact that he continues to engage in extensive sexual behaviors with children younger than himself." Further, it was found that J.W. "[presented] a risk of potentially becoming increasingly more aggressive" and "continuing sexually inappropriate behaviors." The Center warned that J.W. "may seek out victims who are children and coerce them to engage in sexual activity." And again the Center recommended specific counseling for J.W. and appropriate training for his caregivers, the Hanns.

Finally, in October 2003, the Hanns requested J.W. be placed in a therapeutic treatment facility as they did not feel equipped to provide him with services and interventions he needed. Therapeutic placement was authorized for J.W. and he was referred to Alternate Family Care in Jupiter, Florida. The

Hanns were told that if J.W. was removed from their home they would not be permitted visitation privileges with him at the facility. The Hanns did not want to be the next in a series of parental figures that abandoned J.W. so they ultimately made the decision to maintain him in their home with a request for additional services to treat his ongoing issues. At this time the Hanns begin training to become therapeutic foster parents.

C.M.H.'s problems due to J.W.'s presence in the home continued at school. Beginning in late 2003 to early 2004, C.M.H. began to act out and have more conflicts in school. He received a student discipline referral for ongoing behavioral problems in the classroom. Additionally, in early 2004 he began gaining weight and would subsequently gain about 40 pounds over the next two years.

The Department of Children and Families failed to remove a dangerous child it had placed in the Hann home when requested by the Hanns.

Mrs. Hann was diagnosed with terminal cancer on March 3, 2004. As a result, Mr. Hann contacted DCF within 48 hours of the diagnosis and requested the process of having J.W.'s placement with them as "long-term non-relative care" be stopped and asked that J.W. be placed elsewhere. Ms. Parchment visited the Hann home within 24 hours after the request and advised the family that "we'll get on it."

Nothing was done and contrary to the express request and wishes of the Hanns and without their knowledge, DCF had the Hanns declared as "long term non-relative caregivers" of J.W. The department subsequently closed the dependency case, leaving J.W. him the care of the Hanns.

The Department of Children and Family Services withdrew support for the Hann family when it was needed most.

The Hanns were not part of the foster care system so when DCF closed its dependency case, the Hann family lost approximately 50 percent of their services and counseling. Father Flanagan's suspended services to J.W. and the Hann family in April 2004. The Hanns would later directly attribute the resurgence in J.W.'s inappropriate sexual behavior to the loss of counseling services.

With almost no support from DCF, the Hanns grew more desperate as they tried to deal with Mrs. Hann's illness and J.W.'s escalating behavior.

C.M.H.'s troubles also continued. An April 2005 treatment plan from St. Mary's Child Development Center's Children's Provider Network noted that he began to have nightmares and was easily frustrated. The report also noted that his mother's diagnosis of terminal cancer and intensive chemotherapy treatments were contributing to C.M.H.'s increasing separation anxiety and grief issues. He was diagnosed with post-traumatic stress disorder.

In April 2005, Mr. Hann wrote DCF and the juvenile judge requesting help in placing J.W. in a residential placement. There was no response to his request, and J.W. remained in the Hann home.

A report from Child & Family Connections, the lead agency for community-based care in Palm Beach County, dated June 16, 2005, provided a description of J.W.'s personality and behavior, the high risk of sexual behavior problems and increasing aggression, his excessive masturbation, seeking out younger children, lies, and refusal to take responsibility for his actions. The report stated that the Hanns "[had] been told that it is not a matter of will J.W. perpetrate on their son again, but a matter of when the perpetration would occur. [J.W. was] in need of a more restrictive setting with intensive services specializing in sexual specific treatment." The report also noted that J.W.'s previous therapist, current therapist, and a psychosexual evaluation all recommended a full-time group home facility specializing in sexual specific treatment. The report concluded that J.W.'s condition was "so severe and the situation so urgent that treatment [could not] be safely attempted in the community."

Predictably, the numerous failures of the Department and its Family Services resulted in the sexual assault of another child.

On June 29, 2005, after a physical altercation between J.W. and Mrs. Hann, C.M.H., then 10 years old, told his parents that 2 years prior, J.W. had forced him to engage in oral sex while the boys were at a sleepover at this cousin's house. Mr. Hann called Girls & Boys Town and demanded that J.W. be removed from the home immediately. Later that same day, the

department finally removed J.W. from the Hann home, and he was taken to an emergency shelter until a placement could be determined.

The court entered an order on August 11, 2005, authorizing the placement of J.W. into a residential treatment center. The court found that although a previous court order authorized placement in a specialized therapeutic group home, due to another incident that occurred while in emergency shelter, J.W. required a higher level of care.

Theresa Hann passed away the next year shortly after initiating litigation against DCF and its providers.

CLAIMANT'S POSITION:

The lawsuit was filed against the department, Camelot Community Care, Inc., Elaine Beckwith, Chrysalis Center, and Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida. The suit alleged the defendants were negligent and directly liable for the injuries suffered by C.M.H. as a result of the sexual abuse due to:

1. The initial placement of J.W. in the Hann home;
2. The failure of DCF to follow its own rules and operating procedures to provide the necessary treatment and services for J.W.;
3. The failure of DCF to provide the required information to the Hanns regarding J.W.'s history of sexual abuse and sexual aggressiveness, including the failure to formulate a safety plan for J.W. and all the children residing in the Hann home;
4. The failure of DCF to maintain the safety of J.W. and any children residing in the placement;
5. The failure of the DCF employee to report the allegations of sexual abuse of J.W. as mandated by s. 39.201, F.S.; and

DCF moving forward with having the court declare the Hanns "long-term non-relative caregivers," closing the case file, and leaving J.W. in the custody of the Hanns without notice to them and despite their request to stop the process.

RESPONDENT'S POSITION:

The Department of Children and Families defended the lawsuit. On November 18, 2013, after a 4-week jury trial, a judgment was entered in the amount of \$10,000,000. DCF was found to be 50 percent liable (\$5,000,000) and Mr. and Mrs. Hann were found to be 50 percent liable (\$5,000,000). The jury attributed no liability to the remaining defendants.

CONCLUSIONS OF LAW:

Every claim bill must be based on facts sufficient to meet the preponderance of evidence standard. With respect to this claim bill, which is based on a negligence claim, the claimant proved that the state had a duty to the claimant, the state breached that duty, and that the breach caused the claimant's damages.

Duty

The Department of Children and Families had a duty pursuant to exercise reasonable care when placing a child involved in child-on-child sexual abuse or sexual assault in substitute care; to provide caregivers of children with sexual aggression and sexual abuse with written, detailed and complete information of the child's history; to establish appropriate safeguards and strategies to protect all children living in the foster or temporary care; to ensure the foster family is properly trained and equipped to meet the serious needs of the foster child; and to exercise reasonable care under the circumstances.

Breach

A preponderance of the evidence establishes that DCF breached its duties by failing to follow its governing statutes, rules, and internal operating procedures by:

- Placing J.W., a known sexually aggressive, severely emotionally disturbed, and dangerous child in the Hann home without legal authority and in direct conflict with recommendations of DCF service providers that J.W. not have access to young children;
- Failing to ensure that Mr. and Mrs. Hann were duly licensed and trained as required by department rule, making them capable of safely caring for a child with J.W.'s extensive needs;
- Failing to fully and completely inform the Hanns of J.W.'s history, and the risk and danger he posed to C.M.H. as required by department rule; and
- Failing to remove J.W. from the Hann home when it became clear that the placement was inappropriate and dangerous to the Hanns and C.M.H. particularly.

Causation

The sexual, physical and emotional abuse suffered by C.M.H. was the direct and proximate result of DCF's failure to fulfill its

duties regarding the foster placement of a known sexually aggressive child.

Damages

At the conclusion of a 2-week trial, the jury found DCF and Mr. and Mrs. Hann each 50 percent responsible for the negligence that resulted in the injuries suffered by C.M.H. The jury awarded C.M.H. \$6 million for past pain and suffering, \$3.5 million for future pain and suffering, \$250,000.00 for future treatment and services and \$250,000.00 for future loss of earning capacity for a total award of \$10 million. The department and Mr. and Mrs. Hann were each responsible for \$5 million. The jury did not assess any liability for negligence against the remaining 6 defendants.

C.M.H. was initially diagnosed with post-traumatic stress disorder in 2005. Thomas N. Dikel, Ph.D., reaffirmed the diagnosis in 2010, finding that C.M.H.'s severe PTSD was caused by his "experiences of child-on-child sexual abuse, exacerbated and magnified by his mother's diagnosis of stage 4, metastatic colon cancer."

He was re-evaluated by Dr. Stephen Alexander in October 2014. Dr. Alexander found C.M.H. to continue to suffer from PTSD and major depression, but had become even more dysfunctional since his initial evaluation due to lack of services. Dr. Alexander attributed the majority of C.M.H.'s psychological trauma to this mother's illness and death; however, he did note that due to J.W.'s presence in the home during her illness, the two events have become inextricably intertwined in this psyche.

Comprehensive Rehabilitation Consultants, Inc., created a life plan for C.M.H. to determine the funds necessary to provide the support needed by C.M.H. as a direct consequence of the sexual abuse he experienced. It was determined the cost for medical, psycho-therapies, educational and support services as well as ancillary services of transportation, housing and personal items would be \$2.23 million over C.M.H.'s life.

As a result of the judgment entered by the court against DCF, the state paid \$100,000 (the maximum allowed under the state's sovereign immunity waiver) with the remaining \$4.9 million to be paid if this claim bill is passed by the Legislature and signed into law by the Governor.

COLLATERAL SOURCES OF RECOVERY:

Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida (Father Flanagan) was a named defendant in the lawsuit. Father Flanagan executed a settlement agreement with Claimants on July 30, 2013, in the amount of \$340,000. However, in October 2013, the jury found that Father Flanagan was not negligent for any loss, injury or damage to C.M.H.

ATTORNEYS FEES:

Claimant's attorneys have acknowledged in writing that nothing in excess of 25 percent of the gross recovery will be withheld or paid as attorneys' fees.

RECOMMENDATIONS:

The negligence of the department and the Hanns were the legal proximate cause of the damages suffered by C.M.H. However, The jury award of \$9.5 million for non-economic damages or pain and suffering is not supported by the weight of the evidence. According to Dr. Alexander's October 2014 report, C.M.H. continues to suffer from PTSD but attributes a majority of C.M.H.'s psychological trauma to the illness and death of his mother. The department should not be held financially liable for C.M.H.'s psychological trauma that occurred due to the illness and death of his mother.

Damages awarded by the jury in the amount of \$500,000 for future treatment and services and lost wages due to the sexual abuse are reasonable under the circumstances and are fully supported by the weight of the evidence. C.M.H. requires intensive and long-term psychotherapy, psychiatric evaluation and treatment and possible psychotropic mediations to assist him in dealing with his PTSD.

It should be noted that since receiving the settlement from Father Flanagan's in 2013, C.M.H. has only sought psychiatric treatment one time.

Accordingly, I recommend that SB 58 be reported FAVORABLY, with the amount to be paid amended to \$2.5 million. The jury awarded \$9.5 million (\$4.75 million assessed to DCF) for past and future pain and suffering. Based on a lack of objective evidence in the record, a 50 percent reduction of DCF's obligation or \$2.375 million may be a more appropriate amount to be paid for the non-economic damages. A corresponding reduction of 50 percent of DCF's

share of the economic damages (\$125,000) would be appropriate.

I further recommend that the funds be paid into a trust established for C.M.H. in equal installments over 10 years to pay for expenses related to education, psycho-therapies and living expenses. Any funds remaining in the trust after 10 years should be distributed in full to C.M.H.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

cc: Secretary of the Senate

CS by Judiciary:

The committee substitute, in conformity with a recent opinion of the Florida Supreme Court, does not include limits on the amount of lobbying fees that may be paid from the proceeds of the bill.

By the Committee on Judiciary; and Senator Braynon

590-02429-17

201734c1

A bill to be entitled

An act for the relief of C.M.H.; providing an appropriation to compensate C.M.H. for injuries and damages sustained as a result of the negligence of the Department of Children and Families, formerly known as the Department of Children and Family Services; requiring certain funds to be placed into an irrevocable trust; providing a limitation on attorney fees; providing an effective date.

WHEREAS, beginning at a very young age, J.W. was subjected to incidents of physical and sexual abuse, which caused him to become sexually aggressive, and

WHEREAS, on September 5, 2002, J.W., then in the custody of the Department of Children and Families (DCF), formerly known as the Department of Children and Family Services, was placed into the home of C.M.H., whose parents volunteered to have J.W. live in their home, and

WHEREAS, prior to the placement of J.W. with the family, DCF obtained a comprehensive behavioral health assessment that stated that J.W. was sexually aggressive and that recommended specific precautions and training for potential foster parents, which C.M.H.'s parents did not receive, and

WHEREAS, the testimony of the DCF caseworker confirmed that DCF was aware that then-10-year-old J.W. and then-8-year-old C.M.H. were sharing a bedroom, and

WHEREAS, on October 31, 2002, J.W. sexually assaulted a 4-year-old child who was visiting C.M.H.'s home, and

WHEREAS, although DCF knew that J.W. was sexually

Page 1 of 4

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

590-02429-17

201734c1

aggressive, the agency did not remove him from the home, and

WHEREAS, after November 2002, J.W.'s behavioral problems escalated, and he deliberately squeezed C.M.H.'s pet mouse to death in front of C.M.H. and made physical threats toward C.M.H., and

WHEREAS, C.M.H.'s parents began to discuss adopting J.W., whom they considered a part of their family, and

WHEREAS, in January 2004, the family began taking therapeutic parenting classes to better meet J.W.'s needs, and

WHEREAS, in March 2004, after C.M.H.'s mother was diagnosed with Stage 4, terminal, metastatic colon cancer, which had spread to her liver, C.M.H.'s father requested that DCF stop the process of having the family designated as "long-term nonrelative caregivers," and

WHEREAS, in April 2004, DCF closed out J.W.'s dependency file, leaving J.W. in the custody of the family, and

WHEREAS, in April 2005, C.M.H.'s father wrote DCF and the juvenile judge assigned to the case to request help in placing J.W. in a residential treatment facility, and

WHEREAS, on July 28, 2005, after a physical altercation between J.W. and C.M.H., C.M.H. disclosed to his parents that J.W. had sexually assaulted him, and J.W. was immediately removed from the home, and

WHEREAS, C.M.H. sustained severe and permanent psychiatric injuries, including posttraumatic stress disorder, as a result of the sexual and emotional abuse perpetrated by J.W., and

WHEREAS, the sexual assault of C.M.H. by J.W. was predictable and preventable, and

WHEREAS, on April 14, 2006, a lawsuit, Case No. 2006 CA

Page 2 of 4

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

590-02429-17

201734c1

003727, was filed in the 15th Judicial Circuit in and for Palm Beach County on behalf of C.M.H., by and through his parents, alleging negligence on the part of DCF and its providers which allowed the perpetration of sexual abuse against and the victimization of C.M.H. by J.W., and

WHEREAS, a mutually agreeable settlement could not be reached, and a jury trial was held in Palm Beach County, and

WHEREAS, on January 2, 2014, after a jury trial and verdict, the court entered a judgment against DCF for \$5,176,543.08, including costs, and

WHEREAS, the Division of Risk Management of the Department of Financial Services paid the family of C.M.H. \$100,000, the statutory limit at that time under s. 768.28, Florida Statutes, and

WHEREAS, C.M.H., now a young adult, is at a vulnerable stage in his life and urgently needs to recover the balance of the judgment awarded him so that his psychiatric injuries may be addressed and he may lead a normal life, and

WHEREAS, the balance of the judgment is to be paid into an irrevocable trust through the passage of this claim bill in the amount of \$5,076,543.08, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. There is appropriated from the General Revenue Fund to the Department of Children and Families the sum of \$5,076,543.08 for the relief of C.M.H. for the personal injuries

590-02429-17

201734c1

and damages he sustained. After payment of attorney fees and costs, lobbying fees, and other similar expenses relating to this claim, the remaining funds shall be placed into an irrevocable trust created for C.M.H. for his exclusive use and benefit.

Section 3. The Chief Financial Officer is directed to draw a warrant in favor of C.M.H. in the sum of \$5,076,543.08 upon funds of the Department of Children and Families in the State Treasury, and the Chief Financial Officer is directed to pay the same out of such funds in the State Treasury not otherwise appropriated.

Section 4. The amount paid by the Department of Children and Families pursuant to s. 768.28, Florida Statutes, and the amount awarded under this act are intended to provide the sole compensation for all present and future claims arising out of the factual situation described in the preamble to this act which resulted in the personal injuries and damages to C.M.H. The total amount of attorney fees relating to this claim may not exceed 25 percent of the amount awarded under this act.

Section 5. This act shall take effect upon becoming a law.



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

302 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
1/9/17	SM	Favorable
2/22/17	JU	Fav/CS
4/17/17	AHS	Pre-meeting
	AP	

January 9, 2017

The Honorable Joe Negrón
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 38** – Judiciary Committee and Senator Lizabeth Benacquisto
HB 6511 – Representative Mike Miller
Relief of L.T. by the State of Florida

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED EQUITABLE CLAIM FOR \$800,000 FROM GENERAL REVENUE BASED ON A SETTLEMENT AGREEMENT BETWEEN THE LEGAL GUARDIAN OF L.T. AND THE DEPARTMENT OF CHILDREN AND FAMILIES FOR THE SEXUAL ABUSE SUFFERED BY L.T. WHEN SHE WAS LEFT BY THE DEPARTMENT IN THE FOSTER CARE OF A REGISTERED SEX OFFENDER

CURRENT STATUS:

On December 14, 2010, an administrative law judge from the Division of Administrative Hearings, serving as a Senate special master, held a de novo hearing on a previous version of this bill, SB 18 (2012). After the hearing, the judge issued a report containing findings of fact and conclusions of law and recommended that the bill be reported favorably with an amendment to correct an erroneous claim amount. (The 2012 bill failed to account for the \$200,000 that DCF had already paid; therefore, the proper claim amount was \$800,000 rather than \$1,000,000.) The 2012 Special Master's Final Report is attached as an addendum to this report. The amount claimed in SB 38 (2017) on the date of this report is \$800,000.

Due to the passage of time since the hearing, the Senate President reassigned the claim to me, Mary K. Kraemer. My responsibilities were to review the records relating to the claim bill, be available for questions from the members, and determine whether any changes have occurred since the hearing, which if known at the hearing, might have significantly altered the findings or recommendation in the previous report.

The provisions of SB 38 (2017) address and update the circumstances (with additional detail) upon which the claim for relief is based. It should be noted that the prior claim bill, SB 18 (2012), evaluated by the then-Senate special master, sought relief of the claimant as a minor. The record reflects that the claimant is now over the age of eighteen.

SB 38 requires that after “payment of attorney fees and costs, lobbying fees, and other similar expenses relating to this claim; outstanding medical liens other than Medicaid liens and other immediate needs,” the remaining funds are to be placed in a trust for the exclusive use and benefit of the claimant. (see Section 2). SB 38 requires that all Medicaid liens from the treatment and care of claimant due to the injuries and damages to her shall be waived or paid by the State (see Section 4).

Administration of the trust will be handled by an institutional trustee selected by the claimant, until the trust is terminated upon the claimant's 25th birthday when the remaining principal and interest will revert to the claimant. In case of the claimant's death prior to termination of the trust, any remaining trust funds will revert to her heirs, beneficiaries, or estate.

The position of the Department of Children and Families (DCF) on the settlement of the case by payment as described in the bill is unchanged. Counsel for DCF stated in a letter dated November 30, 2016 that “DCF needs to continue to have claim bills funded from General Revenue. DCF is operating at minimal trust fund reserves that are essential to meeting cash flow and Department program needs. Any appropriation from a trust fund could have an effect on DCF operations and its ability to meet future related obligations.”

In update letters dated December 12, 2016 and December 13, 2016, claimant's counsel states that DCF "specifically agreed to support a claim bill for \$800,000 as the unpaid balance of the mediated settlement amount of \$1,000,000 pursuant to a Mediation Settlement Agreement) between DCF and claimant's then-guardian dated June 21, 2010. The Agreement defines DCF's support "to include all those actions . . . set forth in the Archille v. DCF case. Claimant's counsel cites to the Act for the Relief of [Archille] enacted in 2010-235, *Laws of Florida*. Claimant's counsel provided a copy of the Settlement Agreement in that matter from 2007, which states support of a claims bill "shall include personal support by the Secretary [of DCF], including reasonable and good faith efforts to personally appear and testify before the legislature at hearings", although not "requiring the Secretary's personal appearance or attendance at any particular meeting, hearing or session."

The position of Claimant's counsel's position is the Legislature should be assisted by DCF to fund the Mediation Settlement Agreement that resolve the lawsuit filed on L.T.'s behalf.

Claimant's counsel also provided a summary of claimant's report of her current status, which indicates:

1. Claimant's name is now "L.A." She is married and lives with her husband and two daughters in Jacksonville, where her husband, Petty Officer D.A. is an active duty hospital Corpsman, stationed at the naval base there;
2. Claimant is working toward her bachelor's degree in general psychology at Florida State College at Jacksonville. She plans to pursue a master's degree next fall and a doctoral program thereafter. Claimant's career goal is to become a pediatric mental health specialist, for the treatment of children who have suffered trauma; and
3. Claimant continues to undergo therapy and takes daily medication to address the continuing effects of her trauma.

CONCLUSIONS OF LAW:

See the Conclusions of Law on page 3 of the attached Special Master's Final Report dated December 1, 2011, which were made in the de novo proceeding on a previous version of the bill.

ATTORNEYS FEES:

SB 38 requires that the total amount paid for attorney fees, lobbying fees, costs, and other similar expenses related to the claim may not exceed 25 percent of the award (i.e., not exceeding \$200,000 of the proposed \$800,000 payment to the trust created for the benefit of the claimant).

RECOMMENDATIONS:

That SB 38 be reported FAVORABLY, based on the conclusions in the attached Special Master's Final Report dated December 1, 2011 (page 3) as reached by the administrative law judge from the Division of Administrative Hearings, that:

DCF has a duty to exercise reasonable care when it places foster children and to protect them from known dangers, and DCF knew or should have known of the serious risk of harm to L.T. These breaches of duty were the proximate cause of the injuries that L.T. suffered.

Respectfully submitted,

Mary K. Kraemer
Senate Special Master

cc: Secretary of the Senate

CS by Judiciary:

The committee substitute, in conformity with a recent opinion of the Florida Supreme Court, does not include the limits on costs, lobbying fees, and other similar expenses, which were included in the original bill.



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

402 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

	COMM	ACTION
12/1/11	SM	Fav/1 amendment

December 1, 2011

The Honorable Mike Haridopolos
President, The Florida Senate Suite
409, The Capitol Tallahassee, Florida
32399-110

Re: **SB 18 (2012)** Senator Jeremy Ring
Relief of L.T., a Minor

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED EQUITABLE CLAIM FOR \$800,000 FROM GENERAL REVENUE BASED ON A SETTLEMENT AGREEMENT BETWEEN THE LEGAL GUARDIAN OF L.T. AND THE DEPARTMENT OF CHILDREN AND FAMILIES FOR THE SEXUAL ABUSE SUFFERED BY L.T. WHEN SHE WAS LEFT BY THE DEPARTMENT IN THE FOSTER CARE OF A REGISTERED SEX OFFENDER.

FINDINGS OF FACT:

In August 1995, when LT. was less than two years old, the Department of Children and Families (DCF) removed LT. and her brother from their mother and placed them in the foster care of their great uncle, Eddie Thomas, and his wife, who lived in Gadsden County. Less than a year after the placement, Thomas was charged with sexually molesting a 13-year-old girl. He plead no contest to lewd, lascivious, or indecent assault upon a child and was sentenced to five years' probation and required to receive sex abuse counseling. He was also registered as a sex offender.

Despite the fact that DCF was aware of Thomas' conviction and his registration as a sex offender, it decided

that the risk of harm to L.T. was low and did not remove L.T. from Thomas' care and custody. DCF also terminated protective supervision of L.T., meaning that a social worker no longer visited the Thomas home from time to time to see how L.T. was doing. Protective supervision is often terminated by DCF when a child is placed with a relative and DCF is satisfied that supervision is unnecessary.

In 2004, when L.T. was 10 years old, DCF placed an adolescent girl in the foster care of the Thomases. A few months after the placement, this minor girl ran away from the house in the middle of the night, claiming that Thomas had attempted to sexually molest her. DCF removed this girl from the Thomas home, but DCF did not re-evaluate the placement of L.T. with Thomas.

In March 2005, when L.T. was 11 years old (and Thomas was 44), she ran away from home and told authorities that she had been repeatedly sexually abused by Thomas. She also said that Thomas and his wife used drugs. DCF then removed L.T. from the Thomas home.

It was later revealed by L.T. that she was roughly disciplined by the Thomases and that they were verbally abusive to her, frequently calling her derogatory names and telling her that she was worthless.

L.T. is now 17 years old and in a good foster home. However, as a result of the sexual abuse she endured while living with Thomas, L.T. suffers from post traumatic stress disorder, depression, and low self esteem. She has occasionally attempted suicide and for 10 months was a resident of Tampa Bay Academy, a mental health facility. She is receiving psychological counseling and will likely need counseling for many years. A trial consultant projected her future lost earnings as \$540,000. Her projected future medical expenses are \$760,000 to \$11,580,000, depending on the degree of psychological therapy and supervision she might need, the higher figure reflecting the costs of institutionalization. A conservative estimate of her total future economic losses is around \$2 million.

LITIGATION HISTORY:

In 2009, a lawsuit against DCF was filed in the Second Judicial Circuit by L.T.'s aunt and legal guardian. The case was successfully mediated and the parties entered into a

settlement agreement pursuant to which L.T. would receive \$1,000,000. The sovereign immunity limit of \$200,000 was paid and the balance of \$800,000 is sought through this claim bill. The court order approving the settlement agreement requires that the net proceeds to L.T. be placed in a special needs trust. After deducting legal fees and costs from the \$200,000, and accounting for a Medicaid lien, \$11,084 remained to be placed in a special needs trust for L.T.

CONCLUSIONS OF LAW:

The claim bill hearing was a *de novo* proceeding for the purpose of determining, based on the evidence presented to the Special Master, whether DCF is liable in negligence for the injuries suffered by L.T., and, if so, whether the amount of the claim is reasonable.

DCF has a duty to exercise reasonable care when it places foster children and to protect them from known dangers. DCF breached that duty when it learned that Thomas had been convicted of a sexual offense on a child, but did not remove L.T. from the Thomas home. DCF acted negligently again when it did not remove L.T. following the charge of sexual abuse against Thomas made by another foster child in 2004. DCF knew or should have known that Thomas posed a serious risk of harm to L.T. These breaches of duty were the proximate cause of the injuries that L.T. suffered.

The amount of the claim is fair and reasonable.

ATTORNEY'S FEES:

In compliance with s. 768.28(8), Florida Statutes, L.T.'s attorneys have agreed to limit their fees to 25 percent of any amount awarded by the Legislature.

OTHER ISSUES:

The bill erroneously states that the claim is for \$1 million, failing to account for the \$200,000 that DCF has already paid. The bill should be amended to state that the claim is for \$800,000.

SPECIAL MASTER'S FINAL REPORT – SB 18 (2012)

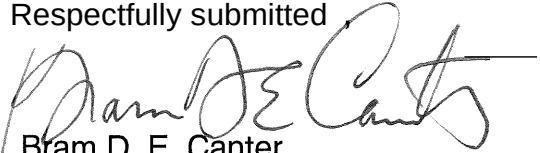
December 1, 2011

Page 4

RECOMMENDATIONS:

For the reasons set forth above, I recommend that Senate Bill 18 (2012) be reported FAVORABLY, as amended.

Respectfully submitted



Bram D. E. Canter
Senate Special Master

cc: Senator Ring
Debbie Brown, Secretary of the Senate
Counsel of Record

By the Committee on Judiciary; and Senator Benacquisto

590-01953-17

201738c1

A bill to be entitled

An act for the relief of L.T.; providing an appropriation to compensate L.T. for injuries and damages sustained as a result of the negligence of employees of the Department of Children and Families, formerly known as the Department of Children and Family Services; providing legislative intent regarding certain Medicaid liens; providing a limitation on the payment of attorney fees; providing an effective date.

WHEREAS, on August 15, 1995, the Department of Children and Families removed 14-month-old L.T. and her infant brother from their mother's custody because they were not receiving adequate care, and

WHEREAS, the Department of Children and Families temporarily placed the children into the home of the children's great aunt and uncle, Vicki and Eddie Thomas, and

WHEREAS, a background check that was conducted shortly after L.T. and her brother were placed in the Thomases' home indicated that Mr. Thomas had once been convicted of a misdemeanor and possession of narcotics equipment, and

WHEREAS, the background check also revealed that Ms. Thomas had been charged with, but apparently not convicted of, larceny, and

WHEREAS, the background check did not reveal any prior history of violence, sex offenses, or child abuse, and

WHEREAS, after conducting a home study, interviews, and an investigation, the Department of Children and Families concluded

Page 1 of 6

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

590-01953-17

201738c1

that the Thomases were capable of providing a safe home for L.T. and her brother and approved the placement, and

WHEREAS, on August 21, 1996, approximately 1 year after L.T. and her brother had been placed in the Thomases' home, Mr. Thomas was charged with committing a lewd and lascivious act on a child under the age of 16, and

WHEREAS, the alleged victim was the 13-year-old daughter of a woman with whom Mr. Thomas was having an extramarital affair, and the state later amended the charge to add a count for sexual battery on a child by a familial or custodial authority, and

WHEREAS, after two hung jury trials in January and March of 1997, Mr. Thomas pled no contest in April 1997 to committing a lewd, lascivious, and indecent act on a child under the age of 16, and

WHEREAS, Mr. Thomas was sentenced to 5 years' probation and required to attend sex offender classes and register as a sex offender, and

WHEREAS, on May 9, 1997, 1 month after Mr. Thomas entered his plea and was convicted of a child sex crime, the Department of Children and Families recommended, and the judge approved, an order allowing Mr. Thomas to return home and have unsupervised contact with the children, and

WHEREAS, although the policies of the Department of Children and Families barred Mr. Thomas from being able to adopt a child because of his conviction for a sex act with a child and his sex offender status, the policies did not prohibit the continued placement of L.T. and her brother in the Thomases' home, and so the children remained with the Thomases, and

WHEREAS, the Department of Children and Families

Page 2 of 6

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

590-01953-17

201738c1

subsequently recommended to the court the permanent, long-term placement of L.T. and her brother in the Thomases' home and further recommended that the children be removed from protective services, with no further supervision by the department, and

WHEREAS, on March 3, 2000, following the recommendation of the Department of Children and Families, the court approved L.T. and her brother's long-term placement with the Thomases and removed the children from continued protective services, and

WHEREAS, on March 24, 2003, an abuse hotline call to the Department of Children and Families reported that L.T. was being abused by Mr. Thomas and that both Mr. and Ms. Thomas were using drugs in the children's presence, and

WHEREAS, the next day, a child protective investigator for the Department of Children and Families interviewed L.T. and her brother while in the presence of Ms. Thomas, and neither child was asked to be interviewed outside Ms. Thomas's presence, and

WHEREAS, L.T. and her brother denied the abuse allegations while Ms. Thomas watched and listened to them, and

WHEREAS, results from new background checks and drug screens were negative, and the Department of Children and Families concluded that L.T. and her brother were not at risk of abuse and closed the case, and

WHEREAS, on February 24, 2005, L.T. ran away from the Thomases' home and was found by law enforcement officers, and

WHEREAS, L.T. ran away from home because she had been repeatedly sexually and physically abused by Mr. Thomas and physically, verbally, and emotionally abused for years by Ms. Thomas, and

WHEREAS, L.T. and her brother were finally removed from the

590-01953-17

201738c1

Thomases' home in 2005, and

WHEREAS, during her adolescent and teenaged years, L.T. was the subject of repeated Baker Act proceedings and suicide attempts and was in and out of inpatient and outpatient psychiatric facilities, and

WHEREAS, L.T. has been seen and treated by physicians and mental health care professionals who have diagnosed her with depression, posttraumatic stress disorder, anxiety disorder, and other disorders attributed to her trauma, and

WHEREAS, although L.T. struggles with the symptoms of depression, posttraumatic stress disorder, and anxiety disorder, she is now 22 years of age, is married to a Naval Petty Officer who is stationed at Naval Air Station Jacksonville, is the mother of 2 very young daughters, and attends Florida State College at Jacksonville as she works toward her goal of becoming a mental health care professional specializing in treating children who have been abused, neglected, or traumatized, and

WHEREAS, a lawsuit was brought on L.T.'s behalf in state and federal courts alleging negligence pursuant to s. 768.28, Florida Statutes, and civil rights violations pursuant to 42 U.S.C. s. 1983, and

WHEREAS, the civil rights claims were disposed of by the trial court, but the negligence claims continued to be litigated, and a jury trial of the case was set in Leon County, and

WHEREAS, the parties attended a court-ordered mediation and on June 21, 2010, agreed to a mediated settlement under which L.T. will receive \$1 million, of which \$200,000 has been paid, and the claim for the remaining \$800,000 is being submitted

590-01953-17 201738c1

117 through this bill, which the Department of Children and Families
118 agrees to support, NOW, THEREFORE,

119
120 Be It Enacted by the Legislature of the State of Florida:

121
122 Section 1. The facts stated in the preamble to this act are
123 found and declared to be true.

124 Section 2. There is appropriated from the General Revenue
125 Fund to the Department of Children and Families the sum of
126 \$800,000 for the relief of L.T. for the injuries and damages she
127 sustained. After payment of attorney fees and costs, lobbying
128 fees, and other similar expenses relating to this claim;
129 outstanding medical liens other than Medicaid liens; and other
130 immediate needs, the remaining funds shall be placed into a
131 trust created for the exclusive use and benefit of L.T. The
132 trust shall be administered by an institutional trustee of
133 L.T.'s choosing and shall terminate upon L.T.'s 25th birthday,
134 at which time the remaining principal and interest shall revert
135 to L.T. or, if she predeceases the termination of the trust, to
136 her heirs, beneficiaries, or estate.

137 Section 3. The Chief Financial Officer is directed to draw
138 a warrant in favor of L.T. in the sum of \$800,000 upon funds in
139 the State Treasury to the credit of the Department of Children
140 and Families, and the Chief Financial Officer is directed to pay
141 the same out of such funds in the State Treasury not otherwise
142 appropriated.

143 Section 4. It is the intent of the Legislature that any and
144 all Medicaid liens arising from the treatment and care of the
145 injuries and damages to L.T. described in this act shall be

590-01953-17 201738c1

146 waived or paid by the state.

147 Section 5. The amount awarded pursuant to the waiver of
148 sovereign immunity under s. 768.28, Florida Statutes, and the
149 amount awarded under this act are intended to provide the sole
150 compensation for all present and future claims arising out of
151 the factual situation described in the preamble to this act
152 which resulted in the injuries and damages to L.T. The total
153 amount paid for attorney fees relating to this claim may not
154 exceed 25 percent of the amount awarded under this act.

155 Section 6. This act shall take effect upon becoming a law.



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

302 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
2/2/17	SM	Favorable
2/22/17	JU	Fav/CS
4/17/17	AHS	Pre-meeting
	AP	

February 2, 2017

The Honorable Joe Negrón
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 50** – Judiciary Committee and Senator Audrey Gibson
Relief of Eddie Weekley and Charlotte Williams

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNOPPOSED CLAIM BILL BY EDDIE WEEKLEY AND CHARLOTTE WILLIAMS OF THE ESTATE OF FRANKLIN WEEKLEY, FOR \$1 MILLION, BASED ON A FINAL JUDGMENT SUPPORTED BY A SETTLEMENT AGREEMENT BETWEEN MR. WEEKLEY AND MS. WILLIAMS AND THE AGENCY FOR PERSONS WITH DISABILITIES AS COMPENSATION FOR THE DEATH OF FRANKLIN WEEKLEY AT THE SUNLAND CENTER IN MARIANNA IN 2002.

CURRENT STATUS:

A claim bill for these Claimants was first filed in the 2008 Session.

An administrative law judge from the Division of Administrative Hearings, serving as a Senate Special Master, held a de novo hearing on the 2008 version of this bill, SB 30 (2008). After the hearing, the judge issued a report containing findings of fact and conclusions of law and recommended that the bill be reported FAVORABLY.

Due to the passage of time since the hearing, the Senate President reassigned the claim to me, Barbara M. Crosier. My responsibilities were to review the records relating to the claim bill, be available for questions from Senators, and determine

whether any changes have occurred since the hearing before Judge T. Kent Wetherell, which if known at the hearing, might have significantly altered the findings or recommendations in the report.

According to counsel for the parties, there have been no substantial changes in the facts and circumstances for the underlying claim. Accordingly, I find no cause to alter the findings and recommendations of the original report.

For the reasons set forth above, the undersigned recommends that Senate Bill 50 (2017) be reported favorably.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

cc: Secretary of the Senate

CS by Judiciary:

The committee substitute, in conformity with a recent opinion of the Florida Supreme Court, does not include the limits on costs, lobbying fees, and other similar expenses, which were included in the original bill.



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

402 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
02/05/08	SM	Fav/1 amendment

February 5, 2008

The Honorable Ken Pruitt
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 30 (2008)** – Senator Al Lawson
HB 451 (2008) – Representative Matthew Meadows
Relief of Eddie Weekly and Charlotte Williams

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNOPPOSED EQUITABLE CLAIM FOR \$1 MILLION AGAINST THE AGENCY FOR PERSONS WITH DISABILITIES ARISING OUT OF THE DEATH OF FRANKLIN WEEKLY AT THE SUNLAND CENTER IN MARIANNA IN 2002.

FINDINGS OF FACT:

Franklin Weekly was committed to the care of the Department of Children and Family Services (DCF) in 1999 after he was determined to be incompetent to stand trial for the alleged arson of his home. Franklin was 15 years old at the time, but he had the mental capacity of a first grader and Franklin was mildly retarded with an IQ between 52 and 65.

Franklin was initially placed in group homes in Orlando and Ft. Walton Beach. However, those facilities proved to be inadequate for Franklin because of his behavioral problems and because he ran away on several occasions.

In November 2001, Franklin was transferred by court order to the Sunland Center (Sunland) in Marianna. DCF recommended to the court that Franklin be placed at Sunland because it was a more secure facility and could provide the constant supervision that Franklin required. DCF and Sunland

staffs were aware that Franklin did not have “survival skills” and that he would be at risk of serious injury or death if he ran away from the facility.

DCF was, at the time, responsible for operating Sunland. When the Agency for Persons with Disabilities (APD) was created in 2004, it became responsible for operating Sunland.

At Sunland, Franklin lived in the Hayes House with 22 other developmentally disabled individuals. The house had three exits, only two of which had locked doors. The door right across from Franklin’s room did not lock.

On December 5, 2002, Franklin was involved in several altercations with other residents and staff members that required him to be physically restrained. He also attempted to run away that day.

Two staff members, Gertrude Sims and James Duncan, were on duty at the Hayes House the night of December 5. Their shift started at 10:15 p.m. and went to 6:15 a.m. the following day.

The primary job duties of Ms. Sims and Mr. Duncan were custodial in nature, e.g., doing laundry, mopping floors, etc. They were also responsible for making sure that all of the residents were accounted for throughout the night, and to that end, Ms. Sims was responsible for making “rounds” on the residents every 30 minutes to be sure they were asleep in their beds.

Ms. Sims testified in her deposition that she made her rounds every 30 minutes from 10:30 p.m. to 5:30 a.m. and that she observed Franklin sleeping in his bed each time she checked his room. She and Mr. Duncan also testified that at least one of them was stationed at all times at a desk near the unlocked door across from Franklin’s room.

Notwithstanding this testimony, the more persuasive evidence establishes that the door was not being watched for at least a short period after Ms. Sims made her 5:30 a.m. rounds because Ms. Sims and Mr. Duncan were tending to a resident who had soiled himself. Mr. Duncan testified in his deposition that the soiled resident was in Room D, which was Franklin’s room and that he recalled seeing Franklin sleeping, but

Ms. Sims testified that the soiled resident was in Room B. Ms. Sims' testimony is more credible because she had been working at the Hayes House for a number of years, whereas Mr. Duncan was "pulled" to the Hayes House just for that night because of a staffing issue.

While Ms. Sims and Mr. Duncan were tending to the resident in Room B and the unlocked doors were unsupervised, Franklin left the Hayes House through those doors. Mr. Duncan discovered that Franklin was missing after he finished helping Ms. Sims with the soiled resident and he made his way into Franklin's room to mop the connected bathroom.

Ms. Sims and Mr. Duncan notified Sunland's main office that Franklin was missing, and a search for Franklin on the Sunland campus was immediately commenced. Local law enforcement was also notified. They assisted in the search.

Franklin's parents were notified of his disappearance at approximately 8:30 a.m., and they immediately came to the Sunland to help in the search. It not entirely clear whether or to what extent they were allowed to help in the search, but Franklin's father testified that at some point the family was told that they could no longer assist in the search on the Sunland property.

One of the buildings on the Sunland campus searched in the days following Franklin's disappearance was a dilapidated building known as the "boiler building." The building was several hundred yards from the Hayes House and was being used for storage. The doors on the building were chained and padlocked, but there was enough space for a person to fit between the doors and get into the building.

Butch Edwards, the maintenance and construction supervisor at Sunland, testified that he went into the building during the search for Franklin but that he saw no sign of him. He testified that he could not get all the way to the back of the building because it was full of junk.

Sunland suspended the search for Franklin after approximately 2 weeks. His family continued to search for him, and from time to time there were unconfirmed sightings of Franklin reported around Northwest Florida. At some point,

Franklin's parents were accused of harboring Franklin by Sunland staff and/or local law enforcement of harboring Franklin. In January 2003, Franklin was found in contempt of the Order committing him to Sunland due to his apparent elopement from the facility.

In October 2004, contractors hired to demolish the dilapidated boiler building found what turned out to be Franklin's remains in a basement of the building. The only clothing found with the remains was decomposed underwear and an undershirt with Franklin's name written on them.

There is no credible evidence that Franklin ever left the Sunland campus after he ran away from the Hayes House. The weather on the day of his disappearance was very cold, and it is more likely than not that Franklin died of exposure to the elements in the building where he was ultimately found.

In January 2005, the Bay County Medical Examiner determined that the remains were those of Franklin. A death certificate was issued and the remains were released to Franklin's parents for burial. However, it was not until 2007 that DCF and APD formally acknowledged that the remains were those of Franklin. DNA tests performed by the Florida Department of Law Enforcement (FDLE) confirmed that the remains are Franklin's.

FDLE commenced an investigation into Franklin's disappearance in 2007. The FDLE investigation was still open as of the date of the Special Master hearing, but the claimants' attorney represented that it was his understanding that the FDLE investigation would soon be closed based upon a lack of evidence of a crime having been committed in relation to Franklin's disappearance and death.

Franklin was survived by his parents, Eddie Weekly and Charlotte Wheeler, and a younger brother. Franklin's parents are not married, but they have been together for 23 years.

Franklin's parents are developmentally disabled and are unable to work. His father receives assisted living services from the local Association for Retarded Citizens. To be eligible for such services, a person has to have an IQ below 70.

By all accounts, Franklin and his parents had a very close relationship. Franklin wanted to go home to his parents and Franklin's parents wanted him to come home. Franklin's parents were "devastated" by Franklin's disappearance and death.

Special needs trusts have been established for Franklin's parents because of their developmental disabilities. The trusts are subject to federal law (e.g., 42 U.S.C. § 1396p), which requires that any assets remaining in the trust upon the beneficiary's death first be used to repay state Medicaid benefits.

APD provided an affidavit stating that it does not have funds available to pay this claim. The affidavit represents that APD might lose federal funding and that its ability to provide necessary services to disabled individuals would be "seriously impaired" if APD was required to pay this claim from its budget without an additional appropriation of General Revenue.

In July 2004, in response to Franklin's disappearance, DCF adopted a detailed protocol to be followed when a Sunland resident goes missing. The protocol requires, among other things, that the perimeter of the facility be immediately secured and that "an intense immediate area search, expanding outward of the last contact site" be conducted.

LEGAL PROCEEDINGS:

In 2004, before Franklin's remains were found, Franklin's parents filed a lawsuit against DCF that sought to require DCF to resume searching for Franklin. After Franklin's remains were discovered, the suit was amended to allege a wrongful death claim. The suit also included a civil rights claim under 42 U.S.C. § 1983 against Ms. Sims and Mr. Duncan.

The case was settled through mediation in June 2007, after DCF and APD acknowledged that the remains found at Sunland were Franklin's. The settlement agreement required APD to pay Franklin's parents a total of \$1.3 million.

The settlement was approved by the circuit court in August 2007. The Order approving the settlement requires the proceeds to be paid into "a Medicaid-compliant special needs trust account."

APD has paid Franklin's parents \$300,000, with \$200,000 attributed to the tort claims and \$100,000 attributed to the civil rights claim. APD agreed as part of the settlement to support a claim bill for the remaining \$1 million.

Franklin's parents received \$184,464.38 from the initial \$300,000 payment. Those funds were split equally, with each parent receiving \$92,231.19.

The remainder of the initial payment went to attorney's fees and costs. The claimants' attorney agreed to take only \$37,500 in fees from the initial payment, which is half of the 25% attorney's fee for the initial payment. The remainder of the fee was "deferred" until the claim bill is paid.

CLAIMANT'S POSITION:

- DCF, the predecessor agency to APD, had a duty to safeguard Franklin's well-being while he was at Sunland, and DCF's failure to adequately supervise Franklin on the night he disappeared was the direct and proximate cause of his death.
- The \$1.3 million in damages agreed to by the parties are reasonable under the circumstances.

AGENCY'S POSITION:

- APD admits liability and supports the claim bill.
- APD does not have the funds available to pay the claim without an additional appropriation of General Revenue.

CONCLUSIONS OF LAW:

APD is the successor agency to DCF with respect to the operation of Sunland. Therefore, APD is the agency responsible for paying this claim even though the incident giving rise to the claim occurred while DCF operated Sunland. See Ch. 2004-267, § 87(3), Laws of Fla.

DCF had a duty to safeguard Franklin's well-being while he was confined at Sunland. That duty was breached when Sunland staff left the unlocked doors across from Franklin's room at the Hayes House unsupervised. Franklin's elopement and death were foreseeable consequences of the staff's failure to adequately supervise him because Sunland staff knew that he was an elopement risk and that he lacked the skills to survive if he did elope. The failure of the Sunland staff to supervise Franklin was a direct and proximate cause of his death.

There is no evidence that Franklin had any earning capacity as a result of his mental retardation. The \$1.3 million in damages agreed to by the parties are attributable to the non-economic damages (e.g., mental anguish) suffered by Franklin's parents as a result of his disappearance and death.

There is no way to place a value on the mental anguish suffered by a parent who loses a child, and a jury may have awarded far more than \$1.3 million in damages to Franklin's parents if this case had gone to trial. The amount agreed to by the parties in the mediated settlement is within the range of reasonableness for such an award. Indeed, in the recent Martin Anderson case, the Legislature approved a claim bill for \$5 million for the parents of a child who died while in the custody of the State.

LEGISLATIVE HISTORY:

This is the first year that this claim has been presented to the Legislature.

ATTORNEY'S FEES AND
LOBBYIST'S FEES:

The Order approving the parties' settlement states that the circuit court will determine the amount of attorney's fees to be paid from the proceeds of the claim bill. However, that is an issue for the Legislature, not the circuit court. See Gamble v. Wells, 450 So.2d 850 (Fla. 1984).

The claimants' attorney provided an affidavit stating that attorney's fees are limited to 25%, as required by Section 768.28(8), F.S. There are no outstanding costs.

In order to maximize the proceeds that were paid to Franklin's parents, the claimants' attorney took only \$37,500 in attorney's fees out of the initial payment, rather than the \$75,000 (i.e., 25% of the \$300,000 payment) that he could have taken. The other \$37,500 of attorney's fees related to the initial payment was "deferred" until payment of the claim bill.

The lobbyist's fees are not included as part of the 25 percent attorney's fee. The lobbyist's fees are an additional 5 percent, which is \$50,000 of the \$1 million claim.

The Legislature is free to limit the fees and costs paid in connection with a claim bill as it sees fit. Gamble v. Wells, supra. The bill does so by stating that "[t]he total amount paid for attorney's fees, lobbying fees, costs and other similar

expenses relating to this claim may not exceed 25 percent of the amount awarded [by the bill].”

If this language remains in the bill, Franklin’s parents will receive a total of \$750,000. The remaining \$250,000 will go to attorney’s fees and lobbyist’s fees.

If this language were not in the bill, Franklin’s parents would receive \$662,500. The claimants’ attorney would receive \$287,500 (i.e., \$37,500 in fees “deferred” from the initial payment plus \$250,000 in fees related to the claim bill) and the lobbyist would receive \$50,000.

OTHER ISSUES:

The bill should be amended to clarify that the payment to Franklin’s parents will go to their special needs trust, as required by the court order approving the settlement agreement.

RECOMMENDATIONS:

For the reasons set forth above, I recommend that Senate Bill 30 be reported FAVORABLY, as amended.

Respectfully submitted,

T. Kent Wetherell
Senate Special Master

cc: Senator Al Lawson
Representative Matthew Meadows
Faye Blanton, Secretary of the Senate
House Committee on Constitution and Civil Law
Counsel of Record

By the Committee on Judiciary; and Senators Gibson and Bracy

590-01951-17

201750c1

A bill to be entitled

An act for the relief of Eddie Weekley and Charlotte Williams, individually and as co-personal representatives of the Estate of Franklin Weekley, their deceased son, for the disappearance and death of their son while he was in the care of the Marianna Sunland Center, currently operated by the Agency for Persons with Disabilities; providing an appropriation to compensate them for the disappearance and death of Franklin Weekley, which were due to the negligence of the Department of Children and Families; providing a limitation on the payment of attorney fees; providing an effective date.

WHEREAS, in November of 2001, Franklin Weekley was diagnosed with mental retardation and a seizure disorder and was admitted to the Marianna Sunland Center, which at the time was operated by the Department of Children and Family Services, now known as Department of Children and Families, and

WHEREAS, on December 6, 2002, Franklin Weekley disappeared from the center and, following a search of the premises by employees of the center, was deemed by the center to have run away, and the case was closed, and

WHEREAS, on October 28, 2004, a demolition crew found the skeletal remains of Franklin Weekley in the basement of a building adjacent to the premises of the Marianna Sunland Center where Franklin had resided, and

WHEREAS, legal action was filed on behalf of Franklin Weekly's parents against the Department of Children and Family

Page 1 of 3

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

590-01951-17

201750c1

Services and its employees or agents raising negligence, tort, statutory, and civil rights claims concerning the disappearance and death of their son, and

WHEREAS, the parties and the Agency for Persons with Disabilities, which currently operates the Marianna Sunland Center, mediated and reached a settlement of all claims, and

WHEREAS, the plaintiffs and the Agency for Persons with Disabilities entered into a compromise and settlement agreement in which they agreed to a claim bill under which the agency will pay \$1 million in addition to the \$300,000 it previously paid to settle claims arising out of this matter, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. The sum of \$1 million is appropriated from the General Revenue Fund to the Agency for Persons with Disabilities, as successor to the Department of Children and Family Services, to be paid for the relief of Eddie Weekley and Charlotte Williams, individually and as co-personal representatives of the Estate of Franklin Weekley, deceased.

Section 3. The Chief Financial Officer is directed to draw a warrant in favor of Eddie Weekley and Charlotte Williams, individually and as co-personal representatives of the Estate of Franklin Weekley, deceased, in the sum of \$1 million upon funds of the Agency for Persons with Disabilities in the State Treasury, and to pay the same out of such funds in the State Treasury. Pursuant to the settlement agreement approved by the

Page 2 of 3

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

590-01951-17

201750c1

59 court in August 2007, the funds are to be paid into a Medicaid-
60 compliant special needs trust account established on behalf of
61 Eddie Weekley and Charlotte Williams.

62 Section 4. The amount paid by the Agency for Persons with
63 Disabilities pursuant to s. 768.28, Florida Statutes, and the
64 amount awarded under this act are intended to provide the sole
65 compensation for all present and future claims arising out of
66 the factual situation described in this act resulting in the
67 disappearance and death of Franklin Weekley. The total amount
68 paid for attorney fees relating to this claim may not exceed 25
69 percent of the amount awarded under this act.

70 Section 5. This act shall take effect upon becoming a law.

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 406

INTRODUCER: Health Policy Committee and Senator Bradley and others

SUBJECT: Compassionate Use of Low-THC Cannabis and Marijuana

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	Fav/CS
2.	Fournier/Loe	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 406 amends s. 381.986, F.S., to implement the provisions of article X, section 29 of the State Constitution, Medical Marijuana Production, Possession, and Use. The bill makes numerous changes to the section including:

- Adding legislative intent.
- Amending definitions to incorporate terms used in article X, section 29 of the State Constitution, and to add definitions for “chronic nonmalignant pain” and “close relative.”
- Allowing allopathic¹ and osteopathic² physicians to certify the medical use of marijuana for patients with debilitating medical conditions and other specified patients, including certain patients from other states who meet Florida requirements.
- Establishing requirements that a physician must meet before certifying a patient and after certification.
- Reducing the required course a physician must take prior to certifying patients to a 4-hour course that must be taken only once.³
- Removing the three-month patient treatment prerequisite.
- Amending current criminal penalties to conform with other changes in the bill and establishing new criminal violations for patients and caregivers cultivating or purchasing

¹ Licensed under ch. 458, F.S.

² Licensed under ch. 459, F.S.

³ Section 381.986(4)(a), F.S., requires that physicians take an 8-hour course annually.

marijuana from a source other than a medical marijuana treatment center (MMTC) or who violate other provisions of the act.

- Prohibiting unlicensed activity and providing for criminal and financial penalties.
- Establishing requirements for caregivers including limiting a patient to one caregiver and a caregiver to one patient with certain exceptions, and requiring that caregivers pass a Level 2 background screening with certain exceptions for a caregiver who is a close relative.
- Requiring the Department of Health (DOH) to begin issuing identification cards to patients and caregivers by October 3, 2017.
- Requiring the DOH to establish requirements for the licensure and certification of independent testing laboratories (ITL), a marijuana quality control program, and a seed-to-sale tracking program for marijuana.
- Grandfathering in existing dispensing organizations as MMTCs,⁴ adding five MMTCs by October 3, 2017, and increasing the overall number of MMTCs that may be registered when certain numbers of patients are registered on the compassionate use registry.
- Requiring MMTCs to maintain compliance with the representations made in their applications for registration and allowing the DOH to grant variances in certain circumstances.
- Authorizing emergency rulemaking for implementation and timeframes for initiating nonemergency rulemaking.

The bill also creates s. 1004.4351, F.S., to establish the “Medical Marijuana Research and Education Act” and the Coalition for Medical Marijuana Research and Education within the H. Lee Moffitt Cancer Center and Research Institute, Inc.

The bill also makes other conforming and technical changes to ss. 381.986, 381.987, 385.211, 499.0295, and 1004.411, F.S.

The fiscal impact of the bill is indeterminate. On April 7, 2017, the Revenue Estimating Conference estimated the bill has an indeterminate positive fiscal impact on state revenues.⁵ The increased costs incurred by the DOH and the Florida Department of Law Enforcement (FDLE) should be offset by fees and fines authorized in the bill.

The bill is effective upon becoming a law.

II. Present Situation:

Treatment of Marijuana in Florida

Florida law defines cannabis as “all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin,”⁶ and places it, along with other sources of tetrahydrocannabinol (THC), on the list of Schedule I

⁴ Including dispensing organizations that are currently in litigation but would qualify under ch. 2016-1236, L.O.F.

⁵ Office of Economic and Demographic Research, *Revenue Estimating Impact Conference results for CS/SB 406*, (April 7, 2017) available at <http://edr.state.fl.us/Content/conferences/revenueimpact/archives/2017/pdf/Impact0407.pdf>, pages 527-531 (last visited April 16, 2017).

⁶ Section 893.02(3), F.S.

controlled substances.⁷ The definition excludes “low-THC cannabis” as defined in s. 381.986, F.S., if manufactured, possessed, sold, purchased, delivered, distributed, or dispensed in conformance with that section.

Schedule I controlled substances are substances that have a high potential for abuse and no currently accepted medical use in the United States.⁸ As a Schedule I controlled substance, possession and trafficking of cannabis carry criminal penalties that vary from a first-degree misdemeanor⁹ up to a first-degree felony with a mandatory minimum sentence of 15 years in state prison and a \$200,000 fine.¹⁰ Paraphernalia¹¹ that is sold, manufactured, used, or possessed with the intent to be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance, is also prohibited and carries criminal penalties ranging from a first degree misdemeanor to a third degree felony.¹²

Medical Marijuana in Florida: the Compassionate Medical Cannabis Act of 2014

Patient Treatment with Low-THC Cannabis

The Compassionate Medical Cannabis Act of 2014¹³ (act) legalized a low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)¹⁴ for medical use¹⁵ by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms. The act provides that a Florida licensed allopathic or osteopathic physician who has completed the required training¹⁶ and has examined and is treating such a patient may order low-THC cannabis for that patient to treat such disease, disorder, or condition or to alleviate its symptoms, if no other satisfactory alternative treatment options exist for that patient. In order for a physician to order low-THC cannabis for a patient, all of the following conditions must apply:

- The patient is a permanent resident of Florida;

⁷ Section 893.03(1)(c)7. and 37., F.S.

⁸ Section 893.03(1), F.S.

⁹ This penalty is applicable to possession or delivery of less than 20 grams of cannabis. See s. 893.13(3) and (6)(b), F.S.

¹⁰ Trafficking in more than 25 pounds, or 300 plants, of cannabis is a first-degree felony with a mandatory minimum sentence that varies from three to 15 years in state prison depending on the quantity of the cannabis possessed, sold, etc. See s. 893.135(1)(a), F.S.

¹¹ Section 893.145, F.S.

¹² Section 893.147, F.S.

¹³ Chapter 2014-157, Laws of Fla., codified in s. 381.986, F.S.

¹⁴ Section 381.986(b), F.S., defines “low-THC cannabis,” as the dried flowers of the plant *Cannabis* which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight, or the seeds, resin, or any compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin.

¹⁵ Section 381.986(1)(c), F.S., defines “medical use” as administration of the ordered amount of low-THC cannabis; and the term does not include the possession, use, or administration by smoking, or the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient’s legal representative. Section 381.986(1)(e), F.S., defines “smoking” as burning or igniting a substance and inhaling the smoke; smoking does not include the use of a vaporizer.

¹⁶ Section 381.986(4), F.S., requires such physicians to successfully complete an 8-hour course and examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses the clinical indications for the appropriate use of low-THC cannabis, appropriate delivery mechanisms, contraindications for such use, and the state and federal laws governing its ordering, dispensing, and processing.

- The physician has treated the patient for at least 3 months immediately preceding the patient's registration and has determined that the risks of ordering low-THC cannabis are reasonable in light of the potential benefit for that patient;¹⁷
- The physician registers as the orderer of low-THC cannabis for the patient on the compassionate use registry (registry) maintained by the DOH and updates the registry to reflect the contents of the order;
- The physician maintains a patient treatment plan that includes the dose, route of administration, planned duration, and monitoring of the patient's symptoms and other indicators of tolerance or reaction to the low-THC cannabis;
- The physician submits the patient treatment plan quarterly to the University of Florida, College of Pharmacy (UFCP) for research on the safety and efficacy of low-THC cannabis on patients; and
- The physician obtains the voluntary informed consent of the patient or the patient's legal guardian to treatment with low-THC cannabis after sufficiently explaining the current state of knowledge in the medical community about the effectiveness of treatment of the patient's condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects.¹⁸

The act creates exceptions to existing law to allow qualified patients¹⁹ and their legal representatives to purchase, acquire, and possess low-THC cannabis – up to the amount ordered – for that patient's medical use; and to allow dispensing organizations (DO) and their owners, managers, and employees to acquire, possess, cultivate, and dispose of excess product in reasonable quantities to produce low-THC cannabis and to possess, process, and dispense low-THC cannabis. The DOs and their owners, managers, and employees are not subject to licensure and regulation under ch. 465, F.S., relating to pharmacies.²⁰

Patient Treatment with Medical Cannabis

Chapter 2016-123, Laws of Florida, amended the act to expand the regulatory structure relating to dispensing low-THC cannabis and authorized approved dispensing organizations to cultivate and dispense medical cannabis to eligible patients as defined under the Right to Try Act (RTTA).²¹ In conjunction with s. 381.986, F.S., the RTTA allows physicians to treat eligible patients with terminal conditions with medical cannabis by including medical cannabis²² within the definition of an investigational drug, biological product, or device. Physicians must order the use of medical cannabis for those patients pursuant to the provisions of s. 381.986, F.S.

¹⁷ If a patient is younger than 18 years of age, a second physician must concur with this determination, and such determination must be documented in the patient's medical record.

¹⁸ Section 381.986(2), F.S.

¹⁹ Section 381.986(1)(d), F.S., defines a "qualified patient" as a Florida resident who has been added by a physician licensed under ch. 458 or 459, F.S., to the compassionate use registry to receive low-THC cannabis from a DO.

²⁰ Section 381.986(7), F.S.

²¹ Section 499.0295, F.S.

²² "Medical cannabis" means all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, sale, derivative, mixture, or preparation of the plant or its seeds or resin that is dispensed only from a DO for medical use by an eligible patient as defined in the Right to Try Act.

Dispensing Organizations under the Act

Section 381.986, F.S., requires that the DOH approve five DOs, one in each of five regions throughout the state. In order to be approved as a DO, an applicant must possess a certificate of registration issued by the Department of Agriculture and Consumer Services (DACS) for the cultivation of more than 400,000 plants, be operated by a nurseryman, and have been operating as a registered nursery in this state for at least 30 continuous years. DOs must be vertically integrated, meaning the DO performs all stages in the production, processing, marketing, and retailing of low-THC and medical cannabis. Applicants are required to demonstrate:

- The technical and technological ability to cultivate and produce low-THC cannabis;
- The ability to secure the premises, resources, and personnel necessary to operate as a DO;
- The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances;
- An infrastructure reasonably located to dispense low-THC cannabis to registered patients statewide or regionally as determined by the DOH;
- The financial ability to maintain operations for the duration of the two year approval cycle, including the provision of certified financials to the DOH;
- That all owners and managers have been fingerprinted and have successfully passed a Level 2 background screening pursuant to s. 435.04, F.S.; and
- The employment of a medical director, who must be a physician²³ and successfully completed a course and examination that encompasses appropriate safety procedures and knowledge of low-THC cannabis.²⁴

An approved DO must post a \$5 million performance bond within 10 business days of approval. The DOH is authorized to charge an initial application fee and a licensure renewal fee, but is not authorized to charge an initial licensure fee.²⁵ An approved DO must maintain all approval criteria at all times.²⁶

Beginning on July 7, 2014, the DOH held several rule workshops²⁷ to write and adopt rules implementing the provisions of s. 381.986, F.S., and the DOH put forward a proposed rule on September 9, 2014.²⁸ This proposed rule was challenged by multiple organizations involved in the rulemaking workshops and was found to be an invalid exercise of delegated legislative authority by an administrative law judge on November 14, 2014.²⁹ Afterward, the DOH held a negotiated rulemaking workshop in February of 2015, which resulted in a new proposed rule being published on February 6, 2015.³⁰ The new proposed rule was also challenged on, among other things, the DOH's statement of estimated regulatory costs and the DOH's conclusion that

²³ Licensed under ch. 458 or 459, F.S.

²⁴ *Id.*

²⁵ *Id.*

²⁶ Section 381.986(6), F.S.

²⁷ Audio recordings of the rule development workshops are available on the DOH website at: <http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/resources/rulemaking/index.html> (last visited Mar. 20, 2017).

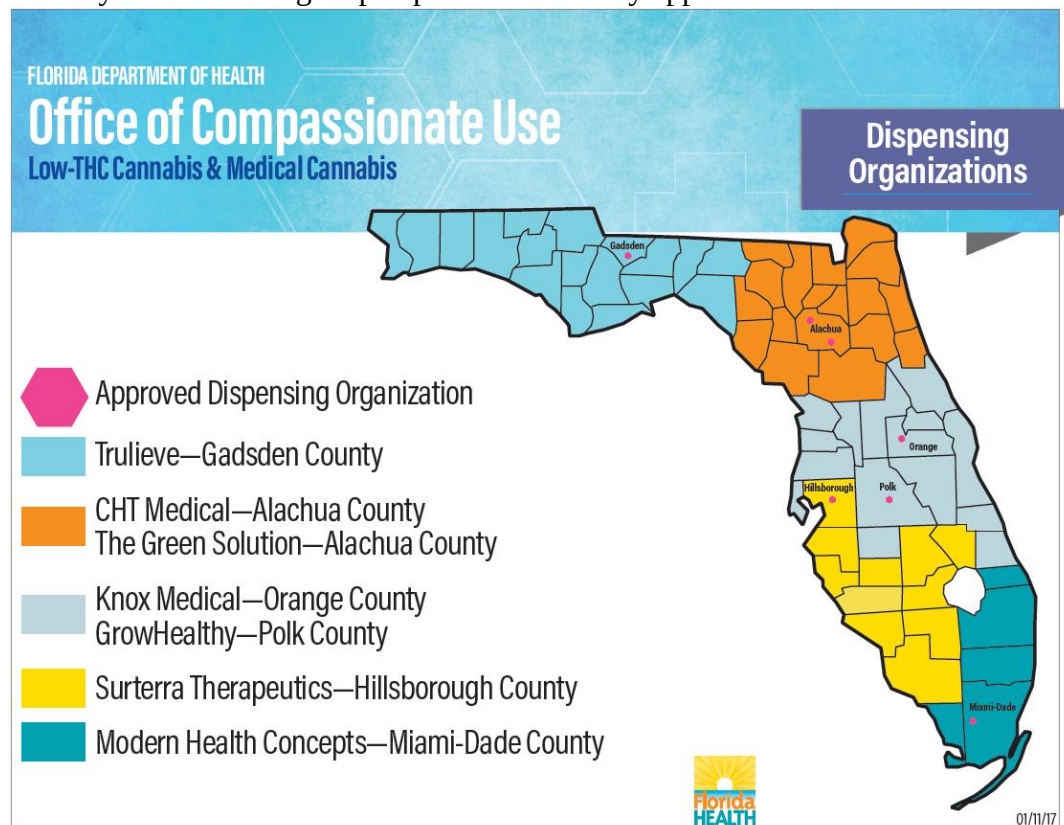
²⁸ Proposed Rule ch. 64-4, F.A.C., ID 14941024, (Aug. 14, 2014) and changed, ID 15040352, (Sept. 9, 2014).

²⁹ Tornello Landscape Corp. v. DOH, Case No. 14-4547RP; Fl. Medical Cannabis Assoc. v. DOH, Case No. 14-4517RP; Plants of Ruskin, Inc. v. DOH, Case No. 14-4299RP; Costa Farms, LLC v. DOH, Case No. 14-4296RP (Fla. DOAH 2014). A copy of each Final Order is available on the Division of Administrative Hearings website.

³⁰ Proposed Rule ch. 64-4, F.A.C., ID 15645147, (Feb. 2, 2015).

the rule will not require legislative ratification. Hearings were held on April 23 and 24, 2015, and a final order was issued on May 27, 2015, which found the rule to be valid.³¹ The rule took effect June 17, 2015, and the DOH held an application period for DO approval which ended on July 8, 2015. Twenty-eight applications were submitted.³²

On November 23, 2015, the DOH approved a DO in each of the following five regions as required by the act: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida.³³ Numerous petitions were filed challenging the DOH's selection process. In order to allow the approved DOs to begin dispensing products, the 2016 Legislature required the DOH to approve as a DO applicants that received the highest aggregate score through the DOH's evaluation process, notwithstanding any prior determination by the DOH that the applicant failed to meet the requirements of s. 381.986, F.S. The Legislature also provided that if the Division of Administrative Hearings, the DOH, or a court of competent jurisdiction makes a final determination that an applicant was entitled to be a DO, that both this DO and currently approved DOs may operate in the same region.³⁴ Currently, in addition to the five DOs originally approved, the DOH has since approved The Green Solution in Alachua County and Grow Health in Polk County. The following map depicts the currently approved DOs.



³¹ Baywood Nurseries Co., Inc. v. DOH, Case No. 15-1694RP (Fla. DOAH 2015).

³² Information about the applications and the approved DOs is available on the DOH, Office of Compassionate Use, website, available at: <http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/dispensing-organizations/dispensing-application-process/index.html> (last visited Mar. 20, 2017).

³³ Section 381.986(5)(b), F.S. A map of the dispensing regions and approved dispensing organizations is available on the DOH website at: <http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/documents/ocu-dispensing-map.pdf> (last visited Mar. 20, 2017).

³⁴ Chapter 2016-123, Laws of Fla.

In addition to the currently approved DOs, s. 381.986(5)(c), F.S., requires the DOH to approve three additional DOs upon the registration of 250,000 active qualified patients in the compassionate use registry. At least one of the newly approved DOs must be an applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In Re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011), and a member of the Black Farmers and Agriculturalists Association. These additional applicants are not required to meet the requirement to possess a certificate of registration issued by the DACS for the cultivation of more than 400,000 plants, be operated by a nurseryman, and have been operating as a registered nursery in Florida for at least 30 continuous years.

The Compassionate Use Registry

The act requires the DOH to create a secure, electronic, and online registry for the registration of physicians and patients and for the verification of patient orders by DOs, which is accessible to law enforcement.³⁵ The registry must allow DOs to record the dispensing of low-THC cannabis, and must prevent an active registration of a patient by multiple physicians. Physicians must register qualified patients with the registry and DOs are required to verify that the patient has an active registration in the registry, that the order presented matches the order contents as recorded in the registry, and that the order has not already been filled before dispensing any low-THC cannabis. The DOs are also required to record in the registry the date, time, quantity, and form of low-THC cannabis dispensed.³⁶ The Compassionate Use Registry became operational on July 11, 2016.³⁷ As of the end of February 2017, there were 4,079 patients registered with the Compassionate Use Registry.³⁸

The Office of Compassionate Use and Research on Low-THC Cannabis

The DOH was required to establish the Office of Compassionate Use under the direction of the deputy state health officer to administer the act.^{39, 40}

The act includes several provisions related to research on low-THC cannabis and cannabidiol including:

- Requiring physicians to submit quarterly patient treatment plans to the UFCP for research on the safety and efficacy of low-THC cannabis,⁴¹

³⁵ Section 381.986(5)(a), F.S.

³⁶ Section 381.986(6), F.S.

³⁷ Office of Compassionate Use, *Implementation Timeline* (October 2016) available at <http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/documents/ocu-timeline.pdf>, (last visited Mar. 21, 2017).

³⁸ Revenue Estimating Conference, *Use of Marijuana for Debilitating Medical Conditions* (March 2, 2017), p. 3, (on file with the Senate Committee on Health Policy).

³⁹ Section 385.212, F.S.

⁴⁰ The Office of Compassionate Use is authorized to enhance access to investigational new drugs for Florida patients through approved clinical treatment plans or studies by: creating a network of state universities and medical centers recognized for demonstrating excellence in patient-centered coordinated care for persons undergoing cancer treatment and therapy in this state; making any necessary application to the U.S. Food and Drug Administration (FDA) or a pharmaceutical manufacturer to facilitate enhanced access to compassionate use for Florida patients; and entering into agreements necessary to facilitate enhanced access to compassionate use for Florida patients. See ss. 381.925 and 385.212, F.S.

⁴¹ Section 381.986(2)(e), F.S.

- Authorizing state universities to perform research on cannabidiol and low-THC cannabis and exempting them from the provisions in ch. 893, F.S., for the purposes of such research;⁴² and
- Appropriating \$1 million to the James and Esther King Biomedical Research Program for research on cannabidiol and its effects on intractable childhood epilepsy.⁴³

Medical Marijuana in Florida: Amendment 2 (2016)

On November 4, 2016, Amendment 2 was voted into law and established article X, section 29 of the State Constitution. This section of the constitution became effective on January 3, 2017, and creates several exemptions from criminal and civil liability for:

- Qualifying patients medically using marijuana in compliance with the amendment;
- Physicians, solely for issuing physician certifications with reasonable care and in compliance with the amendment; and
- Medical Marijuana Treatment Centers (MMTCs), their agents, and employees for actions or conduct under the amendment and in compliance with DOH rules.

The constitution defines multiple terms including:

- “Qualifying patient” to mean a person who:
 - Has been diagnosed with a “debilitating medical condition;”
 - Has a “physician certification;” and
 - Has a valid qualifying patient identification card issued by the DOH.
 - In the case of a minor patient, must also have the consent of a parent or legal guardian prior to both obtaining a physician certification and obtaining an identification card from the DOH.⁴⁴
- “Debilitating Medical Condition” to mean:
 - Cancer;
 - Epilepsy;
 - Glaucoma;
 - HIV/AIDS;
 - Post-Traumatic Stress Disorder (PTSD);
 - Amyotrophic lateral sclerosis (ALS);
 - Crohn’s Disease;
 - Parkinson’s Disease;
 - Multiple Sclerosis; or
 - Another debilitating medical condition of the same kind or class as, or comparable to, the enumerated conditions.
 - Additionally, a physician must believe that the medical use of marijuana would likely outweigh the potential health risks for the patient.
- “Marijuana” to have the meaning given to cannabis in section 893.02(3), F.S. (2014), and, in addition, “low-THC cannabis” as defined in section 381.986(1)(b), F.S. (2014), shall also be included in the meaning of the term “marijuana.”

⁴² Section 385.211, F.S.

⁴³ Chapter 2014-157, Laws of Fla. The DOH and the University of Florida executed a contract (ID 5EP01) on June 5, 2015, and \$483,334 of the \$1 million grant award has been spent. Florida Accountability Contract Tracking System (FACTS). Available at: <https://facts.fldfs.com/Search/ContractDetail.aspx?AgencyId=640000&ContractId=5EP01>. (last visited April 16, 2017).

⁴⁴ This provision is included in the definition of “physician certification.”

- “Medical Marijuana Treatment Center” or “MMTC” to mean an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their caregivers and is registered by the DOH.
- “Medical use” to mean the acquisition, possession, use, delivery, transfer, or administration of an amount of marijuana not in conflict with DOH rules, or of related supplies by a qualifying patient or caregiver for use by the caregiver’s designated qualifying patient for the treatment of a debilitating medical condition.
- “Physician Certification” to mean a written document signed by a person who is “licensed to practice medicine” in Florida stating:
 - The physician has conducted a medical examination of the patient and a full assessment of the patient’s medical history;
 - That, in the physician’s professional opinion, the patient has a debilitating medical condition;
 - That, in the physician’s professional opinion, the medical use of marijuana will outweigh the health risks for the patient; and
 - For how long the physician recommends the medical use of marijuana for the patient.

Once certified, a patient may designate one or more caregivers to assist him or her with the medical use of marijuana. The amendment defines a “caregiver” as a person who is at least 21 years of age who has agreed to assist with a qualifying patient’s medical use of marijuana and has qualified for and obtained a caregiver identification card issued by the DOH. Caregivers:

- Are prohibited from consuming medical marijuana;
- Must obtain an ID card from the DOH;
- Are subject to standards and qualifications established by the DOH including:
 - Background checks;
 - Procedures for issuing ID cards; and
 - Limitations on the number of caregivers per patient and the number of patients per caregiver.

The DOH is required to register MMTCs that will be authorized to acquire, cultivate, possess, process, transfer, transport, sell, distribute, dispense, or administer medical marijuana, related supplies, or educational materials to patients and caregivers. The DOH is required to adopt rules regarding MMTCs including:

- Procedures to register as an MMTC;
- Procedures for the issuance, renewal, suspension, and revocation of MMTC registrations; and
- Standards to ensure proper security, record keeping, testing, labeling, inspection, and safety.

The amendment requires the DOH to adopt rules no later than July 3, 2017, six months after its effective date. The stated purpose of the rules is to ensure the availability and safe use of medical marijuana by qualifying patients. Currently, the DOH has begun the rulemaking process to implement article X, section 29 of the State Constitution and has held several workshops around Florida.⁴⁵ The DOH is required to adopt rules for:

⁴⁵ Rule 64-4.012, F.A.C., rule notice published on Jan. 17, 2017, *available at* <https://www.flrules.org/gateway/ruleNo.asp?id=64-4.012>, (last visited on Mar. 20, 2017).

- Issuing patient and caregiver ID cards;⁴⁶
- Procedures for establishing caregiver qualifications;
- Procedures for registering MMTCs; and
- A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply, based on the best available medical evidence. This presumption can be overcome on an individual patient basis.

If the DOH does not adopt rules by the deadline, the amendment creates a cause of action for any Florida citizen to seek judicial relief to compel the DOH's compliance.

Additionally, the DOH is required to begin registering MMTCs and issuing patient and caregiver ID cards by October 3, 2017, nine months after the amendment's effective date. If the DOH does not comply with this requirement, the amendment states that a physician certification is sufficient for a person to become a qualifying patient without being issued an ID card from the DOH.

The amendment also creates a number of specific restrictions on its exemption from liability, and its grants of authority, including specifically:

- Not repealing or allowing violations of other laws related to the non-medical use of marijuana;
- Not permitting the operation of any vehicle under the influence of marijuana;
- Not requiring the accommodation of the use of marijuana in specific areas or in any public place;
- Not requiring any health insurance provider to cover the medical use of marijuana; and
- Not affecting laws related to negligence or malpractice on the part of any patient, caregiver, physician, or MMTC agent or employee.

The State Constitution authorizes the Legislature to enact laws consistent with the constitution's language, and provides for severability so that if any clause, sentence, paragraph or section of the amendment, or an application thereof, is found to be invalid by a court of competent jurisdiction, other provisions shall continue to be in effect to the fullest extent possible.

The Revenue Estimating Conference has estimated that under Amendment 2 and the proposed DOH rules, sales tax revenue from medical marijuana sales will be \$2.6 million in Fiscal Year 2017-2018 and will increase to \$24.3 million in Fiscal Year 2021-2022.

Medical Marijuana in Florida: The Necessity Defense

Despite the fact that the use, possession, and sale of marijuana are prohibited by state law, Florida courts have found that circumstances can necessitate medical use of marijuana and circumvent the application of criminal penalties. The necessity defense was successfully applied in a marijuana possession case in *Jenks v. State* where the First District Court of Appeal found

⁴⁶ On Feb. 18, 2017, the DOH adopted Rule 64-4.011, F.A.C., addressing the issuance of Compassionate Use Registry Identification Cards. This rule may bring the DOH into compliance with the requirement to adopt rules for issuing ID cards by July 3, 2017; however, the rule may need requiring amending to comply with constitutional terms and to comply with changes to s. 381.986, F.S., provided in this bill.

that s. 893.03, F.S., does not preclude the defense of medical necessity for the use of marijuana if the defendant:

- Did not intentionally bring about the circumstance which precipitated the unlawful act;
- Could not accomplish the same objective using a less offensive alternative available; and
- The evil sought to be avoided was more heinous than the unlawful act.⁴⁷

In the cited case, the defendants, a married couple, were suffering from uncontrollable nausea due to AIDS treatment and had testimony from their physician that he could find no effective alternative treatment. Under these facts, the court found that the defendants met the criteria to qualify for the necessity defense and ordered an acquittal of the charges of cultivating cannabis and possession of drug paraphernalia.

Medical Marijuana Laws in Other States

Currently, 28 states, the District of Columbia, and Guam have some form of law that permits the use of marijuana for medicinal purposes.⁴⁸ These laws vary widely in detail but most share certain features. For example, most state laws require an identification card and registry for patients and caregivers to use medical marijuana; require the patient to receive certification from up to two physicians that the patient has a qualifying condition before the patient may use medical marijuana; allow a patient to designate a caregiver who can possess the medical marijuana and assist the patient in using the medical marijuana; and provide general restrictions on how medical marijuana can be obtained (self-cultivated or from a dispensary) and where it can be used.⁴⁹

Of the 17 states with low-THC cannabis laws similar to s. 381.986, F.S., most specify that the use of such low-THC cannabis is reserved for patients with epileptic or seizure disorders. Florida allows the treatment of cancer and Georgia allows the treatment of end stage cancer and other specified conditions. Additionally, the definition of low-THC cannabis differs from state to state. The THC level allowed ranges from a high of below five percent to less than 0.3 percent; most states restrict the level of THC to below one percent. CBD levels are generally required to be high, with most states requiring at least 10 percent.⁵⁰

⁴⁷ *Jenks v. State*, 582 So.2d 676, 679 (Fla. 1st DCA 1991), *review denied*, 589 So.2d 292 (Fla. 1991).

⁴⁸ These states include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington. California was the first to establish a medical marijuana program in 1996 and New York was the most recent state to pass medical marijuana legislation in June 2014. Seventeen states allow limited access to marijuana products (low-THC and/or high CBD-cannabidiol). Alabama, Florida, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. National Conference of State Legislatures, *State Medical Marijuana Laws*, (Mar. 16, 2017), available at <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> (last visited Mar. 20, 2017).

⁴⁹ Analysis by Senate Health Policy committee staff of *supra* note 49.

⁵⁰ *Supra* note 49.

Interaction with the Federal Government

The federal Controlled Substances Act lists marijuana as a Schedule 1 drug and provides no exceptions for medical uses.⁵¹ Possession, manufacture, and distribution of marijuana is a crime under federal law.⁵² Although a state's medical marijuana laws protect patients from prosecution for the legitimate use of marijuana under state law, state medical marijuana laws, or Constitutional provisions, do not protect individuals from prosecution under federal law.

In 2013, the U.S. Department of Justice (USDOJ) issued statements indicating that the federal government would not pursue cases for low-level drug crimes, leaving such prosecutions largely up to state authorities. The U.S. Attorney General issued a statement that the USDOJ was changing policy such that individuals “who have committed low-level, nonviolent drug offenses, who have no ties to large-scale organizations, gangs, or cartels, will no longer be charged with offenses that impose draconian mandatory minimum sentences... [and] would instead receive sentences better suited to their individual conduct...”⁵³ Further, the USDOJ issued a memorandum clarifying that the department considers small-scale marijuana use to be a state matter which states may choose to punish, and certain operations adhering to state laws legalizing marijuana in conjunction with robust state regulatory systems would be far less likely to come under federal scrutiny.⁵⁴ In addition, a rider in recent appropriations acts and continuing resolutions has prohibited the USDOJ from using appropriated funds to prevent specified states (including Florida) from implementing the states' own medical marijuana laws.⁵⁵ It is worth noting that, with the election of President Trump and changes to the leadership of the USDOJ, the guidance issued by the USDOJ may be amended in the future; however, it would require an act of Congress to amend the rider preventing the USDOJ from using funds to prevent specified states from implementing medical marijuana laws.

III. Effect of Proposed Changes:

In addition to technical and conforming changes made by the bill to ss. 381.986, 381.987, 385.211, 499.0295, and 1004.441, the bill substantially amends s. 381.986, F.S.

⁵¹ 21 U.S.C. s. 812. Note: On August 11, 2016, the Federal Drug Enforcement Administration refused two petitions to reschedule marijuana under the Controlled Substances Act, see <https://www.dea.gov/divisions/hq/2016/hq081116.shtml>, (last visited on Mar. 20, 2017).

⁵² The punishments vary depending on the amount of marijuana and the intent with which the marijuana is possessed. See 21 U.S.C ss. 841-865.

⁵³ USDOJ, *Smart on Crime: Reforming the Criminal Justice System for the 21st Century*, (Aug. 2013), p. 3, available at <http://www.justice.gov/ag/smart-on-crime.pdf> (last visited on Mar. 20, 2017).

⁵⁴ USDOJ Memorandum for all U.S. Attorneys from James M. Cole, Deputy Attorney General, *Guidance Regarding Marijuana Enforcement* (August 29, 2013), available at <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf> (last visited Mar. 20, 2017).

⁵⁵ See Pub. Law No. 114-113, s. 542 (Consolidated Appropriations Act, 2016). A recent court order by the U.S. District Court for the Northern District of California recently held that a similar provision in the previous appropriations act (s. 538, Pub. L. No. 113-235) does not prohibit the USDOJ from enforcing violations of *federal* marijuana laws by individuals or businesses who are complying with state medical marijuana laws. *U.S. v. Marin Alliance for Medical Marijuana and Shaw*, Order re: Motion to Dissolve Permanent Injunction, No. C 98-00086 CB, (Oct. 19, 2015), available at <http://www.scribd.com/doc/286089509/US-vs-Marin-Alliance-for-Medical-Marijuana#scribd> (last visited Mar. 20, 2017).

Legislative Intent

The bill:

- Adds the legislative intent:
 - To implement s. 29, Art. X of the State Constitution by creating a unified regulatory structure for the acquisition, cultivation, possession, processing, transfer, transportation, sale, distribution, and dispensing of marijuana, marijuana products, related supplies, and educational materials;
 - That all rules adopted by the DOH to implement the section be adopted pursuant to ch. 120, F.S., and that the DOH may use emergency rulemaking procedures to adopt rules if necessary to meet any rulemaking deadlines established in s. 29, Art. X of the State Constitution; and
 - That all registrations for MMTC activities be issued solely in accordance with the requirements of this section and rules adopted under the section.

Definitions

The bill:

- Conforms the definitions for “caregiver,” “debilitating medical condition,” “marijuana,” “medical marijuana treatment center” or “MMTC,” to the definitions in article X section 29 of the State Constitution.
- Uses the constitutional definition for “medical use” but amends the definition to restrict:
 - Smoking;
 - The possession, use, or administration of marijuana not purchased from an MMTC;
 - The transfer of marijuana to anyone other than a qualifying patient or his or her caregiver;
 - The use or administration of any type or amount of marijuana not specified on a qualifying patient’s physician certification; and
 - The use or administration of marijuana:
 - On any form of public transportation;
 - In any public place;
 - In a qualifying patient’s place of employment if restricted by his or her employer;
 - In a state correctional institution;
 - On the grounds of a preschool, primary school, or secondary school; or
 - On a school bus or in a vehicle, aircraft, or motorboat.
- Uses the constitutional definition for “qualifying patient,” but also includes “eligible patients” as defined in the Right to Try Act, patients suffering from a physical medical condition that produces symptoms of seizures or severe and persistent muscle spasms, and patients suffering from chronic nonmalignant pain.
- Adds definitions for:
 - “Chronic nonmalignant pain” to mean pain that is caused by a debilitating medical condition or that originates from a debilitating medical condition and persists beyond the usual course of that debilitating medical condition; and
 - “Close relative” to mean a spouse, parent, sibling, grandparent, child, or grandchild, whether related by whole or half-blood, by marriage, or by adoption.

Physician Certifications

The bill allows physicians to issue physician certifications to:

- A patient suffering from a debilitating medical condition;
- A patient suffering from a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms;⁵⁶
 -
- A patient suffering from chronic nonmalignant pain, if the physician has diagnosed an underlying debilitating medical condition as the cause of the pain, which allows the patient to receive marijuana for the patient's medical use to alleviate the patient's pain;
- An eligible patient as defined in the Right to Try Act; or
- A patient who is not a Florida resident and who qualifies under one of the above listed conditions and who can lawfully receive marijuana in the state in which he or she resides.

Before certifying a patient the physician must:

- Be licensed under ch. 458 or 459, F.S.;
- Have successfully completed the required 4-hour course and exam administered by the Florida Medical Association or the Florida Osteopathic Medical Association;⁵⁷
- Have conducted a full assessment of the patient's medical history;
- Have determined that, in the physician's professional opinion, the patient meets one of the criteria specified above;
- Have determined that the medical use of marijuana would likely outweigh the potential health risks to the patient; and
- Have obtained the voluntary written informed consent of the patient or, if the patient is a minor, the patient's parent or legal guardian, after having sufficiently explained the current state of knowledge in the medical community of the effectiveness of treatment of the patient's condition with marijuana and the potential risks and side effects.⁵⁸

For patients under the age of 18, a second physician must concur with the treating physician's determination that the medical use of marijuana would likely outweigh the health risks for the patient. Additionally, patients under the age of 18 are restricted from purchasing marijuana and are required to have a parent, legal guardian, caregiver, or health care provider assist them in purchasing and administering marijuana.

The physician must also register as the treating physician with the compassionate use registry and maintain a patient treatment plan that must be submitted to the University of Florida College of Pharmacy on a quarterly basis. The bill increases the amount of marijuana a physician may certify a patient to receive from a 45-day supply to a 90-day supply and allows a physician to certify a patient for longer than the 90-day period if the physician believes that the patient will use the additional marijuana in a medically appropriate way. Patients must be recertified at least annually. A physician may not issue physician certifications if he or she is a medical director employed by an MMTC.

⁵⁶ Such patient may receive only low-THC cannabis if the patient does not meet any of the other qualifications.

⁵⁷ Current law requires an 8-hour course and exam which must be retaken annually.

⁵⁸ If the patient is an eligible patient, the physician must obtain written informed consent pursuant to s. 499.0295, F.S.

The bill also grandfathers in all orders for low-THC cannabis issued prior to the effective date of the act as physician certifications, and requires the DOH to consider patients with such orders as qualifying patients until the DOH begins issuing compassionate use registry identification cards.

Prohibited Acts

The bill:

- Conforms existing penalties to the changes made by the bill;
- Creates two new misdemeanors for a qualifying patient or caregiver who cultivates marijuana or who purchases or acquires marijuana from any person or entity other than an MMTC⁵⁹ and a caregiver who violates any of the applicable provisions of this section or applicable department rules;⁶⁰
- Specifies that an MMTC may not advertise services that it is not registered to provide; and
- Prohibits any person or entity from offering or advertising services as an MMTC without being registered as an MMTC. The bill establishes penalties for unlicensed activity including fines of up to \$10,000 per day, and that the DOH or any state attorney may bring action for an injunction of the activity until compliance has been established to the satisfaction of the DOH. The bill also allows the DOH to assess reasonable investigative and legal costs for a successful prosecution.

Caregivers

The bill allows a qualifying patient to designate a caregiver to assist him or her with the medical use of marijuana. The bill requires the DOH to register a caregiver and issue him or her a compassionate use registry identification card if designated by a qualifying patient, and the caregiver:

- Is 21 years of age or older, unless the patient is a close relative of the caregiver;
- Agrees in writing to be the qualifying patient's caregiver;
- Does not receive compensation, other than actual expenses incurred, for assisting the qualifying patient with the medical use of marijuana unless the caregiver is acting pursuant to employment in a licensed facility in accordance with subparagraph (c)2.; and
- Passes a Level 2 background screening pursuant to ch. 435, F.S., unless the patient is a close relative of the caregiver.

A qualifying patient may have only one designated caregiver at a time unless all of the patient's caregivers are his or her close relatives or legal representatives. A caregiver may assist only one patient at a time unless:

- All qualifying patients the caregiver is assisting are close relatives of each other and the caregiver is the legal representative of at least one of the patients; or
- All qualifying patients the caregiver is assisting are receiving hospice services, or are residents, in the same assisted living facility, nursing home, or other licensed facility and have requested the assistance of that caregiver with the medical use of marijuana; the caregiver is an employee of the hospice or licensed facility; and the caregiver provides

⁵⁹ A first degree misdemeanor.

⁶⁰ A second degree misdemeanor on the first offense and a first degree misdemeanor on subsequent offenses.

personal care or services directly to clients of the hospice or licensed facility as a part of his or her employment duties at the hospice or licensed facility.

Duties of the DOH

Compassionate Use Registry

The bill requires the DOH to expand access to the compassionate use registry to:

- Practitioners licensed under ch. 458 or 459, F.S., to ensure proper care for patients requesting physician certifications; and
- Practitioners licensed to prescribe prescription drugs, to ensure proper care for patients before prescribing medications that may interact with the medical use of marijuana;

The bill specifies that law enforcement agencies may check the registry to verify the authorization of a qualifying patient or a patient's caregiver to possess marijuana or a cannabis delivery device.

Compassionate Use Registry Identification Cards

By July 3, 2017, the bill requires the DOH to adopt rules establishing procedures for the issuance, annual renewal, suspension, and revocation of compassionate use registry identification cards for patients and caregivers who are residents of this state. The bill allows the DOH to charge a reasonable fee for issuing and renewal of identification cards. The bill requires that the DOH begin issuing identification cards to patients and caregivers by October 3, 2017. Minor patients must provide the DOH with written consent from a parent or a legal guardian before being issued an identification card. Identification cards may be issued to out-of-state patients after the DOH confirms they are able to receive marijuana legally in their state of residency through a medical marijuana program.

The bill specifies that the identification cards must be resistant to counterfeiting and tampering and at a minimum contain:

- The name, address, and date of birth of the patient or caregiver, as appropriate;
- A full-face, passport-type, color photograph of the patient or caregiver, as appropriate, taken within the 90 days immediately preceding registration;
- Designation of the cardholder as a patient or caregiver;
- A unique numeric identifier for the patient or caregiver which is matched to the identifier used for such person in the department's compassionate use registry. A caregiver's identification number and file in the compassionate use registry must be linked to the file of the patient or patients the caregiver is assisting so that the caregiver's status may be verified for each patient individually;
- The expiration date, which shall be one year after issuance or the date treatment ends as provided in the patient's physician certification, whichever occurs first; and
- For caregivers who are assisting three or fewer qualifying patients, the names and unique numeric identifiers of the qualifying patient or patients that the caregiver is assisting.

Dispensing Organization Grandfathering

The bill requires the DOH to grandfather in all existing DOs as MMTCs as soon as practicable.⁶¹ The DOH may not charge the DOs a registration fee and the bill states that, for the purposes of the act, all DOs are deemed to be MMTCs on the effective date of the act. The bill requires that the DOs continue to comply with all representations made in their applications to be dispensing organizations after being registered as MMTCs and allows the DOH to grant variances to those representations.

Additional MMTCs

The bill requires that, by October 3, 2017, the DOH register five additional MMTCs with at least one applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999) or *In re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011) and a member of the Black Farmers and Agriculturalists Association. Additionally, within six months of each instance of the registration of 75,000 patients in the compassionate use registry, the DOH must register four additional MMTCs. The bill retains the requirement that MMTCs be vertically integrated, but eliminates the requirements that MMTCs possess a valid certificate of registration issued by the DACS pursuant to s. 581.131, F.S., that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman as defined in s. 581.011, F.S., and have been operated as a registered nursery in this state for at least 30 continuous years. The bill requires that all applicants must be registered to do business in Florida for at least five continuous years prior to applying. The bill also restricts the DOH from issuing more than one MMTC registration to a person or entity.

Independent Testing Laboratories

The bill authorizes the establishment of independent testing laboratories (ITLs) to collect and accept samples of, possess, store, transport, and test marijuana. All MMTCs are required to have their marijuana tested at an ITL to ensure that it meets DOH standards before it is dispensed. All ITLs must be licensed by the DOH except clinical laboratories licensed by the Agency for Health Care Administration (AHCA) which are exempt from this requirement. The DOH is required to adopt rules for ITL licensure requirements and a process for licensing ITLs including an application form, an initial application fee, and a biennial renewal fee.

In addition to licensure, the bill also requires that ITLs be certified by the DOH to perform all required tests. The DOH must issue a certification to an ITL that has been certified by a third-party laboratory certification body approved by the DOH. The DOH must adopt rules for certifying ITLs including rules for personnel qualifications, equipment and methodology, proficiency testing, tracking, sampling, chain of custody, record and sample retention, reporting, audit and inspection, and security.

The bill specifies that an ITL may accept samples only from a sample source approved by the DOH which, at a minimum, must include an MMTC, a researcher affiliated with an accredited university or research hospital, a qualifying patient, or a caregiver.

⁶¹ Including DOs that become MMTCs pursuant to the results of litigation (see present situation for details).

Quality Control Program

The bill requires the DOH to establish a marijuana quality control program that must require MMTCs to submit samples from each batch or lot of marijuana harvested or manufactured to an ITL to ensure that, at a minimum, labeling of the potency of THC and other marketed cannabinoids or terpenes is accurate and that it is safe for human consumption. The MMTC is required to maintain records of all tests conducted including the results and any other information required by the DOH. The DOH is required to adopt rules to create and oversee the program which must, at a minimum, include:

- Permissible levels of variation in potency labeling and standards requiring THC be consistently distributed throughout edible marijuana products;
- Permissible levels of contaminants and mandatory testing for contaminants including, but not limited to, testing for microbiological impurity, residual solvents, and pesticide residues;
- The destruction of marijuana determined to be inaccurately labeled or unsafe for human consumption after the MMTC has an opportunity to take remedial action;
- The collection, storage, handling, recording, and destruction of samples of marijuana by ITLs; and
- Security, inventory tracking, and record retention.

The bill also requires the DOH to reduce or suspend any testing requirement in its quality control program if the number of licensed and certified ITLs is insufficient to process the tests necessary to meet patient demand.

Seed-to-Sale Tracking System

The bill requires the DOH to establish, maintain, and control a computer software tracking system that traces marijuana from seed to sale. The tracking system must allow real-time, 24-hour access by the DOH to data from all MMTCs and ITLs and must, at a minimum, include notification of when marijuana seeds are planted, when marijuana plants are harvested and destroyed, and when marijuana is transported, sold, stolen, diverted, or lost. Each MMTC must use the seed-to-sale tracking system selected by the DOH.

MMTC Requirements

The requirements for MMTCs are substantially similar to the requirements for DOs in current law. The bill amends requirements for MMTCs so that:

- MMTCs are required to maintain compliance with all the representations made to the DOH in the MMTC's application for registration.
 - Upon request, the DOH may grant an MMTC one or more variances from the representations made in the MMTC's application.
 - Consideration of such a variance shall be based upon the individual facts and circumstances surrounding the request.
 - A variance may not be granted unless the requesting MMTC can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the DOH can reasonably determine will not be a lower standard than the specific representation in the application.

- MMTCs are required to label all marijuana with the concentration of THC and CBD in the product and with the recommended dose for the qualifying patient receiving it.
- MMTCs are allowed to produce edible products, but may not produce such items that are designed to be attractive to children. Additionally, MMTCs must meet all food safety standards established in state and federal law, including, but not limited to, the identification of the serving size and the amount of THC in each serving.
- When transporting marijuana, a copy of the transportation manifest must be in the vehicle at all times.

The bill also requires the DOH to adopt by rule a process for approving MMTC changes in ownership and changes in an MMTC owner's investment interest.

Rulemaking

The bill requires the DOH to adopt emergency rules pursuant to s. 120.54(4), F.S., as necessary to implement the section. The bill states that if an emergency rule adopted under this section is voided due to being held unconstitutional or an invalid exercise of delegated legislative authority, the DOH and any applicable boards may adopt an emergency rule to replace the voided rule. However, if the second emergency rule is voided, the DOH and the applicable boards must adopt rules based on standard procedures.

The bill exempts emergency rules from the requirement to make findings pursuant to s. 120.54(4)(a), F.S.,⁶² from ss. 120.54(3)(b),⁶³ 120.541,⁶⁴ and 120.54(4)(c), F.S.⁶⁵ The DOH and applicable boards must meet the procedural requirements in s. 120.54(2)(a), F.S.,⁶⁶ if the DOH or the applicable boards have, before the effective date of the act, held any public workshops or hearings on the subject matter of the emergency rules. Additionally, challenges to emergency rules adopted under this section are subject to the time schedules provided in s. 120.56(5), F.S.⁶⁷ Emergency rules adopted under this section remain in effect until they are replaced by rules adopted through normal procedures. The DOH must begin nonemergency rulemaking by January 1, 2018, and may not use emergency rulemaking procedures after that date, unless replacing emergency rules deemed invalid.

Miscellaneous Provisions

The bill:

- Specifies that nothing in the act limits the ability of an employer to establish, continue, or enforce a drug-free workplace program or policy and that an employer is not required to

⁶² Section 120.54(a)3., F.S., requires the agency publishing emergency rules to also publish in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety, or welfare and its reasons for concluding that the procedure used is fair under the circumstances.

⁶³ The requirement to prepare a statement of estimated regulatory cost (SERC) and to consider the impact of rules on small business, small counties, and small cities.

⁶⁴ Detailing the requirements of a SERC.

⁶⁵ Restricting an emergency rule from being effective for more than 90 days with some exceptions.

⁶⁶ Requiring notice of rule development be published prior to filing for rule adoption.

⁶⁷ The DOAH has seven days to assign an administrative law judge who must conduct the hearing within 14 total days (including the days used in assigning the judge). The judge then has 14 days after the hearing to render a decision.

accommodate the use of marijuana in the workplace or any employee working while under the influence of the marijuana.

- Specifies that nothing in the section creates a cause of action against an employer for wrongful discharge or discrimination.
- Creates an additional exemption from criminal penalties related to marijuana for research institutions established by a public postsecondary educational institution, such as the H. Lee Moffitt Cancer Center and Research Institute, and for state universities that have achieved preeminent state research university designation.⁶⁸

The Medical Marijuana Research and Education Act

The bill creates s. 1004.4351, F.S., to create the Medical Marijuana Research and Education Act. The act:

- Establishes the Coalition for Medicinal Cannabis Research and Education (Coalition) within the H. Lee Moffitt Cancer Center and Research Institute, Inc. (MCCRI) and provides that the Coalition's purpose is to conduct rigorous scientific research, provide education, disseminate research, and to guide policy development for the adoption of a statewide policy on ordering and dosing practices for the medicinal use of cannabis.
- Creates the Medicinal Cannabis Research and Education Board (Board) to direct the Coalition's operations. Additionally, the bill specifies Board membership requirements and requires the Board to:
 - Advise the Board of Governors, the State Surgeon General, the Governor, and the Legislature with respect to medicinal cannabis research and education in Florida.
 - Explore methods of implementing and enforcing medicinal cannabis laws in relation to cancer control, research, treatment, and education.
 - Annually adopt a plan for medicinal cannabis research, known as the Medicinal Cannabis Research and Education Plan (Plan) in accordance with state law, and must include recommendations for the coordination and integration of medical, nursing, paramedical, community, and other resources connected with the treatment of debilitating medical conditions, research related to the treatment of such conditions, and education.
 - Issue an annual report, by February 15, to the Governor, the President of the Senate, and the Speaker of the House Representatives on research projects, community outreach initiatives, and future plans for the Coalition.
- Provides that the Coalition must be administered by a director who, subject to Board approval, must:
 - Propose a budget.
 - Foster the collaboration of scientists, researchers, and other appropriate personnel.
 - Identify and prioritize the Coalition's research.
 - Prepare the Plan for submission to the Board.
 - Apply for grants to obtain funding for the Coalition's research.
 - Perform other Board specified duties.
- Requires the MCCRI to allocate staff, information, and assistance to assist the Board.

The bill is effective upon becoming law.

⁶⁸ Pursuant to s. 1001.7065, F.S.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Article X, section 29 of the State Constitution is a unique provision in that it directs a state agency, the DOH, to implement its provisions without requiring implementing legislation. However, article X, section 29(4)(e) of the State Constitution, does provide that nothing in that section shall limit the Legislature from enacting laws consistent with the section. Given the novelty of the constitutional provision, it is unclear how the courts will interpret its provisions as well as the interaction between its provisions and implementing legislation and rules.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

The Revenue Estimating Conference estimates that the bill has a positive but indeterminate fiscal impact on state revenues.

B. Private Sector Impact:

The bill will create opportunities for new MMTCs that are called for under its provisions, and for independent testing laboratories. Existing DOs may face a more competitive marketplace due to the increase in the number of allowed suppliers of marijuana, but the number of patients using their services is also expected to grow.

Patients and caregivers will be required to pay for identification cards, and caregivers and employees of MMTCs must pay for background screening.

C. Government Sector Impact:

The bill has an indeterminate fiscal impact on the DOH due to the cost of increased regulatory activity required by the bill, which should be offset by fees and fines the DOH is allowed to assess. The DOH estimates that fees and fines may generate between \$6.1

million and \$8.6 million while total expenditures may be between \$6 million and \$8.9 million.⁶⁹

The FDLE estimates that revenues derived from the bill for the FDLE may range from \$9 million to \$18 million generated by fees for criminal history records checks.⁷⁰ The FDLE analysis indicates that implementation of the bill will require 16 FTEs to perform criminal history background checks, two additional toxicology analysts, and two additional fingerprint analysts. Cost estimates provided by the FDLE for the additional staff are \$1,278,157 in Fiscal Year 2017-2018, and \$1,197,237 on a recurring basis; however, fees for criminal history records checks should offset these costs.⁷¹

The bill may have an indeterminate fiscal impact on local governments. Local governments may see a positive fiscal impact from fees associated with licensing and inspecting additional MMTC facilities as permitted by current law and may derive additional tax revenue from the sale of marijuana. Local governments may see a negative fiscal impact due to the expenses associated with implementing ordinances and undertaking regulatory activities required by such ordinances.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Although the bill allows MMTCs to use contractors in general, it is unclear from the text of the bill what limits are placed on how an MMTC may use a contractor. The bill should be clarified to specify the duties a contractor may perform for an MMTC.

The FDLE notes that entering results obtained from a state or criminal history record check into a registry, as the bill appears to require DOH to do with information it receives from physicians, patients and caregivers, is prohibited by Public Law 92-544. Similarly, the provision in the bill that the application form for registration as an MMTC must demonstrate that all owners and managers have been fingerprinted and have successfully passed a level 2 background screening is also prohibited by Public Law 92-544.⁷²

The bill provides circumstances under which a physician may lawfully issue a physician certification to a patient who is not a resident of this state or under which DOH may issue a compassionate use registry identification card to a patient who is not a resident of this state, but never explicitly states that a patient must otherwise be a resident of this state.⁷³

⁶⁹ The DOH states that expenditures are highly dependent on the number of qualifying patients. See DOH, *Senate Bill 406 Analysis* (Feb. 14, 2017) (on file with the Senate Committee on Health Policy).

⁷⁰ The fee depends on whether or not caregivers are intended to be entered into the clearinghouse. See FDLE, *Senate Bill 406 Analysis* (Feb. 15, 2017) (on file with the Senate Committee on Health Policy).

⁷¹ FDLE, *Senate Bill 406 Analysis* (Feb 15, 2017) (on file with the Senate Appropriations Subcommittee on Finance and Tax).

⁷² FDLE, *Senate Bill 406 Analysis* (Feb 15, 2017) (on file with the Senate Appropriations Subcommittee on Finance and Tax).

⁷³ Amendment 2 provides that a “qualifying patient” means a person (not a Florida resident) who meets certain criteria.

The bill allows a physician to certify an amount greater than a 90-day supply of marijuana if he or she has reasonable belief that the patient will use the additional marijuana in a medically appropriate way; however, the bill does not apply the exception to the 90-day supply limit of marijuana to the exemptions from criminal penalties contained in chapter 893, F.S. The bill should be clarified to apply the exception to the 90-day supply limit of marijuana consistently throughout the bill.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.986, 381.987, 385.211, 499.0295, and 1004.441.

The bill creates section 1004.4351 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.)

CS by Health Policy on April 3, 2017:

The CS amends SB 406 to:

- Add legislative intent.
- Reinstate the requirement that a second physician confirm a diagnosis when certifying a person under the age of 18 and require a parent, legal guardian, caregiver, or health care provider to purchase marijuana for qualifying patients under the age of 18.
- Allow a physician to certify out of state patients that meet Florida requirements for treatment with marijuana.
- Allow a physician to certify a patient for greater than a 90-day supply if the physician believes the patient will use the marijuana appropriately.
- Specify that MMTCs may not advertise services that they are not registered to provide.
- Prohibit any person or entity from offering or advertising services as an MMTC without being registered as an MMTC and provide penalties for unlicensed activity.
- Require the DOH to register five additional MMTCs by October 3, 2017, including one that is a member of the Black Farmers and Agriculturalists Association.
- Require the Department of Health to add four new MMTCs within six months after the registration of each instance of 75,000 patients in the Compassionate Use Registry.
- Require that all MMTC applicants be registered to do business in Florida for at least five consecutive years prior to submitting their application.
- Prohibit any person or entity from being issued more than one MMTC registration.
- Require the DOH to license ITLs (clinical laboratories licensed by the AHCA are exempt from this requirement). ITLs must also be certified by the DOH to perform all required tests. The DOH must certify an ITL that has third-party accreditation from

an accrediting body approved by the DOH. The DOH must adopt rules for licensure and certification of ITLs.

- Require the DOH to establish a quality control program for the testing of marijuana. The program must require MMTCs to submit samples of marijuana to an ITL to ensure minimum standards are met. The DOH must adopt rules to create and oversee the program.
- Require the DOH to establish, maintain, and control a seed-to-sale tracking system.
- Authorize an employer to deny accommodation for the ingestion of marijuana in the workplace or for any employee working while under the influence of marijuana.
- Specify that the section does not create a cause of action for wrongful discharge or discrimination.
- Incorporate an exemption from criminal laws for research institutions performing research on marijuana.
- Require the DOH to abide by the provisions of ch. 120, F.S., when adopting rules to implement this section and allows the department to use emergency rulemaking procedures.
- Establish the “Medical Marijuana Research and Education Act” to:
 - Create the Coalition for Medical Marijuana Research and Education within the H. Lee Moffitt Cancer Center and Research Institute, Inc.;
 - Task the coalition with conducting rigorous scientific research, providing education, disseminating research, and guiding policy for the adoption of a statewide policy on ordering and dosing practices for medical marijuana;
 - Specify the make-up of the coalition including the duties of the director of the coalition;
 - Require the coalition to annually adopt a research plan; and
 - Require the coalition to annually report to the Governor and the Legislature on research projects, community outreach, and future plans.

B. Amendments:

None.



700186

LEGISLATIVE ACTION

Senate

.
. .
. .
. .
. .

House

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

Senate Amendment (with title amendment)

Between lines 702 and 703
insert:

(j) Meet the minority business enterprise procurement goals
set forth in s. 287.042 in the procurement of commodities,
contractual services, and other services and in the selection of
vendors in the administration of activities under this section.
The goal for participation of minority business enterprises, as
defined in s. 288.703(3), in MMTC operations and subcontracting



700186

is 10 percent; however, no more than 35 percent of such minority business enterprises may be owned by any one of the minority persons specified in s. 288.703(4)(a)-(e), respectively.

1. This paragraph does not preclude or prohibit a minority person from competing for any MMTC registration or any other procurement of goods or services awarded by the department.

2. MMTCs have 12 months after the date of their registration to demonstrate to the department compliance with the minority business enterprise participation goal established in this paragraph.

(k) Implement training programs and other educational programs to enable minority persons to compete for MMTC registration and contracts on an equal basis.

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

And the title is amended as follows:

Between lines 52 and 53
insert:

requiring the department to meet a specified minority business enterprise participation goal; providing construction; requiring medical marijuana treatment centers to demonstrate to the department their compliance with such goal; requiring the department to implement training programs and other educational programs for minority persons to enable them to compete for medical marijuana treatment center registration and contracts;



593180

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete lines 635 - 640

and insert:

Agriculturalists Association; and with at least one of the MMTCs
being, at the time of initial application, a veteran business
enterprise as defined s. 295.187(3) which meets the requirements
of this section.

(e) Within 6 months after each instance of the registration
of 75,000 qualifying patients with the compassionate use



593180

registry, register four additional MMTCs if a sufficient number
of MMTC applicants meet the registration requirements
established in this section and by department rule. The
department shall grant preferential and bonus scoring criteria
for applicants that, at the time of initial application, are
veteran business enterprises as defined s. 295.187(3) which meet
the requirements to be awarded and registered as an MMTC.

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

And the title is amended as follows:

Between lines 52 and 53

insert:

requiring the department to meet specified procurement
goals of medical marijuana treatment centers as
veteran business enterprises;



504066

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Between lines 834 and 835
insert:

7. May not dispense marijuana from more than 3 retail
facilities. This subparagraph does not limit MMTC retail
facilities that only dispense low-THC cannabis and sell
marijuana delivery devices to qualified patients.

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



504066

11 And the title is amended as follows:
12 Delete line 63
13 and insert:
14 the compassionate use registry; restricting the number
15 of retail facilities that may dispense marijuana;
16 requiring a medical

By the Committee on Health Policy; and Senators Bradley, Young,
and Hutson

588-03368A-17

2017406c1

1 A bill to be entitled
2 An act relating to compassionate use of low-THC
3 cannabis and marijuana; amending s. 381.986, F.S.;
4 providing legislative intent; defining and redefining
5 terms; authorizing physicians to issue physician
6 certifications to specified patients who meet certain
7 conditions; authorizing physicians to make specific
8 determinations in certifications; requiring physicians
9 to meet certain conditions to be authorized to issue
10 and make determinations in physician certifications;
11 specifying certain persons who may assist a qualifying
12 patient under the age of 18 in the purchasing and
13 administering of marijuana; prohibiting qualifying
14 patients under the age of 18 from purchasing
15 marijuana; providing that a physician may in certain
16 circumstances certify an amount greater than a 90-day
17 supply; requiring written consent of a parent or legal
18 guardian for the treatment of minors; requiring that
19 certain physicians annually reexamine and reassess
20 patients and update patient information in the
21 compassionate use registry; revising criminal
22 penalties; prohibiting a medical marijuana treatment
23 center from advertising services it is not authorized
24 to provide; providing fines; prohibiting a person or
25 entity from advertising or providing medical marijuana
26 treatment center services without being registered
27 with the department as a medical marijuana treatment
28 center; providing penalties; authorizing a distance
29 learning format for a specified course and reducing

Page 1 of 49

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

588-03368A-17

2017406c1

30 the number of hours required for the course; providing
31 that physicians who meet specified requirements are
32 grandfathered for the purpose of specified education
33 requirements; authorizing qualifying patients to
34 designate caregivers; requiring caregivers to meet
35 specified requirements; prohibiting a qualifying
36 patient from designating more than one caregiver at
37 any given time; providing exceptions; requiring the
38 Department of Health to register caregivers meeting
39 certain requirements on the compassionate use
40 registry; revising the entities to which the
41 compassionate use registry must be accessible;
42 requiring the department to adopt certain rules by a
43 specified date; authorizing the department to charge a
44 fee for identification cards; requiring the department
45 to begin issuing identification cards to qualified
46 registrants by a specific date; providing requirements
47 for the identification cards; requiring the department
48 to register certain dispensing organizations as
49 medical marijuana treatment centers by a certain date;
50 requiring the department to register additional
51 medical marijuana treatment centers in accordance with
52 a specified schedule; deleting obsolete provisions;
53 revising the operational requirements for medical
54 marijuana treatment centers; authorizing the
55 department to waive certain requirements under
56 specified circumstances; requiring that certain
57 receptacles be childproof; requiring that additional
58 information be included on certain labels; requiring

Page 2 of 49

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

588-03368A-17

2017406c1

59 that a medical marijuana treatment center comply with
 60 certain standards in the production and dispensing of
 61 edible or food products; requiring a medical marijuana
 62 treatment center to enter additional information into
 63 the compassionate use registry; requiring a medical
 64 marijuana treatment center to keep a copy of a
 65 transportation manifest in certain vehicles at certain
 66 times; requiring the department to establish a quality
 67 control program that requires medical marijuana
 68 treatment centers to submit samples from each batch or
 69 lot of marijuana to an independent testing laboratory;
 70 requiring a medical marijuana treatment center to
 71 maintain records of all tests conducted; requiring the
 72 department to adopt rules to create and oversee the
 73 quality control program; providing that the department
 74 must license independent testing laboratories;
 75 authorizing an independent testing laboratory to
 76 collect and accept samples of, possess, store,
 77 transport, and test marijuana; prohibiting a person
 78 with an ownership interest in a medical marijuana
 79 treatment center from owning an independent testing
 80 laboratory; requiring the department to develop rules
 81 and a process for licensing requirements; authorizing
 82 the department to impose application and renewal fees;
 83 specifying that an independent testing laboratory must
 84 be certified to perform required tests; requiring the
 85 department to suspend or reduce any mandatory testing
 86 if the number of licensed and certified independent
 87 testing laboratories is insufficient to process the

588-03368A-17

2017406c1

88 tests necessary to meet the patient demand for medical
 89 marijuana treatment centers; providing that an
 90 independent testing laboratory may only accept certain
 91 samples; requiring the department to adopt rules
 92 related to ownership changes or changes in an owner's
 93 investment interest; requiring the department to
 94 establish, maintain, and control a seed-to-sale
 95 tracking system for marijuana; providing
 96 applicability; conforming provisions to changes made
 97 by the act; providing that certain research
 98 institutions may possess, test, transport, and dispose
 99 of marijuana subject to certain conditions and as
 100 provided by department rule; providing for the use of
 101 emergency rulemaking procedures by the department;
 102 creating s. 1004.4351, F.S.; providing a short title;
 103 providing legislative findings; defining terms;
 104 establishing the Coalition for Medical Marijuana
 105 Research and Education within the H. Lee Moffitt
 106 Cancer Center and Research Institute, Inc.; providing
 107 a purpose for the coalition; establishing the Medical
 108 Marijuana Research and Education Board to direct the
 109 operations of the coalition; providing for the
 110 appointment of board members; providing for terms of
 111 office, reimbursement for certain expenses, and the
 112 conduct of meetings of the board; authorizing the
 113 board to appoint a coalition director; prescribing the
 114 duties of the coalition director; requiring the board
 115 to advise specified entities and officials regarding
 116 medical marijuana research and education in this

588-03368A-17

2017406c1

117 state; requiring the board to annually adopt a Medical
 118 Marijuana Research and Education Plan; providing
 119 requirements for the plan; requiring the board to
 120 issue an annual report to the Governor and the
 121 Legislature by a specified date; specifying
 122 responsibilities of the H. Lee Moffitt Cancer Center
 123 and Research Institute, Inc.; amending ss. 381.987,
 124 385.211, 499.0295, and 1004.441, F.S.; conforming
 125 provisions to changes made by the act; providing a
 126 directive to the Division of Law Revision and
 127 Information; providing an effective date.

128

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

130

131 Section 1. Section 381.986, Florida Statutes, is amended to
 132 read:

133 381.986 Compassionate use of low-THC ~~and medical~~ cannabis
 134 and marijuana.—

135 (1) LEGISLATIVE INTENT.—

136 (a) It is the intent of the Legislature to implement s. 29,
 137 Art. X of the State Constitution by creating a unified
 138 regulatory structure within the framework of this section for
 139 the acquisition, cultivation, possession, processing, transfer,
 140 transportation, sale, distribution, and dispensing of marijuana,
 141 products containing marijuana, related supplies, and educational
 142 materials to qualifying patients or their caregivers.

143 (b) The Legislature intends that all rules adopted by the
 144 Department of Health to implement this section be adopted
 145 pursuant to s. 120.536(1) or s. 120.54. The Legislature intends

588-03368A-17

2017406c1

146 that the department use emergency rulemaking procedures pursuant
 147 to s. 120.54(4) to adopt rules under this section if necessary
 148 to meet any deadline for rulemaking established in s. 29, Art. X
 149 of the State Constitution.

150 (c) Further, the Legislature intends that all registrations
 151 for the purposes specified in paragraph (a) be issued solely in
 152 accordance with the requirements of this section and all rules
 153 adopted under this section.

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

155 (a) "Cannabis delivery device" means an object used,
 156 intended for use, or designed for use in preparing, storing,
 157 ingesting, inhaling, or otherwise introducing marijuana ~~low-THC~~
 158 ~~cannabis or medical cannabis~~ into the human body.

159 (b) "Caregiver" has the same meaning as provided in s. 29,
 160 Art. X of the State Constitution.

161 (c) "Chronic nonmalignant pain" means pain that is caused
 162 by a debilitating medical condition or that originates from a
 163 debilitating medical condition and persists beyond the usual
 164 course of that debilitating medical condition.

165 (d) "Close relative" means a spouse, parent, sibling,
 166 grandparent, child, or grandchild, whether related by whole or
 167 half blood, by marriage, or by adoption.

168 ~~(e)(b)~~ "Debilitating medical condition" has the same
 169 meaning as provided in s. 29, Art. X of the State Constitution
 170 "Dispensing organization" means an organization approved by the
 171 department to cultivate, process, transport, and dispense low-
 172 THC ~~cannabis or medical cannabis pursuant to this section.~~

173 ~~(f)(e)~~ "Independent testing laboratory" means a laboratory,
 174 including the managers, employees, or contractors of the

588-03368A-17

2017406c1

laboratory, which has no direct or indirect interest in a medical marijuana treatment center ~~a dispensing organization.~~

(g)(d) "Legal representative" means the qualifying ~~qualified~~ patient's parent, legal guardian acting pursuant to a court's authorization as required under s. 744.3215(4), health care surrogate acting pursuant to the qualifying ~~qualified~~ patient's written consent or a court's authorization as required under s. 765.113, or an individual who is authorized under a power of attorney to make health care decisions on behalf of the qualifying ~~qualified~~ patient.

(h)(e) "Low-THC cannabis" means a plant of the genus *Cannabis*, the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed only by a medical marijuana treatment center ~~from a dispensing organization.~~

(i)(f) "Marijuana" has the same meaning as provided in s. 29, Art. X of the State Constitution ~~"Medical cannabis" means all parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, sale, derivative, mixture, or preparation of the plant or its seeds or resin that is dispensed only from a dispensing organization for medical use by an eligible patient as defined in s. 499.0295.~~

(j) "Medical marijuana treatment center" or "MMTC" has the same meaning as provided in s. 29, Art. X of the State Constitution.

588-03368A-17

2017406c1

(k)(g) "Medical use" has the same meaning as provided in s. 29, Art. X of the State Constitution ~~means administration of the ordered amount of low-THC cannabis or medical cannabis.~~ The term does not include the:

1. Possession, use, or administration of marijuana ~~low-THC cannabis or medical cannabis~~ by smoking.

2. Possession, use, or administration of marijuana that was not purchased or acquired from an MMTC registered with the Department of Health.

3.2. Transfer of marijuana ~~low-THC cannabis or medical cannabis~~ to a person other than the qualifying ~~qualified~~ patient ~~for whom it was ordered or the~~ qualifying ~~qualified~~ patient's caregiver ~~legal representative~~ on behalf of the qualifying ~~qualified~~ patient.

4. Use or administration of any type or amount of marijuana not specified on the qualifying patient's physician certification.

5.3. Use or administration of marijuana ~~low-THC cannabis or medical cannabis:~~

a. On any form of public transportation.

b. In any public place.

c. In a qualifying ~~qualified~~ patient's place of employment, if restricted by his or her employer.

d. In a state correctional institution as defined in s. 944.02 or a correctional institution as defined in s. 944.241.

e. On the grounds of a preschool, primary school, or secondary school.

f. On a school bus or in a vehicle, aircraft, or motorboat.

(l)(h) "Qualifying ~~Qualified~~ patient" has the same meaning

588-03368A-17

2017406c1

as provided in s. 29, Art. X of the State Constitution but also includes eligible patients, as that term is defined in s. 499.0295, and patients who are issued a physician certification under subparagraph (3)(a)2. or subparagraph (3)(a)3. A patient is not a qualifying patient unless he or she is registered with the department and has been issued a compassionate use registry identification card means a resident of this state who has been added to the compassionate use registry by a physician licensed under chapter 458 or chapter 459 to receive low-THC cannabis or medical cannabis from a dispensing organization.

(m)(i) "Smoking" means burning or igniting a substance and inhaling the smoke. Smoking does not include the use of a vaporizer.

(3)(2) PHYSICIAN CERTIFICATION ORDERING.-

(a) A physician is authorized to issue a physician certification to:

1. A patient suffering from a debilitating medical condition, which allows the patient to receive marijuana for the patient's medical use;

2. A ~~order low-THC cannabis to treat a~~ qualified patient suffering from ~~cancer or~~ a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms, which allows the patient to receive low-THC cannabis for the patient's medical use;

3. A patient suffering from chronic nonmalignant pain, if the physician has diagnosed an underlying debilitating medical condition as the cause of the pain, which allows the patient to receive marijuana for the patient's medical use ~~order low-THC cannabis to alleviate the patient's pain symptoms of such~~

588-03368A-17

2017406c1

~~disease, disorder, or condition, if no other satisfactory alternative treatment options exist for the qualified patient;~~

~~4. order medical cannabis to treat~~ An eligible patient as defined in s. 499.0295, which allows the patient to receive marijuana for the patient's medical use; or

5. A patient who is not a resident of this state; who qualifies under subparagraph 1., subparagraph 2., subparagraph 3., or subparagraph 4.; and who can lawfully obtain marijuana through a medical marijuana program in the state that he or she resides in.

(b) In the physician certification, the physician may also specify one or more ~~or order a~~ cannabis delivery devices to assist with device for the patient's medical use of marijuana. ~~low-THC cannabis or medical cannabis,~~

(c) A physician may certify a patient and specify a delivery device under paragraphs (a) and (b) only if the physician:

1. ~~(a)~~ Holds an active, unrestricted license as a physician under chapter 458 or an osteopathic physician under chapter 459;

~~(b) Has treated the patient for at least 3 months immediately preceding the patient's registration in the compassionate use registry;~~

2. ~~(c)~~ Has successfully completed the course and examination required under paragraph (5)(a) ~~(4)(a);~~

3. Has conducted a physical examination and made a full assessment of the medical history of the patient;

4. Has determined that, in the physician's professional opinion, the patient meets one or more of the criteria specified in paragraph (a);

588-03368A-17

2017406c1

291 5.(d) Has determined that the medical use of marijuana
 292 would likely outweigh the potential health risks ~~to of treating~~
 293 ~~the patient with low-THC cannabis or medical cannabis are~~
 294 ~~reasonable in light of the potential benefit to the patient. If~~
 295 a patient is younger than 18 years of age;
 296 a. A second physician must concur with this determination,
 297 and such determination must be documented in the patient's
 298 medical record;
 299 b. Only a parent, legal guardian, caregiver, or health care
 300 provider may assist the qualifying patient in the purchasing and
 301 administering of marijuana for medical use; and
 302 c. The qualifying patient may not purchase marijuana;
 303 6.(e) Registers as the patient's physician orderer of low-
 304 THC cannabis or medical cannabis for the named patient on the
 305 compassionate use registry maintained by the department and
 306 updates the registry to reflect the contents of the order,
 307 including the amount of marijuana low-THC cannabis or medical
 308 cannabis that will provide the patient with not more than a 90-
 309 day 45-day supply and a cannabis delivery device needed by the
 310 patient for the medical use of marijuana low-THC cannabis or
 311 medical cannabis. A physician may certify an amount greater than
 312 a 90-day supply of marijuana if the physician has a reasonable
 313 belief that the patient will use the additional marijuana in a
 314 medically appropriate way. If the physician's recommended amount
 315 of marijuana for a 90-day supply changes, the physician must
 316 also update the registry within 7 days after the any change is
 317 made to the original order to reflect the change. The physician
 318 shall deactivate the registration of the patient and the
 319 patient's legal representative when the physician no longer

Page 11 of 49

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

588-03368A-17

2017406c1

320 recommends the medical use of marijuana for the patient
 321 treatment is discontinued;
 322 7.(f) Maintains a patient treatment plan that includes the
 323 dose, route of administration, planned duration, and monitoring
 324 of the patient's symptoms and other indicators of tolerance or
 325 reaction to the marijuana low-THC cannabis or medical cannabis;
 326 8.(g) Submits the patient treatment plan quarterly to the
 327 University of Florida College of Pharmacy for research on the
 328 safety and efficacy of marijuana low-THC cannabis and medical
 329 cannabis on patients; and
 330 9.(h) Obtains the voluntary written informed consent of the
 331 patient or the patient's legal representative to treatment with
 332 marijuana low-THC cannabis after sufficiently explaining the
 333 current state of knowledge in the medical community of the
 334 effectiveness of treatment of the patient's condition with
 335 marijuana low-THC cannabis, the medically acceptable
 336 alternatives, and the potential risks and side effects. If the
 337 patient is a minor, the patient's parent or legal guardian must
 338 consent to treatment in writing. If the patient is an eligible
 339 patient as defined in s. 499.0295, the physician must obtain
 340 written informed consent as defined in and required by s.
 341 499.0295.
 342 (d) At least annually, a physician must recertify the
 343 qualifying patient pursuant to paragraph (c).
 344 ~~(i) Obtains written informed consent as defined in and~~
 345 ~~required under s. 499.0295, if the physician is ordering medical~~
 346 ~~cannabis for an eligible patient pursuant to that section; and~~
 347 (e)(j) A physician may not issue a physician certification
 348 if the physician is not a medical director employed by an MMTC a

Page 12 of 49

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

588-03368A-17

2017406c1

dispensing organization.

(f) An order for low-THC cannabis or medical cannabis issued pursuant to former s. 381.986, Florida Statutes 2016, and registered with the compassionate use registry on the effective date of this act, shall be considered a physician certification issued pursuant to this subsection. The details and expiration date of such certification must be identical to the details and expiration date of the order as logged in the compassionate use registry. Until the department begins issuing compassionate use registry identification cards, all patients with such orders shall be considered qualifying patients, notwithstanding the requirement that a qualifying patient have a compassionate use registry identification card.

(4)(3) PROHIBITED ACTS PENALTIES.-

(a) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if the physician issues a physician certification for marijuana to orders low-THC cannabis for a patient in a manner other than as required in subsection (3) without a reasonable belief that the patient is suffering from:

1. ~~Cancer or A physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms that can be treated with low-THC cannabis; or~~

2. ~~Symptoms of cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms that can be alleviated with low-THC cannabis.~~

~~(b) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if the~~

588-03368A-17

2017406c1

~~physician orders medical cannabis for a patient without a reasonable belief that the patient has a terminal condition as defined in s. 499.0295.~~

~~(b)(e)~~ A person who fraudulently represents that he or she has a debilitating medical condition ~~cancer~~, a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms, chronic nonmalignant pain, or a terminal condition as defined in s. 499.0295 to a physician for the purpose of being issued a physician certification for marijuana ~~ordered low-THC cannabis, medical cannabis, or a~~ cannabis delivery device by such physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

~~(c)(d)~~ A qualifying patient an eligible patient as defined in s. 499.0295 who uses marijuana medical cannabis, and such patient's caregiver legal representative who administers marijuana medical cannabis, in plain view of or in a place open to the general public, on the grounds of a school, or in a school bus, vehicle, aircraft, or motorboat, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(d) A qualifying patient or caregiver who cultivates marijuana or who purchases or acquires marijuana from any person or entity other than an MMTC commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(e) A caregiver who violates any of the applicable provisions of this section or applicable department rules commits, upon the first offense, a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, and,

588-03368A-17

2017406c1

upon the second and subsequent offenses, a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

~~(f)(e)~~ A physician who issues a physician certification for ~~marijuana orders low-THC cannabis, medical cannabis,~~ or a cannabis delivery device and receives compensation from an MMTC ~~a dispensing organization~~ related to issuing the physician ~~a dispensing organization~~ certification for marijuana ~~the ordering of low-THC cannabis,~~ ~~medical cannabis,~~ or a cannabis delivery device is subject to disciplinary action under the applicable practice act and s. 456.072(1)(n).

(g) An MMTC that advertises or holds out to the public that it may provide services other than services for which it is registered to provide violates this section, and the department may impose a fine on the MMTC pursuant to paragraph (10)(h).

(h) A person or entity that offers or advertises services as an MMTC without registering as an MMTC with the department violates this section. The operation or maintenance of a facility as an MMTC, or the performance of a service that requires registration, without proper registration is a violation of this section.

1. If after receiving notification from the department, such person or entity fails to cease operation, the department may impose an administrative fine of up to \$10,000 per violation. Each day of continued operation is a separate offense.

2. The department or any state attorney may, in addition to other remedies provided in this section, bring an action for an injunction to restrain any unauthorized activity or to enjoin

588-03368A-17

2017406c1

the future operation or maintenance of the unauthorized dispensing organization or entity or the performance of any service in violation of this section until compliance with this section and department rules has been demonstrated to the satisfaction of the department.

3. If found to be in violation of this paragraph, the department may assess reasonable investigative and legal costs for prosecution of the violation against the person or entity.

~~(5)(4)~~ PHYSICIAN EDUCATION.—

(a) Before a physician may issue a physician certification pursuant to subsection (3) ordering low-THC cannabis, medical cannabis, or a cannabis delivery device for medical use by a patient in this state, the appropriate board shall require the ordering physician to successfully complete a 4-hour ~~an 8-hour~~ course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which ~~that~~ encompasses the clinical indications for the appropriate use of marijuana low-THC cannabis and medical cannabis, the appropriate cannabis delivery devices, the contraindications for such use, and the relevant state and federal laws governing the issuance of physician certifications ordering, as well as dispensing, and possessing ~~of~~ these substances and devices. The course and examination shall be administered at least quarterly ~~annually~~. Successful completion of the course may be used by a physician to satisfy 4 hours ~~8 hours~~ of the continuing medical education requirements required by his or her respective board for licensure renewal. This course may be offered in a distance learning format, including an electronic, online format that is available on request. Physicians who have completed an 8-hour

588-03368A-17

2017406c1

465 course and subsequent examination offered by the Florida Medical
 466 Association or the Florida Osteopathic Medical Association which
 467 encompasses the clinical indications for the appropriate use of
 468 marijuana and who are registered in the compassionate use
 469 registry on the effective date of this act are deemed to meet
 470 the requirements of this paragraph.

471 (b) The appropriate board shall require the medical
 472 director of each ~~MMTC dispensing organization~~ to hold an active,
 473 unrestricted license as a physician under chapter 458 or as an
 474 osteopathic physician under chapter 459 and successfully
 475 complete a 2-hour course and subsequent examination offered by
 476 the Florida Medical Association or the Florida Osteopathic
 477 Medical Association which that encompasses appropriate safety
 478 procedures and knowledge of marijuana low-THC cannabis, medical
 479 ~~cannabis~~, and cannabis delivery devices.

480 ~~(c) Successful completion of the course and examination~~
 481 ~~specified in paragraph (a) is required for every physician who~~
 482 ~~orders low-THC cannabis, medical cannabis, or a cannabis~~
 483 ~~delivery device each time such physician renews his or her~~
 484 ~~license. In addition, successful completion of the course and~~
 485 ~~examination specified in paragraph (b) is required for the~~
 486 ~~medical director of each dispensing organization each time such~~
 487 ~~physician renews his or her license.~~

488 ~~(c)(d)~~ A physician who fails to comply with this subsection
 489 and issues a physician certification for marijuana who orders
 490 low-THC cannabis, medical cannabis, or a cannabis delivery
 491 device may be subject to disciplinary action under the
 492 applicable practice act and under s. 456.072(1)(k).

493 (6) CAREGIVERS.—

588-03368A-17

2017406c1

494 (a) During the course of registration with the department
 495 for inclusion on the compassionate use registry, or at any time
 496 while registered, a qualifying patient may designate an
 497 individual as his or her caregiver to assist him or her with the
 498 medical use of marijuana. The designated caregiver must be 21
 499 years of age or older, unless the patient is a close relative of
 500 the caregiver; must agree in writing to be the qualifying
 501 patient's caregiver; may not receive compensation, other than
 502 actual expenses incurred, for assisting the qualifying patient
 503 with the medical use of marijuana, unless the caregiver is
 504 acting pursuant to employment in a licensed facility in
 505 accordance with subparagraph (c)2.; and must pass a level 2
 506 screening pursuant to chapter 435, unless the patient is a close
 507 relative of the caregiver.

508 (b) A qualifying patient may have only one designated
 509 caregiver at any given time unless all of the patient's
 510 caregivers are his or her close relatives or legal
 511 representatives.

512 (c) A caregiver may assist only one qualifying patient at
 513 any given time unless:

514 1. All qualifying patients the caregiver is assisting are
 515 close relatives of each other and the caregiver is the legal
 516 representative of at least one of the patients; or

517 2. All qualifying patients the caregiver is assisting are
 518 receiving hospice services, or are residents, in the same
 519 assisted living facility, nursing home, or other licensed
 520 facility and have requested the assistance of that caregiver
 521 with the medical use of marijuana; the caregiver is an employee
 522 of the hospice or licensed facility; and the caregiver provides

588-03368A-17

2017406c1

personal care or services directly to clients of the hospice or licensed facility as a part of his or her employment duties at the hospice or licensed facility.

(d) The department must register a caregiver on the compassionate use registry and issue him or her a caregiver identification card if he or she is designated by a qualifying patient pursuant to paragraph (a) and meets all of the requirements of this subsection and department rule.

(7) ~~(5)~~ DUTIES OF THE DEPARTMENT.—The department shall:

(a) Create and maintain a secure, electronic, and online compassionate use registry for the registration of physicians, patients, and caregivers ~~the legal representatives of patients~~ as provided under this section. The registry must be accessible to:

1. Practitioners licensed under chapter 458 or chapter 459, to ensure proper care for patients requesting physician certifications;

2. Practitioners licensed to prescribe prescription drugs, to ensure proper care for patients before prescribing medications that may interact with the medical use of marijuana;

3. Law enforcement agencies, to verify the authorization of a qualifying patient or a patient's caregiver to possess marijuana or a cannabis delivery device; and

4. MMTCs, to ~~a dispensing organization to~~ verify the authorization of a qualifying patient or a patient's caregiver ~~legal representative to possess marijuana low-THC cannabis, medical cannabis, or a cannabis delivery device and to record the marijuana low-THC cannabis, medical cannabis, or cannabis delivery device dispensed.~~

588-03368A-17

2017406c1

The registry must prevent ~~an~~ active registration of a patient by multiple physicians.

(b) By July 3, 2017, adopt rules establishing procedures for the issuance, annual renewal, suspension, and revocation of compassionate use registry identification cards for patients and caregivers. The department may charge a reasonable fee associated with the issuance and renewal of patient and caregiver identification cards. By October 3, 2017, the department shall begin issuing identification cards to adult patients who have a physician certification that meets the requirements of subsection (3); minor patients who have a physician certification that meets the requirements of subsection (3) and the written consent of a parent or legal guardian; and caregivers registered pursuant to subsection (6). In addition to the other requirements of this section, the department may issue a compassionate use registry identification card to a patient who is not a resident of this state only after the department has verified that the patient can lawfully obtain marijuana through a medical marijuana program in the state that he or she resides in. Patient and caregiver identification cards must be resistant to counterfeiting and tampering and must include at least the following:

1. The name, address, and date of birth of the patient or caregiver, as appropriate;

2. A full-face, passport-type, color photograph of the patient or caregiver, as appropriate, taken within the 90 days immediately preceding registration;

3. Designation of the cardholder as a patient or caregiver;

588-03368A-17

2017406c1

4. A unique identification number for the patient or caregiver which is matched to the identification number used for such person in the department's compassionate use registry. A caregiver's identification number and file in the compassionate use registry must be linked to the file of the patient or patients the caregiver is assisting so that the caregiver's status may be verified for each patient individually;

5. The expiration date, which shall be 1 year after the date of issuance of the identification card or the date treatment ends as provided in the patient's physician certification, whichever occurs first; and

6. For caregivers who are assisting three or fewer qualifying patients, the names and identification number of the qualifying patient or patients that the caregiver is assisting.

(c) As soon as practicable after the effective date of this act, update its records by registering each dispensing organization approved pursuant to chapter 2014-157, Laws of Florida, or chapter 2016-123, Laws of Florida, as an MMTC with an effective registration date that coincides with that dispensing organization's date of approval as a dispensing organization. On the effective date of this act, all dispensing organizations approved pursuant to chapter 2014-157, Laws of Florida, or chapter 2016-123, Laws of Florida, are deemed to be registered MMTCs. The department may not require a dispensing organization approved pursuant to chapter 2014-157, Laws of Florida, or chapter 2016-123, Laws of Florida, to submit an application and may not charge the dispensing organization an application or registration fee for the initial registration of that dispensing organization as an MMTC pursuant to this

588-03368A-17

2017406c1

section. For purposes of the requirement that an MMTC comply with the representations made in its application pursuant to subsection (8), an MMTC registered pursuant to this paragraph shall continue to comply with the representations made in its application for approval as a dispensing organization, including any revision authorized by the department before the effective date of this act. After the effective date of this act, the department may grant variances from the representations made in a dispensing organization's application for approval pursuant to subsection (8). For purposes of the definition of the term "marijuana" in s. 29, of Art. X of the State Constitution, an MMTC is deemed to be a dispensing organization as that term is defined in former s. 381.986(1)(a), Florida Statutes 2014. Authorize the establishment of five dispensing organizations to ensure reasonable statewide accessibility and availability as necessary for patients registered in the compassionate use registry and who are ordered low-THC cannabis, medical cannabis, or a cannabis delivery device under this section, one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida.

(d) By October 3, 2017, register five additional MMTCs with at least one of the MMTCs being an applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011), and a member of the Black Farmers and Agriculturalists Association.

(e) Within 6 months after each instance of the registration of 75,000 qualifying patients with the compassionate use registry, register four additional MMTCs if a sufficient number

588-03368A-17

2017406c1

of MMTC applicants meet the registration requirements established in this section and by department rule.

(f) Not issue more than one registration as an MMTC to a person or an entity.

(g) ~~The department shall~~ Develop an application form for registration as an MMTC and impose an initial application and biennial renewal fee that is sufficient to cover the costs of administering this section. To be registered as an MMTC, the an applicant ~~for approval as a dispensing organization~~ must be able to demonstrate:

1. That the applicant has been registered to do business in this state for the previous 5 consecutive years before submitting the application.

2.1- The technical and technological ability to cultivate and produce low-THC cannabis and marijuana. ~~The applicant must possess a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131 that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman as defined in s. 581.011, and have been operated as a registered nursery in this state for at least 30 continuous years.~~

3.2- The ability to secure the premises, resources, and personnel necessary to operate as an MMTC a dispensing organization.

4.3- The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

5.4- An infrastructure reasonably located to dispense low-

588-03368A-17

2017406c1

THC cannabis and marijuana to registered qualifying patients statewide ~~or regionally as determined by the department.~~

6.5- The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financials to the department. Upon approval, the applicant must post a \$5 million performance bond. However, upon ~~an MMTC a dispensing organization's~~ serving at least 1,000 qualifying ~~qualified~~ patients, the MMTC dispensing organization is only required to maintain a \$2 million performance bond.

7.6- That all owners and managers have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04.

8.7- The employment of a medical director to supervise the activities of the MMTC dispensing organization.

(e) ~~Upon the registration of 250,000 active qualified patients in the compassionate use registry, approve three dispensing organizations, including, but not limited to, an applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In Re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011), and a member of the Black Farmers and Agriculturalists Association, which must meet the requirements of subparagraphs (b)2.-7. and demonstrate the technical and technological ability to cultivate and produce low-THC cannabis.~~

(h)(d) ~~Allow an MMTC a dispensing organization to make a wholesale purchase of marijuana low-THC cannabis or medical cannabis from, or a distribution of marijuana low-THC cannabis or medical cannabis to, another MMTC dispensing organization.~~

(i)(e) Monitor physician registration in the compassionate

588-03368A-17

2017406c1

use registry and the issuance of physician certifications pursuant to subsection (3) ~~ordering of low-THC cannabis, medical cannabis, or a cannabis delivery device for ordering practices that could facilitate unlawful diversion or misuse of marijuana low-THC cannabis, medical cannabis, or a cannabis delivery devices device~~ and take disciplinary action as indicated.

~~(8)(6) MEDICAL MARIJUANA TREATMENT CENTERS DISPENSING ORGANIZATION.~~ Each MMTC must register with the department. A registered MMTC An approved dispensing organization must, at all times, maintain compliance with paragraph (7)(g), the criteria demonstrated for selection and approval as a dispensing organization under subsection(5) and the criteria required in this subsection, and all representations made to the department in the MMTC's application for registration. Upon request, the department may grant an MMTC one or more variances from the representations made in the MMTC's application. Consideration of such a variance shall be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting MMTC can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application.

(a) When growing marijuana ~~low-THC cannabis or medical cannabis, an MMTC a dispensing organization:~~

1. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human

588-03368A-17

2017406c1

consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

2. Must grow marijuana ~~low-THC cannabis or medical cannabis~~ within an enclosed structure and in a room separate from any other plant.

3. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state, notify the Department of Agriculture and Consumer Services within 10 calendar days after a determination that a plant is infested or infected by such plant pest, and implement and maintain phytosanitary policies and procedures.

4. Must perform fumigation or treatment of plants, or the removal and destruction of infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

(b) When processing marijuana ~~low-THC cannabis or medical cannabis, an MMTC a dispensing organization~~ must:

1. Process the marijuana ~~low-THC cannabis or medical cannabis~~ within an enclosed structure and in a room separate from other plants or products.

2. Have the marijuana tested by an independent testing laboratory to ensure it meets the standards established by the department's quality control program ~~Test the processed low-THC cannabis and medical cannabis before it is they are dispensed. Results must be verified and signed by two dispensing organization employees. Before dispensing low-THC cannabis, the dispensing organization must determine that the test results indicate that the low-THC cannabis meets the definition of low-THC cannabis and, for medical cannabis and low-THC cannabis, that all medical cannabis and low-THC cannabis is safe for human~~

588-03368A-17

2017406c1

consumption and free from contaminants that are unsafe for human consumption. The dispensing organization must retain records of all testing and samples of each homogenous batch of cannabis and low-THC cannabis for at least 9 months. The dispensing organization must contract with an independent testing laboratory to perform audits on the dispensing organization's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the low-THC cannabis or medical cannabis meets the requirements of this section and that the medical cannabis and low-THC cannabis is safe for human consumption.

3. Package the marijuana low-THC cannabis or medical cannabis in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

4. Package the marijuana low-THC cannabis or medical cannabis in a childproof receptacle that has a firmly affixed and legible label stating the following information:

a. A statement that the marijuana low-THC cannabis or medical cannabis meets the requirements of subparagraph 2.;

b. The name of the MMTC dispensing organization from which the marijuana medical cannabis or low-THC cannabis originates; and

c. The batch number and harvest number from which the marijuana medical cannabis or low-THC cannabis originates; and

d. The concentration of tetrahydrocannabinol and cannabidiol in the product.

e. Any other information required by department rule

5. ~~Reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of testing~~

588-03368A-17

2017406c1

pursuant to the audit required under subparagraph 2.

(c) When dispensing marijuana low-THC cannabis, medical cannabis, or a marijuana cannabis delivery device, an MMTC a dispensing organization:

1. May not dispense more than the ~~a 45 day~~ supply of marijuana authorized by a qualifying patient's physician certification low-THC cannabis or medical cannabis to a qualifying patient or caregiver the patient's legal representative.

2. Must ensure that the have the dispensing organization's employee who dispenses the marijuana low-THC cannabis, medical cannabis, or marijuana a cannabis delivery device enters enter into the compassionate use registry his or her name or unique employee identifier.

3. Must verify that the qualifying patient and the caregiver, if applicable, both have an active and valid compassionate use registry identification card and that the amount and type of marijuana dispensed match the physician certification in the compassionate use registry for that qualifying patient that a physician has ordered the low-THC cannabis, medical cannabis, or a specific type of a cannabis delivery device for the patient.

4. Must label the marijuana with the recommended dose for the qualifying patient receiving the marijuana.

5.4. May not dispense or sell any other type of marijuana cannabis, alcohol, or illicit drug-related product, including pipes, bongs, or wrapping papers, other than a physician-ordered cannabis delivery device required for the medical use of marijuana which is specified in a physician certification low-

588-03368A-17

2017406c1

~~THC cannabis or medical cannabis, while dispensing low-THC cannabis or medical cannabis. An MMTC may produce and dispense marijuana as an edible or food product but may not produce such items in a format designed to be attractive to children. In addition to the requirements of this section and department rule, food products produced by an MMTC must meet all food safety standards established in state and federal law, including, but not limited to, the identification of the serving size and the amount of tetrahydrocannabinol in each serving.~~

5. Must verify that the patient has an active registration in the compassionate use registry, ~~the patient or patient's legal representative holds a valid and active registration card, the order presented matches the order contents as recorded in the registry, and the order has not already been filled.~~

6. Must, upon dispensing the marijuana low-THC cannabis, medical cannabis, or marijuana cannabis delivery device, record in the registry the date, time, quantity, and form of marijuana low-THC cannabis or medical cannabis dispensed; ~~and the type of marijuana cannabis~~ delivery device dispensed; and the name and compassionate use registry identification number of the qualifying patient or caregiver to whom the marijuana delivery device was dispensed.

(d) To ensure the safety and security of its premises and any off-site storage facilities, and to maintain adequate controls against the diversion, theft, and loss of marijuana low-THC cannabis, medical cannabis, or marijuana cannabis delivery devices, ~~an MMTC a dispensing organization~~ shall:

1.a. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is

588-03368A-17

2017406c1

equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms; or

b. Maintain a video surveillance system that records continuously 24 hours each day and meets at least one of the following criteria:

(I) Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms;

(II) Cameras are fixed in entrances and exits to the premises, which shall record from both indoor and outdoor, or ingress and egress, vantage points;

(III) Recorded images must clearly and accurately display the time and date; or

(IV) Retain video surveillance recordings for a minimum of 45 days, or longer upon the request of a law enforcement agency.

2. Ensure that the MMTC's organization's outdoor premises have sufficient lighting from dusk until dawn.

3. Implement ~~Establish and maintain~~ a tracking system using a vendor approved by the department ~~which that~~ traces the marijuana low-THC cannabis or medical cannabis from seed to sale. The tracking system ~~must shall~~ include notification of key events as determined by the department, including when cannabis seeds are planted, when cannabis plants are harvested and destroyed, and when marijuana low-THC cannabis or medical cannabis is transported, sold, stolen, diverted, or lost.

4. Not dispense from its premises marijuana low-THC cannabis, medical cannabis, or a cannabis delivery device

588-03368A-17

2017406c1

between the hours of 9 p.m. and 7 a.m., but may perform all other operations and deliver ~~marijuana low-THC cannabis and medical cannabis~~ to qualifying ~~qualified~~ patients 24 hours each day.

5. Store ~~marijuana low-THC cannabis or medical cannabis~~ in a secured, locked room or a vault.

6. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the premises at all times.

7. Require each employee or contractor to wear a photo identification badge at all times while on the premises.

8. Require each visitor to wear a visitor's pass at all times while on the premises.

9. Implement an alcohol and drug-free workplace policy.

10. Report to local law enforcement within 24 hours after it is notified or becomes aware of the theft, diversion, or loss of ~~marijuana low-THC cannabis or medical cannabis~~.

(e) To ensure the safe transport of ~~marijuana low-THC cannabis or medical cannabis~~ to ~~MMTC dispensing organization~~ facilities, independent testing laboratories, or qualifying patients, the ~~MMTC dispensing organization~~ must:

1. Maintain a transportation manifest, which must be retained for at least 1 year. A copy of the manifest must be in the vehicle at all times when transporting marijuana.

2. Ensure only vehicles in good working order are used to transport ~~marijuana low-THC cannabis or medical cannabis~~.

3. Lock ~~marijuana low-THC cannabis or medical cannabis~~ in a separate compartment or container within the vehicle.

4. Require at least two persons to be in a vehicle

588-03368A-17

2017406c1

transporting ~~marijuana low-THC cannabis or medical cannabis~~, and require at least one person to remain in the vehicle while the ~~marijuana low-THC cannabis or medical cannabis~~ is being delivered.

5. Provide specific safety and security training to employees transporting or delivering ~~marijuana low-THC cannabis or medical cannabis~~.

(9) MARIJUANA QUALITY CONTROL PROGRAM AND INDEPENDENT TESTING LABORATORY LICENSURE.-

(a) The department shall establish a quality control program requiring marijuana to be tested by an independent testing laboratory for potency and contaminants before sale to qualifying patients and caregivers.

1. The quality control program must require MMTCs to submit samples from each batch or lot of marijuana harvested or processed to an independent testing laboratory for testing to ensure, at a minimum, that the labeling of the potency of tetrahydrocannabinol and all other marketed cannabinoids or terpenes is accurate and that the marijuana dispensed to qualifying patients is safe for human consumption.

2. An MMTC must maintain records of all tests conducted, including the results of each test and any additional information, as required by the department.

3. The department shall adopt all rules necessary to create and oversee the quality control program, which must include, at a minimum:

a. Permissible levels of variation in potency labeling and standards requiring tetrahydrocannabinol in edible marijuana products to be distributed consistently throughout the product;

588-03368A-17

2017406c1

929 b. Permissible levels of contaminants and mandatory testing
 930 for contaminants to confirm that the tested marijuana is safe
 931 for human consumption. This testing must include, but is not
 932 limited to, testing for microbiological impurity, residual
 933 solvents, and pesticide residues;
 934 c. The destruction of marijuana determined to be
 935 inaccurately labeled or unsafe for human consumption after the
 936 MMTC has an opportunity to take remedial action;
 937 d. The collection, storage, handling, recording, and
 938 destruction of samples of marijuana by independent testing
 939 laboratories; and
 940 e. Security, inventory tracking, and record retention.
 941 (b) The department must license all independent testing
 942 laboratories to ensure that all marijuana is tested for potency
 943 and contaminants in accordance with the department's quality
 944 control program. An independent testing laboratory may collect
 945 and accept samples of, and possess, store, transport, and test
 946 marijuana. An independent testing laboratory may not be owned by
 947 a person who also possesses an ownership interest in an MMTC. A
 948 clinical laboratory that is licensed by the Agency for Health
 949 Care Administration pursuant to part I of chapter 483 and that
 950 performs nonwaived clinical tests is exempt from the requirement
 951 to be licensed by the department pursuant to this paragraph but
 952 must be certified to perform all required tests pursuant to
 953 subparagraph 2.
 954 1. The department shall develop rules establishing
 955 independent testing laboratory license requirements and a
 956 process for licensing independent testing laboratories; develop
 957 an application form for an independent testing laboratory

588-03368A-17

2017406c1

958 license; and impose an initial application fee and a biennial
 959 renewal fee sufficient to cover the costs of administering this
 960 subsection.
 961 2. In addition to licensure, an independent testing
 962 laboratory must be certified to perform all required tests by
 963 the department. The department must issue a certification to an
 964 independent testing laboratory that has been certified by a
 965 third-party laboratory certification body approved by the
 966 department. The department shall establish reasonable rules for
 967 the certification and operation of independent testing
 968 laboratories. Rules for certification must, at a minimum,
 969 address standards relating to:
 970 a. Personnel qualifications;
 971 b. Equipment and methodology;
 972 c. Proficiency testing;
 973 d. Tracking;
 974 e. Sampling;
 975 f. Chain of custody;
 976 g. Record and sample retention;
 977 h. Reporting;
 978 i. Audit and inspection; and
 979 j. Security.
 980 3. The department shall suspend or reduce any mandatory
 981 testing requirement specified in its quality control program if
 982 the number of licensed and certified independent testing
 983 laboratories is insufficient to process the tests necessary to
 984 meet the patients' demand for marijuana.
 985 4. An independent testing laboratory may accept only
 986 samples composed of marijuana which are obtained from a sample

588-03368A-17

2017406c1

source approved by the department. At a minimum, these sources must include an MMTC, a researcher affiliated with an accredited university or research hospital, a qualifying patient, and a caregiver.

~~(10)(7)~~ DEPARTMENT AUTHORITY AND RESPONSIBILITIES.—

(a) The department may conduct announced or unannounced inspections of ~~MMTCs dispensing organizations~~ to determine compliance with this section or rules adopted pursuant to this section.

(b) The department shall inspect an MMTC ~~a dispensing organization~~ upon complaint or notice provided to the department that the MMTC dispensing organization has dispensed marijuana ~~low THC cannabis or medical cannabis~~ containing any mold, bacteria, or other contaminant that may cause or has caused an adverse effect to human health or the environment.

(c) The department shall conduct at least a biennial inspection of each MMTC ~~dispensing organization~~ to evaluate the MMTC's dispensing organization's records, personnel, equipment, processes, security measures, sanitation practices, and quality assurance practices.

(d) The department shall adopt by rule a process for approving changes in MMTC ownership or a change in an MMTC owner's investment interest. This process must include specific criteria for the approval or denial of an application for change of ownership or a change in investment interest and procedures for screening applicants' criminal and financial histories.

(e) The department shall establish, maintain, and control a computer software tracking system that traces marijuana from seed to sale and allows real-time, 24-hour access by the

588-03368A-17

2017406c1

department to data from all MMTCs and independent testing laboratories. The tracking system must, at a minimum, include notification of when marijuana seeds are planted, when marijuana plants are harvested and destroyed, and when marijuana is transported, sold, stolen, diverted, or lost. Each MMTC shall use the seed-to-sale tracking system selected by the department.

~~(f)(d)~~ The department may enter into interagency agreements with the Department of Agriculture and Consumer Services, the Department of Business and Professional Regulation, the Department of Transportation, the Department of Highway Safety and Motor Vehicles, and the Agency for Health Care Administration, and such agencies are authorized to enter into an interagency agreement with the department, to conduct inspections or perform other responsibilities assigned to the department under this section.

~~(g)(e)~~ The department must make a list of all approved MMTCs, ~~dispensing organizations and qualified ordering~~ physicians who are qualified to issue physician certifications, and medical directors publicly available on its website.

~~(f)~~ The department may establish a system for issuing and renewing registration cards for patients and their legal representatives, establish the circumstances under which the cards may be revoked by or must be returned to the department, and establish fees to implement such system. The department must require, at a minimum, the registration cards to:

1. Provide the name, address, and date of birth of the patient or legal representative.

2. Have a full face, passport type, color photograph of the patient or legal representative taken within the 90 days

588-03368A-17

2017406c1

1045 ~~immediately preceding registration.~~

1046 3. ~~Identify whether the cardholder is a patient or legal~~
 1047 ~~representative.~~

1048 4. ~~List a unique numeric identifier for the patient or~~
 1049 ~~legal representative that is matched to the identifier used for~~
 1050 ~~such person in the department's compassionate use registry.~~

1051 5. ~~Provide the expiration date, which shall be 1 year after~~
 1052 ~~the date of the physician's initial order of low-THC cannabis or~~
 1053 ~~medical cannabis.~~

1054 6. ~~For the legal representative, provide the name and~~
 1055 ~~unique numeric identifier of the patient that the legal~~
 1056 ~~representative is assisting.~~

1057 7. ~~Be resistant to counterfeiting or tampering.~~

1058 (h)(g) The department may impose reasonable fines not to
 1059 exceed \$10,000 on an MMTC a dispensing organization for any of
 1060 the following violations:

1061 1. Violating this section, s. 499.0295, or department rule.

1062 2. Failing to maintain qualifications for registration with
 1063 the department approval.

1064 3. Endangering the health, safety, or security of a
 1065 qualifying ~~qualified~~ patient.

1066 4. Improperly disclosing personal and confidential
 1067 information of a qualifying ~~the qualified~~ patient.

1068 5. Attempting to procure MMTC registration with the
 1069 department dispensing organization approval by bribery,
 1070 fraudulent misrepresentation, or extortion.

1071 6. Any owner or manager of the MMTC being convicted or
 1072 found guilty of, or entering a plea of guilty or nolo contendere
 1073 to, regardless of adjudication, a crime in any jurisdiction

588-03368A-17

2017406c1

1074 which directly relates to the business of an MMTC a dispensing
 1075 organization.

1076 7. Making or filing a report or record that the MMTC
 1077 ~~dispensing organization~~ knows to be false.

1078 8. Willfully failing to maintain a record required by this
 1079 section or department rule.

1080 9. Willfully impeding or obstructing an employee or agent
 1081 of the department in the furtherance of his or her official
 1082 duties.

1083 10. Engaging in fraud or deceit, negligence, incompetence,
 1084 or misconduct in the business practices of an MMTC a dispensing
 1085 organization.

1086 11. Making misleading, deceptive, or fraudulent
 1087 representations in or related to the business practices of an
 1088 MMTC a dispensing organization.

1089 12. Having a license or the authority to engage in any
 1090 regulated profession, occupation, or business that is related to
 1091 the business practices of an MMTC a dispensing organization
 1092 suspended, revoked, or otherwise acted against by the licensing
 1093 authority of any jurisdiction, including its agencies or
 1094 subdivisions, for a violation that would constitute a violation
 1095 under Florida law.

1096 13. Violating a lawful order of the department or an agency
 1097 of the state, or failing to comply with a lawfully issued
 1098 subpoena of the department or an agency of the state.

1099 (i)(h) The department may suspend, revoke, or refuse to
 1100 renew an MMTC's registration with the department a dispensing
 1101 organization's approval if the MMTC a dispensing organization
 1102 commits a violation specified ~~any of the violations~~ in paragraph

588-03368A-17

2017406c1

(h) ~~(g)~~.

~~(j)(i)~~ The department shall renew an MMTC's registration with the department ~~the approval of a dispensing organization~~ biennially if the MMTC dispensing organization meets the requirements of this section and pays the biennial renewal fee.

~~(k)(j)~~ The department may adopt rules necessary to implement this section.

~~(11)(8)~~ PREEMPTION.—

(a) All matters regarding the regulation of the cultivation and processing of marijuana medical cannabis or low-THC cannabis by MMTCs dispensing organizations are preempted to the state.

(b) A municipality may determine by ordinance the criteria for the number and location of, and other permitting requirements that do not conflict with state law or department rule for, dispensing facilities of MMTCs dispensing organizations located within its municipal boundaries. A county may determine by ordinance the criteria for the number, location, and other permitting requirements that do not conflict with state law or department rule for all dispensing facilities of MMTCs dispensing organizations located within the unincorporated areas of that county.

~~(12)(9)~~ EXCEPTIONS TO OTHER LAWS.—

(a) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, a qualifying qualified patient, or a caregiver who has obtained a valid compassionate use registry identification card from the department, and the qualified patient's legal representative may purchase from an MMTC, and possess for the qualifying patient's medical use, up to the amount of marijuana

588-03368A-17

2017406c1

in the physician certification low-THC cannabis or medical cannabis ordered for the patient, but not more than a 90-day 45-day supply, and a cannabis delivery device specified in the physician certification ordered for the qualifying patient.

(b) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an MMTC an approved dispensing organization and its owners, managers, contractors, and employees may manufacture, possess, sell, deliver, distribute, dispense, administer, and lawfully dispose of reasonable quantities, as established by department rule, of marijuana low-THC cannabis, medical cannabis, or a cannabis delivery device. For purposes of this subsection, the terms "manufacture," "possession," "deliver," "distribute," and "dispense" have the same meanings as provided in s. 893.02.

(c) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an approved independent testing laboratory may possess, test, transport, and lawfully dispose of marijuana low-THC cannabis or medical cannabis as provided by department rule.

(d) An MMTC approved dispensing organization and its owners, managers, contractors, and employees are not subject to licensure or regulation under chapter 465 or chapter 499 for manufacturing, possessing, selling, delivering, distributing, dispensing, or lawfully disposing of reasonable quantities, as established by department rule, of marijuana low-THC cannabis, medical cannabis, or a cannabis delivery device.

(e) Exercise by an MMTC of An approved dispensing organization that continues to meet the requirements for

588-03368A-17

2017406c1

1161 ~~approval is presumed to be registered with the department and to~~
 1162 ~~meet the regulations adopted by the department or its successor~~
 1163 ~~agency for the purpose of dispensing medical cannabis or low-THC~~
 1164 ~~cannabis under Florida law. Additionally, the authority provided~~
 1165 ~~to MMTCs a dispensing organization in s. 499.0295 does not~~
 1166 ~~impair its registration with the department the approval of a~~
 1167 ~~dispensing organization.~~

1168 (f) This subsection does not exempt a person from
 1169 prosecution for a criminal offense related to impairment or
 1170 intoxication resulting from the medical use of marijuana low-THC
 1171 ~~cannabis or medical cannabis~~ or relieve a person from any
 1172 requirement under law to submit to a breath, blood, urine, or
 1173 other test to detect the presence of a controlled substance.

1174 (g) This section does not limit the ability of an employer
 1175 to establish, continue, or enforce a drug-free workplace program
 1176 or substance abuse policy. Notwithstanding any other provision
 1177 of law, this section does not require an employer to accommodate
 1178 the ingestion of marijuana in any workplace or any employee
 1179 working while under the influence of marijuana. Notwithstanding
 1180 any other provision of law, this section does not create a cause
 1181 of action against an employer for wrongful discharge or
 1182 discrimination.

1183 (h) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or
 1184 any other provision of law, but subject to the requirements of
 1185 this section, a research institute established by a public
 1186 postsecondary educational institution, such as the H. Lee
 1187 Moffitt Cancer Center and Research Institute established under
 1188 s. 1004.43, or a state university that has achieved the
 1189 preeminent state research university designation pursuant to s.

588-03368A-17

2017406c1

1190 1001.7065 may possess, test, transport, and lawfully dispose of
 1191 marijuana for research purposes as provided by department rule.

1192 (13) RULEMAKING.—

1193 (a) The department and the applicable boards shall adopt
 1194 emergency rules pursuant to s. 120.54(4) and this subsection
 1195 necessary to implement this section. If an emergency rule
 1196 adopted under this subsection is held to be unconstitutional or
 1197 an invalid exercise of delegated legislative authority and
 1198 becomes void, the department and the applicable boards may adopt
 1199 an emergency rule to replace the rule that has become void. If
 1200 the emergency rule adopted to replace the void emergency rule is
 1201 also held to be unconstitutional or an invalid exercise of
 1202 delegated legislative authority and becomes void, the department
 1203 and the applicable boards must follow the nonemergency
 1204 rulemaking procedures of the Administrative Procedures Act to
 1205 replace the rule that has become void.

1206 (b) For emergency rules adopted under this subsection, the
 1207 department and the applicable boards need not make the findings
 1208 required by s. 120.54(4)(a). Emergency rules adopted under this
 1209 subsection are exempt from ss. 120.54(3)(b) and 120.541. The
 1210 department and the applicable boards shall meet the procedural
 1211 requirements in s. 120.54(2)(a) if the department or the
 1212 applicable boards have, before the effective date of this act,
 1213 held any public workshops or hearings on the subject matter of
 1214 emergency rules adopted under this subsection. Challenges to
 1215 emergency rules adopted under this subsection are subject to the
 1216 time schedules provided in s. 120.56(5).

1217 (c) Emergency rules adopted under this section are exempt
 1218 from s. 120.54(4)(c) and shall remain in effect until replaced

588-03368A-17

2017406c1

by rules adopted under the nonemergency rulemaking procedures of the Administrative Procedures Act. By January 1, 2018, the department and the applicable boards shall initiate nonemergency rulemaking pursuant to the Administrative Procedures Act by publishing a notice of rule development in the Florida Administrative Register. Except as provided in paragraph (a), after January 1, 2018, the department and applicable boards may not adopt rules pursuant to the emergency rulemaking procedures provided in this subsection.

Section 2. Section 1004.4351, Florida Statutes, is created to read:

1004.4351 Medical marijuana research and education.-

(1) SHORT TITLE.-This section shall be known and may be cited as the "Medical Marijuana Research and Education Act."

(2) LEGISLATIVE FINDINGS.-The Legislature finds that:

(a) The present state of knowledge concerning the use of marijuana to alleviate pain and treat illnesses is limited because permission to perform clinical studies on marijuana is difficult to obtain, with access to research-grade marijuana so restricted that little or no unbiased studies have been performed.

(b) Under the State Constitution, marijuana is available for the treatment of certain debilitating medical conditions.

(c) Additional clinical studies are needed to ensure that the residents of this state obtain the correct dosing, formulation, route, modality, frequency, quantity, and quality of marijuana for specific illnesses.

(d) An effective medical marijuana research and education program would mobilize the scientific, educational, and medical

588-03368A-17

2017406c1

resources that presently exist in this state to determine the appropriate and best use of marijuana to treat illness.

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

(a) "Board" means the Medical Marijuana Research and Education Board.

(b) "Coalition" means the Coalition for Medical Marijuana Research and Education.

(c) "Marijuana" has the same meaning as provided in s. 29, Art. X of the State Constitution.

(4) COALITION FOR MEDICAL MARIJUANA RESEARCH AND EDUCATION.-

(a) There is established within the H. Lee Moffitt Cancer Center and Research Institute, Inc., the Coalition for Medical Marijuana Research and Education. The purpose of the coalition is to conduct rigorous scientific research, provide education, disseminate research, and guide policy for the adoption of a statewide policy on ordering and dosing practices for the medicinal use of marijuana. The coalition shall be physically located at the H. Lee Moffitt Cancer Center and Research Institute, Inc.

(b) The Medical Marijuana Research and Education Board is established to direct the operations of the coalition. The board shall be composed of seven members appointed by the chief executive officer of the H. Lee Moffitt Cancer Center and Research Institute, Inc. Board members must have experience in a variety of scientific and medical fields, including, but not limited to, oncology, neurology, psychology, pediatrics, nutrition, and addiction. Members shall be appointed to 4-year terms and may be reappointed to serve additional terms. The

588-03368A-17

2017406c1

chair shall be elected by the board from among its members to serve a 2-year term. The board shall meet no less than semiannually, at the call of the chair or, in his or her absence or incapacity, the vice chair. Four members constitute a quorum. A majority vote of the members present is required for all actions of the board. The board may prescribe, amend, and repeal a charter governing the manner in which it conducts its business. A board member shall serve without compensation but is entitled to be reimbursed for travel expenses by the coalition or the organization he or she represents in accordance with s. 112.061.

(c) The coalition shall be administered by a coalition director, who shall be appointed by and serve at the pleasure of the board. The coalition director shall, subject to the approval of the board:

1. Propose a budget for the coalition.
2. Foster the collaboration of scientists, researchers, and other appropriate personnel in accordance with the coalition's charter.
3. Identify and prioritize the research to be conducted by the coalition.
4. Prepare the Medical Marijuana Research and Education Plan for submission to the board.
5. Apply for grants to obtain funding for research conducted by the coalition.
6. Perform other duties as determined by the board.

(d) The board shall advise the Board of Governors, the State Surgeon General, the Governor, and the Legislature with respect to medical marijuana research and education in this

588-03368A-17

2017406c1

state. The board shall explore methods of implementing and enforcing medical marijuana laws in relation to cancer control, research, treatment, and education.

(e) The board shall annually adopt a plan for medical marijuana research, known as the "Medical Marijuana Research and Education Plan," which must be in accordance with state law and coordinate with existing programs in this state. The plan must include recommendations for the coordination and integration of medical, nursing, paramedical, community, and other resources connected with the treatment of debilitating medical conditions, research related to the treatment of such medical conditions, and education.

(f) By February 15 of each year, the board shall issue a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on research projects, community outreach initiatives, and future plans for the coalition.

(5) RESPONSIBILITIES OF THE H. LEE MOFFITT CANCER CENTER AND RESEARCH INSTITUTE, INC.—The H. Lee Moffitt Cancer Center and Research Institute, Inc., shall allocate staff and provide information and assistance, as the coalition's budget permits, to assist the board in fulfilling its responsibilities.

Section 3. Paragraph (b) of subsection (3) of section 381.987, Florida Statutes, is amended to read:

381.987 Public records exemption for personal identifying information in the compassionate use registry.—

(3) The department shall allow access to the registry, including access to confidential and exempt information, to:

- (b) A medical marijuana treatment center registered with

588-03368A-17

2017406c1

dispensing organization approved by the department pursuant to s. 381.986 which is attempting to verify the authenticity of a physician certification ~~physician's order~~ for marijuana low-THC cannabis, including whether the physician certification order had been previously filled and whether the physician certification order was written for the person attempting to have it filled.

Section 4. Subsection (1) of section 385.211, Florida Statutes, is amended to read:

385.211 Refractory and intractable epilepsy treatment and research at recognized medical centers.—

(1) As used in this section, the term "low-THC cannabis" means "low-THC cannabis" as defined in s. 381.986 which that is dispensed only from a medical marijuana treatment center dispensing organization as defined in s. 381.986.

Section 5. Present paragraphs (b) and (c) of subsection (2) of section 499.0295, Florida Statutes, are redesignated as paragraphs (a) and (b), respectively, present paragraphs (a) and (c) of that subsection are amended, a new paragraph (c) is added to that subsection, and subsection (3) of that section is amended, to read:

499.0295 Experimental treatments for terminal conditions.—

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

~~(a) "Dispensing organization" means an organization approved by the Department of Health under s. 381.986(5) to cultivate, process, transport, and dispense low-THC cannabis, medical cannabis, and cannabis delivery devices.~~

(b)(c) "Investigational drug, biological product, or device" means:

588-03368A-17

2017406c1

1. A drug, biological product, or device that has successfully completed phase 1 of a clinical trial but has not been approved for general use by the United States Food and Drug Administration and remains under investigation in a clinical trial approved by the United States Food and Drug Administration; or

2. Marijuana Medical cannabis that is manufactured and sold by an MMTC a dispensing organization.

(c) "Medical marijuana treatment center" or "MMTC" means an organization registered with the Department of Health under s. 381.986.

(3) Upon the request of an eligible patient, a manufacturer may, or upon the issuance of a physician certification a physician's order pursuant to s. 381.986, an MMTC a dispensing organization may:

(a) Make its investigational drug, biological product, or device available under this section.

(b) Provide an investigational drug, biological product, device, or cannabis delivery device as defined in s. 381.986 to an eligible patient without receiving compensation.

(c) Require an eligible patient to pay the costs of, or the costs associated with, the manufacture of the investigational drug, biological product, device, or cannabis delivery device as defined in s. 381.986.

Section 6. Subsection (1) of section 1004.441, Florida Statutes, is amended to read:

1004.441 Refractory and intractable epilepsy treatment and research.—

(1) As used in this section, the term "low-THC cannabis"

588-03368A-17

2017406c1

1393 means "low-THC cannabis" as defined in s. 381.986 which ~~that~~ is
1394 dispensed only from a medical marijuana treatment center
1395 ~~dispensing organization~~ as defined in s. 381.986.

1396 Section 7. The Division of Law Revision and Information is
1397 directed to replace the phrase "the effective date of this act"
1398 wherever it occurs in this act with the date the act becomes a
1399 law.

1400 Section 8. This act shall take effect upon becoming a law.

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 510

INTRODUCER: Health Policy Committee and Senator Gainer and others

SUBJECT: Grant Program for Rural Hospitals

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van	Stovall	HP	Fav/CS
2.	Loe	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 510 establishes the Florida Rural Hospital Capital Improvement Competitive Grant Program to award funds of up to \$750,000, subject to an appropriation, to eligible rural hospitals through a competitive grant application process. The competitive grant program replaces the Rural Hospital Capital Improvement Grant Program that has not received an appropriation since Fiscal Year 2008-2009.

The competitive grant program will be administered by the Department of Health (DOH). The funds may only be used for the purchase of hospital and medical equipment or infrastructure improvements. To be eligible for grant funds a rural hospital must demonstrate that:

- Grant funds are necessary to maintain or improve the quality of its health care services;
- Grant funds will result in a return on investment to the taxpayers of this state; and
- A satisfactory record-keeping system exists for grant expenditures.

The bill requires DOH to develop criteria for scoring and ranking grant applicants, including:

- The social and economic benefit to the surrounding community;
- The promotion of economic development in the surrounding community;
- The expansion of available services to the underserved populations in the community; and
- The availability of private or public matching funds, or in-kind contributions, for the requested grant funds.

The DOH is required to submit an annual report to the Governor and the Legislature pertaining to grants awarded under the program.

The bill has an indeterminate fiscal impact and is subject to an appropriation. SB 2500, the Senate General Appropriations Act for Fiscal Year 2017-2018, includes an appropriation to implement the competitive grant program established by the bill.

The bill takes effect upon becoming a law.

II. Present Situation:

In 1999, the Legislature enacted s. 395.6061, F.S., to establish a rural hospital capital improvement grant program, in furtherance of its finding that rural hospitals were the nucleus or “backbone” of rural health care systems.¹ The program is a mechanism for rural hospitals to apply for grant funds from the DOH if funds are appropriated for this purpose. Upon application to the DOH, each rural hospital must receive a minimum of \$100,000 annually, if funds are available, for projects to acquire, repair, improve, or upgrade systems, facilities, or equipment.

Section 395.602, F.S., defines a “rural hospital” as a licensed, acute care hospital having 100 or fewer licensed beds, and an emergency room, which is:

- The sole provider in a county with a population density no greater than 100 persons per square mile;
- In a county with a population density no greater than 100 persons per square mile, and at least 30 minutes travel time from another acute care hospital in the same county;
- Supported by a tax district or sub-district whose boundaries encompass a population no greater than 100 persons per square mile;
- Classified by the Centers for Medicare and Medicaid Services (CMS) as a sole community hospital;²
- A hospital with a service area³ that has a population no greater than 100 persons per square mile; or

¹ See s. 395.602(1), F.S.

² A *sole community hospital* is defined by 42 C.F.R. s. 412.92, as a hospital located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

- No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;
- The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or
- Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

³ *Service area* means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the Agency for Health Care Administration. See s. 408.07 (43)(d), F.S.

- A critical access hospital.⁴

As of January 30, 2017, Florida has 28 rural hospitals.⁵

The rural hospital grant program application must include the following:

- A description of the problem to be solved with the grant funds;
- The strategy proposed to resolve the problem;
- The organizational structure, financial system, and facilities that are essential to the proposed solution;
- The projected longevity of the proposed solution after the grant funds are expended;
- Evidence of participation in a rural health network;⁶
- Evidence that the rural hospital has difficulty in obtaining funding or that funds available for the proposed solution are inadequate;
- Evidence that the grant funds will assist in maintaining or returning the hospital to an economically stable condition or will involve innovative alternatives for discontinued services;
- Evidence of a satisfactory record-keeping system to account for grant fund expenditures within the rural county; and
- A rural health network plan that includes a description of how the plan was developed, the goals of the plan, the links with existing health care providers under the plan, indicators quantifying the hospital's financial well-being, measurable outcome targets, and the current physical and operational condition of the hospital.

Under s. 395.6061, F.S., any rural hospital that completes an application to DOH that contains the above criteria shall receive a minimum of \$100,000. The DOH must consider any information submitted in a grant application to determine eligibility and the amount of the award. None of the individual items in the application by itself may be used to deny grant eligibility.

In administering this grant program, the DOH is required to establish, by rule, criteria for awarding grants for any remaining funds available after each eligible applicant is awarded a minimum of \$100,000. The additional awards must be used exclusively for the support and assistance of rural hospitals. Criteria shall include:

- The level of uncompensated care rendered by the hospital;
- Participation in a rural health network; and
- The proposed use of the grant by the rural hospital to resolve a specific problem.

⁴ A *Critical Access Hospital* is a small rural hospital of 25 beds or less that is reimbursed for 101 percent of the cost of providing services to Medicare patients as a means to stabilize and improve access to hospital care in rural areas. A critical access hospital must provide emergency, outpatient, and limited inpatient services 24 hours a day, and must meet other requirements to support the services provided. The Centers for Medicare and Medicaid Services designates which hospitals are critical access hospitals. See s. 408.07(15), F.S. and Agency for Health Care Administration, *Special Designations*, available at: <http://www.floridahealthfinder.gov/about-ahca/facility-locator-glossary.aspx#topic9> (last viewed Feb. 15, 2017).

⁵ Florida Department of Health, Programs and Services, Rural Health, *Florida Rural Hospital Directory*, available at: <http://www.floridahealth.gov/programs-and-services/community-health/rural-health/index.html>, (last viewed Feb. 15, 2017).

⁶ A *rural health network* is a non-profit legal entity, consisting of rural and urban health care providers, organized to plan and deliver health care services on a competitive basis in a rural area. See s. 381.0406, F.S.

The Rural Hospital Capital Improvement Fund last received an appropriation of \$3 million in nonrecurring funds from the Administrative Trust Fund in the Fiscal Year 2008-2009 General Appropriations Act. The DOH currently has no staff dedicated to this program.⁷

III. Effect of Proposed Changes:

The bill amends s. 395.6061, F.S., declaring that rural hospitals have a limited ability to increase operating revenues, or access other sources of public or private funding, that are needed to replace or maintain high-cost medical equipment, or improve infrastructure. This inability to access alternative funding sources places rural patients' access to quality health care at risk.

The bill requires the DOH to establish and administer the Florida Rural Hospital Capital Improvement Competitive Grant Program and repeals the Rural Hospital Capital Improvement Grant Program. Eligible rural hospitals may apply for grants up to \$750,000, subject to legislative appropriation. In order to be eligible for a grant, a rural hospital must demonstrate that:

- Grant funds are necessary to maintain or improve the quality of its health care services;
- There is a return on investment to the taxpayers of this state; and
- A satisfactory record-keeping system exists for grant expenditures.

The DOH is required to establish, by rule, a competitive grant application process and determine criteria to score and rank applications. The criteria must include, at a minimum:

- The social and economic benefit to the surrounding community;
- The promotion of economic development in the surrounding community;
- The expansion of available services to the underserved populations in the community; and
- The availability of private or public matching funds, or in-kind contributions, for the requested grant funds.

Grant funds are restricted to equipment purchases or facility infrastructure improvements in the rural hospital's service area.

The DOH must provide an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes the list of grantees and, for each grantee, includes:

- The amount awarded;
- A brief description detailing what the funds will be used for;
- The anticipated outcomes to be achieved; and
- The return on investment to the taxpayers of this state

The bill takes effect upon becoming a law.

⁷ Email from Paul Runk, Legislative Planning Director, Florida Department of Health (Feb. 14, 2017) (on file with the Senate Committee on Health Policy).

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

Contingent upon an appropriation, there are currently 28 rural hospitals that could participate in the competitive grant program established by the bill. A rural hospital could receive a grant award up to \$750,000.

C. Government Sector Impact:

The bill has an indeterminate fiscal impact and is subject to an appropriation. SB 2500, the Senate General Appropriations Act for Fiscal Year 2017-2018, includes an appropriation to implement the competitive grant program established by the bill. The DOH would incur costs for additional workload to implement and administer the program; however, due to the grant program being subject to an appropriation, it is unknown at this time whether the additional workload could be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not specify a due date for submitting the annual report.

VIII. Statutes Affected:

This bill substantially amends section 395.6061 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.)

CS by Health Policy on February 21, 2017:

The CS adds the requirement for the applicant to demonstrate that a record-keeping system exists for grant expenditures in order to be eligible to compete for a grant award. The CS also removes preferences for grant award decision making, and specifies minimum criteria the DOH is to use in scoring and ranking applicants.

- B. **Amendments:**

None.

By the Committee on Health Policy; and Senators Gainer and Montford

588-01939-17

2017510c1

A bill to be entitled

An act relating to a grant program for rural hospitals; amending s. 395.6061, F.S.; providing legislative findings and intent; requiring the Department of Health to establish and administer the Florida Rural Hospital Capital Improvement Competitive Grant Program for certain rural hospitals; revising the amount of a grant award; revising grant eligibility; providing criteria for grant application ranking; establishing allowable use of funds; requiring the department to submit an annual report to the Governor and the Legislature; deleting requirements for certain information in grant applications; deleting provisions relating to the disbursement of funds; providing an effective date.

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

Section 1. Section 395.6061, Florida Statutes, is amended to read:

395.6061 Rural hospital capital improvement.—

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that rural hospitals have limited ability to increase operating revenues or to access other public or private funding sources that are needed to maintain critical infrastructure, including, but not limited to, the replacement of high-cost medical care equipment or improvements to facility infrastructure. Rural hospitals that do not have reasonable access to alternative sources of revenue to pay for critical infrastructure needs are

588-01939-17

2017510c1

at risk, and patient access, care, and quality are threatened. Therefore, the Legislature finds that it is necessary to establish the Florida Rural Hospital Capital Improvement Competitive Grant Program for eligible rural hospitals to ensure their sustainability.

(2) FLORIDA RURAL HOSPITAL CAPITAL IMPROVEMENT COMPETITIVE GRANT PROGRAM.—The Department of Health shall establish and administer the Florida Rural Hospital Capital Improvement Competitive Grant Program for rural hospitals. Subject to annual appropriation, the department shall establish grant awards up to \$750,000 for each hospital that meets the eligibility requirements in subsection (3). Grants must be made available to eligible rural hospitals based on the competitive grant program and on criteria established by the department.

(3) GRANT ELIGIBILITY.—In order to be eligible for a grant award, a hospital must be a rural hospital, as defined in s. 395.602, and must demonstrate that:

(a) Grant funds are necessary to maintain or improve the quality of its health care services;

(b) There is a return on investment to the taxpayers of this state; and

(c) A satisfactory recordkeeping system will be in place to account for the expenditures of grant funds within the rural county.

(4) AWARD OF GRANTS.—The department shall establish by rule a grant application process and criteria for the evaluation of applications. The department shall score and rank grant applications based on criteria that must include, at a minimum, the following:

588-01939-17

2017510c1

59 (a) The social and economic benefit to the surrounding
 60 community.
 61 (b) The promotion of economic development in the
 62 surrounding community.
 63 (c) The expansion of available services to the underserved
 64 populations in the community.
 65 (d) The availability of private or public matching funds,
 66 or in-kind contributions, for the requested grant funds.
 67 (5) ALLOWABLE USES OF FUNDS.—Grant awards may be used only
 68 for hospital medical equipment purchases or facility
 69 infrastructure improvements in the rural area serviced by the
 70 grantee.
 71 (6) REPORT.—The department shall provide an annual report
 72 to the Governor, the President of the Senate, and the Speaker of
 73 the House of Representatives which includes the list of grantees
 74 and, for each grantee, the amount awarded, a brief description
 75 detailling what the funds will be used for, the anticipated
 76 outcomes to be achieved, and the return on investment to the
 77 taxpayers of this state. There is established a rural hospital
 78 capital improvement grant program.
 79 ~~(1) A rural hospital as defined in s. 395.602 may apply to~~
 80 ~~the department for a grant. The grant application must provide~~
 81 ~~information that includes:~~
 82 ~~(a) A statement indicating the problem the rural hospital~~
 83 ~~proposes to solve with the grant funds;~~
 84 ~~(b) The strategy proposed to resolve the problem;~~
 85 ~~(c) The organizational structure, financial system, and~~
 86 ~~facilities that are essential to the proposed solution;~~
 87 ~~(d) The projected longevity of the proposed solution after~~

588-01939-17

2017510c1

88 ~~the grant funds are expended;~~
 89 ~~(e) Evidence of participation in a rural health network as~~
 90 ~~defined in s. 381.0406;~~
 91 ~~(f) Evidence that the rural hospital has difficulty in~~
 92 ~~obtaining funding or that funds available for the proposed~~
 93 ~~solution are inadequate;~~
 94 ~~(g) Evidence that the grant funds will assist in~~
 95 ~~maintaining or returning the hospital to an economically stable~~
 96 ~~condition or that any plan for closure or realignment of~~
 97 ~~services will involve development of innovative alternatives for~~
 98 ~~the discontinued services;~~
 99 ~~(h) Evidence of a satisfactory record keeping system to~~
 100 ~~account for grant fund expenditures within the rural county;~~
 101 ~~(i) A rural health network plan that includes a description~~
 102 ~~of how the plan was developed, the goals of the plan, the links~~
 103 ~~with existing health care providers under the plan, indicators~~
 104 ~~quantifying the hospital's financial well-being, measurable~~
 105 ~~outcome targets, and the current physical and operational~~
 106 ~~condition of the hospital.~~
 107 ~~(2) Each rural hospital as defined in s. 395.602 shall~~
 108 ~~receive a minimum of \$100,000 annually, subject to legislative~~
 109 ~~appropriation, upon application to the Department of Health, for~~
 110 ~~projects to acquire, repair, improve, or upgrade systems,~~
 111 ~~facilities, or equipment.~~
 112 ~~(3) Any remaining funds shall annually be disbursed to~~
 113 ~~rural hospitals in accordance with this section. The Department~~
 114 ~~of Health shall establish, by rule, criteria for awarding grants~~
 115 ~~for any remaining funds, which must be used exclusively for the~~
 116 ~~support and assistance of rural hospitals as defined in s.~~

588-01939-17

2017510c1

~~395.602, including criteria relating to the level of
uncompensated care rendered by the hospital, the participation
in a rural health network as defined in s. 381.0406, and the
proposed use of the grant by the rural hospital to resolve a
specific problem. The department must consider any information
submitted in an application for the grants in accordance with
subsection (1) in determining eligibility for and the amount of
the grant, and none of the individual items of information by
itself may be used to deny grant eligibility.~~

~~(4) The department shall ensure that the funds are used
solely for the purposes specified in this section. The total
grants awarded pursuant to this section shall not exceed the
amount appropriated for this program.~~

Section 2. This act shall take effect upon becoming a law.

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 732

INTRODUCER: Health Policy Committee and Senator Steube

SUBJECT: Physician Assistant Workforce Surveys

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	Fav/CS
2.	Loe	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 732 requires a physician assistant (PA) to complete a workforce survey as part of his or her biannual licensure renewal under chapter 458 or 459, F.S. The Department of Health (DOH) must report the data collected from the PA workforce surveys to the Board of Medicine and the Board of Osteopathic Medicine every two years.

The fiscal impact of the bill is indeterminate; however, any costs incurred by the DOH related to additional workload should be absorbed within existing resources.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Physician Assistants

Chapter 458, F.S., sets forth the provisions for the regulation of the practice of allopathic medicine by the Board of Medicine (BOM). Chapter 459, F.S., sets forth the provisions for the regulation of the practice of osteopathic medicine by the Board of Osteopathic Medicine (BOOM). PAs are regulated by either the BOM or the BOOM, as applicable.

PAs are trained and required by statute to work under the supervision and control of allopathic physicians or osteopathic physicians.¹ The BOM and the BOOM have adopted rules that set out the general principles a supervising physician must use in developing the scope of practice of the PA under both direct² and indirect³ supervision. These principles are required to recognize the diversity of both specialty and practice settings in which PAs are employed.⁴

PAs may perform services delegated by a supervising physician in accordance with the PA's education and training unless expressly prohibited under ch. 458, F.S., ch. 459, F.S., or by rules adopted under either chapter.⁵ A supervising physician's decision to permit a PA to perform a task or procedure under direct or indirect supervision must be based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient. The supervising physician must be certain that the PA is knowledgeable and skilled in performing the tasks and procedures assigned.⁶ Each physician or group of physicians supervising a licensed PA must be qualified in the medical areas in which the PA is to practice and must be individually and collectively liable for the acts and omissions of the PA.⁷

Licensure of PAs is overseen jointly by the BOM and BOOM through the Council on Physician Assistants. Licensure as a PA requires that the individual:

- Is at least 18 years of age;
- Has passed a proficiency examination with an acceptable score established by the National Commission on Certification of Physician Assistants (NCCPA);⁸
- Has completed the DOH application form, remitted an application fee, and included the following:
 - A certificate of completion of a BOM or BOOM approved PA program;
 - Acknowledgment of any prior felony convictions;
 - Acknowledgement of any revocations or denials of licensure in any state; and
 - A copy of PA training course descriptions and transcripts in pharmacotherapy, if prescribing privileges are desired.⁹

Renewal of a PA's license is biennial and contingent upon completion of a certain type and quantity of continuing medical education requirements. A PA with delegated prescribing authority must submit a signed affidavit that he or she has completed a minimum of ten

¹ Sections 458.347(4) and 459.022(4), F.S.

² "Direct supervision" requires the physician to be on the premises and immediately available. (See Rules 64B8-30.001(4) and 64B15-6.001(4), F.A.C.).

³ "Indirect supervision" refers to the easy availability of the supervising physician to the PA, which includes the ability to communicate by telecommunications, and requires the physician to be within reasonable physical proximity. (See Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.)

⁴ Sections 458.347(4)(a) and 459.002(4)(a), F.S.

⁵ Section 458.347(4)(h) and 459.022(4)(g), F.S.

⁶ Rules 64B8-30.012(2) and 64B15-6.010(2), F.A.C.

⁷ Sections 458.347(3) and 459.022(3), F.S.

⁸ If an applicant does not hold a current certificate issued by the NCCPA, and has not actively practiced within the immediately preceding four years, the applicant must retake and successfully complete the entry-level examination of the NCCPA to be eligible for licensure.

⁹ Sections 458.347(7)(a) and 459.022(7)(a), F.S.

continuing medical education hours in the specialty practice in which the PA has prescriptive privileges.¹⁰

Physician Workforce Surveys

There is currently no statutory requirement for the DOH to develop or administer, or for a PA to complete, a survey before he or she can renew a license. However, physicians licensed under the same chapters as PAs are required to complete a survey at licensure renewal.¹¹ The DOH may issue a nondisciplinary citation if the physician does not complete the survey at least 90 days after renewal. The citation must notify the physician that his or her license will not be renewed in any subsequent renewal period unless the survey is completed.¹²

III. Effect of Proposed Changes:

PA Workforce Survey as a Renewal Requirement

The bill requires a PA, as a condition of licensure renewal, to complete a workforce survey, which will be administered in the same manner as the physician's survey,¹³ and must contain the following:¹⁴

1. Licensee information, including, but not limited to:
 - Frequency and geographic location of practice within the state;
 - Practice setting;
 - Percentage of time spent in direct patient care;
 - Anticipated change to license or practice status; and
 - Areas of specialty or certification.
2. Availability and trends relating to critically needed services, including, but not limited to:
 - Obstetric care and services, including incidents of deliveries;
 - Radiological services, particularly performance of mammograms and breast-imaging services;
 - Physician services for hospital emergency departments and trauma centers, including on-call hours; and
 - Other critically needed specialty areas as determined by the department.

The information submitted must include a statement that the information provided is true and accurate to the best of the PA's knowledge and the submission does not contain any knowingly false information.¹⁵

The bill requires the DOH to administer the PA survey in the same manner as the physician survey. Accordingly, the DOH must:

¹⁰ Section 458.347(4)(e)3., F.S., and s. 459.022(4)(e)3., F.S.

¹¹ See s. 458.3191, F.S.

¹² Sections 458.3191 and 459.0081, F.S.

¹³ See sections 458. 319 and 459.0081, F.S.

¹⁴ *Id.*

¹⁵ *Id.*

- Include in PA licensure renewals a notice that the PA survey must be completed prior to renewal of the license, and that the DOH may not renew the license until the survey is completed;
- Issue a nondisciplinary citation to PAs who do not complete the survey within 90 days after filing an application for renewal; and
- Include in the nondisciplinary citation notice that the PA's license will not be renewed unless the survey is completed.

Beginning July 1, 2018, and every two years thereafter, the DOH must report the survey data to the BOM and BOOM. The DOH has been granted rulemaking authority to implement the survey process.

The effective date of the bill is July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The fiscal impact of the bill is indeterminate; however, any costs incurred by the DOH related to additional workload should be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill requires PAs licensed under chapter 458 and 459, F.S., to provide personal identifying information without making that information confidential and exempt from disclosure. A public records exemption exists for records containing personal identifying information that the DOH receives in response to the mandatory workforce survey for physicians.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.347 and 459.022.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

CS by Health Policy on April 3, 2017

The CS:

- Deletes specific components of a PA survey, and instead requires the PA workforce survey to contain the same information required by physicians and be administered in the same manner;
- Deletes reference to designated supervising physician or PAs; and
- Deletes changes to the composition of the Council on Physician Assistants.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Steube

588-03384-17

2017732c1

A bill to be entitled

An act relating to physician assistant workforce surveys; amending ss. 458.347 and 459.022, F.S.; requiring that a physician assistant license renewal include the submission of a physician assistant workforce survey; requiring the Department of Health to report the data collected from such surveys to the boards; providing rulemaking authority; providing an effective date.

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

Section 1. Paragraph (b) of subsection (7) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(7) PHYSICIAN ASSISTANT LICENSURE.—

(b)1. The license must be renewed biennially. Each renewal must include:

a.1- A renewal fee not to exceed \$500 as set by the boards.

b.2- Acknowledgment of no felony convictions in the previous 2 years.

c. A completed physician assistant workforce survey, which shall be administered in the same manner as the physician survey established in s. 458.3191 and must contain the same information required in s. 458.3191(1) and (2).

2. Beginning July 1, 2018, and every 2 years thereafter, the department shall report the data collected from the physician assistant workforce surveys to the boards.

3. The department shall adopt rules to implement this

588-03384-17

2017732c1

paragraph.

Section 2. Paragraph (b) of subsection (7) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(7) PHYSICIAN ASSISTANT LICENSURE.—

(b)1. The licensure must be renewed biennially. Each renewal must include:

a.1- A renewal fee not to exceed \$500 as set by the boards.

b.2- Acknowledgment of no felony convictions in the previous 2 years.

c. A completed physician assistant workforce survey, which shall be administered in the same manner as the physician survey established in s. 459.0081 and must contain the same information required in s. 459.0081(1) and (2).

2. Beginning July 1, 2018, and every 2 years thereafter, the department shall report the data collected from the physician assistant workforce surveys to the boards.

3. The department shall adopt rules to implement this paragraph.

Section 3. This act shall take effect upon becoming a law.

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 780

INTRODUCER: Education Committee and Senator Stargel

SUBJECT: Adoption Benefits

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Androff	Graf	ED	Fav/CS
2.	Sneed	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 780 expands the definition of qualifying adoptive employee to include full-time or part-time employees of charter schools and the Florida Virtual School (FLVS) for the purpose of extending to the employees of such schools the benefits that are currently available to qualifying adoptive employees of state agencies. The State Employee Adoption Benefit Program administered through the Department of Children and Families (DCF) allows qualifying employees who adopt a child from the child welfare system to receive a one-time benefit of \$5,000, or \$10,000 for the adoption of a child with special needs. The bill also provides that charter and FLVS employees who were employees of charter schools or FLVS on or after July 1, 2015 that adopted a child from DCF during that time may retroactively apply for the adoption benefit.

The State Employee Adoption Benefit Program has a \$2.75 million recurring appropriation from the General Revenue Fund. The annual cost to expand participation in the program to charter school and FLVS employees is currently indeterminate. If funding is insufficient to absorb the increased number of participants, applicants may reapply for the adoption benefit payments the following year.

The bill takes effect July 1, 2017.

II. Present Situation:

In Florida, the Department of Children and Families (DCF) provides child welfare services.¹ Florida law requires that child welfare services, including adoption services, be delivered through community-based care (CBC) lead agencies contracted by DCF.² For example, CBCs provide pre- and post-adoption services and administer maintenance adoption subsidies that provide ongoing financial support for children adopted from the foster care system.

The State Employee Adoption Incentive Program

The State Employee Adoption Incentive Program (Program) was reenacted in July 1, 2015.³ The original program, enacted in 2000,⁴ was repealed in 2010.⁵ The program was designed to increase the number of adoptions in Florida by offering an incentive to certain state employees and other applicants.⁶ The program provides a lump-sum benefit payment for the adoption of a child within the child welfare system (\$5,000), and a higher benefit amount for adoptions of children with special needs within the child welfare system (\$10,000).⁷

The program is currently available to both full and part-time employees of a state agency who are paid from regular salary appropriations.⁸ A “qualifying adoptive employee” includes individuals who are regular, and not temporary, employees of:⁹

- A branch, department, or agency of state government for which the Chief Financial Officer processes payroll requisitions;
- A state university or Florida College System institution as defined in law;
- A school district unit as defined in law;
- A water management district as defined in law;
- The Florida School for the Deaf and Blind (limited to instructional personnel as defined in law).

The receipt of a benefit payment through the program does not preclude the employee from receiving adoption assistance under any other state program.¹⁰ The program’s capacity is limited by the amount of funds appropriated for the program.¹¹ Payments under the program are based

¹ Section 20.19(4)(a)3., F.S.

² Section 409.986(1), F.S.

³ Section 6, ch. 2015-130, L.O.F.

⁴ Section 1, ch. 2000-241, L.O.F.

⁵ Chapter 2010-158, L.O.F.

⁶ Chapter 2010-158, L.O.F. Currently the following applicants who adopt a child within the child welfare system after July 1, 2015 are eligible for the program: full or part-time employees of the state (Executive, Legislative and Judicial Branches, including the Department of the Lottery), the state universities, community colleges, school districts, water management districts and instructional personnel employed by the Florida School for the Deaf and Blind, provided the employee is paid from regular salary appropriations (not OPS or otherwise “temporary” or casual labor). In state fiscal year 2015-2016, 139 applicants received the State Employee Adoption Incentive benefit. Florida Department of Children and Family, *SB 780 Analysis* (2014), at 2.

⁷ Section 409.1664, F.S. Section 409.166(2)(a), F.S. defines a special needs child for purposes of the State Employee Adoption Incentive Program.

⁸ Section 409.1664(1)(b), F.S.

⁹ *Id.* at (1)(c).

¹⁰ *Id.* at (4).

¹¹ *Id.* at (2)(c).

solely on the employment relationship between the employed individual and the employing state entity.

Charter Schools

Charter schools are nonsectarian, public schools that operate under a performance contract with a sponsor. The performance contract is known as a “charter.”¹² One of the guiding principles of charter schools is to “meet high standards of student achievement while providing parents the flexibility to choose among diverse educational opportunities within the state’s public school system.”¹³

The Florida Virtual School

The Florida Virtual School (FLVS) was established for the development and delivery of online and distance learning education.¹⁴ The mission of the FLVS is to provide students with technology-based educational opportunities to gain the knowledge and the skills necessary to succeed.¹⁵ The FLVS is a fully accredited public school choice providing elementary, middle, and high school curriculum to Florida residents for free. All courses are provided online.¹⁶

III. Effect of Proposed Changes:

CS/SB 780 expands the definition of qualifying adoptive employee to include a full-time or part-time employee of a charter school and the Florida Virtual School (FLVS) for the purpose of extending to the employees of such schools the benefits specified in law for qualifying adoptive employees of state agencies. Extending the state employee adoption benefit to additional employees may increase the number of children adopted from the foster care system in Florida.

The bill also provides that a qualifying adoptive employee of a charter school and the FLVS may retroactively apply for the adoption benefit under certain conditions. The employee may apply for retroactive benefits if he or she was employed by a charter school or the FLVS at the time of the adoption of a child from the child welfare system and if the adoption occurred on or after July 1, 2015. Authorizing retroactive adoption benefits may provide financial support to qualifying adoptive employees of charter schools and the FLVS who have adopted a child under these circumstances.

The bill takes effect July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

¹² Section 1002.33(5)(a), (6)(h), (7) and (9)(a), F.S.

¹³ *Id.* at (2)(a)1.

¹⁴ Section 1002.37(1)(a), F.S.

¹⁵ *Id.* at (b).

¹⁶ Florida Virtual School, *Accreditation*, <https://www.flvs.net/meet-flvs/accreditation> (last visited March 20, 2017).

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under the bill, private individuals who are employed by a charter school or the FLVS who adopt a child from the Department of Children and Families (DCF) and meet the guidelines of the State Employee Adoption Benefit program may receive \$5,000 for a non-special needs child or \$10,000 for a special needs child.¹⁷

C. Government Sector Impact:

DCF receives annual recurring funding of \$2.75 million for the State Employee Adoption Benefit Program. Program award payments of \$1,469,145 were made in Fiscal Year 2015-2016 to 139 applicants. Applications for benefits must be submitted to DCF during an “open enrollment” period (March 1 through April 30). Although the FY 2016-2017 open enrollment period is currently underway, the department reported that a total of 182 applications have been received as of April 12, 2017. A full accounting of the benefit payment information for FY 2016-2017 will not be available until open enrollment ends on April 30. Based on prior year expenditures, the applications received to date could total approximately \$1.9 million.

The additional adoption benefits to expand participation to charter school and FLVS employees is indeterminate.

Adoption award payments are disbursed to qualified applicants on a first-come, first served basis. If sufficient funding is not available to pay an eligible applicant, the applicant may reapply for the adoption benefit the following year.

VI. Technical Deficiencies:

None.

¹⁷ Florida Department of Children and Family, *SB 780 Analysis* (2014), at 3.

VII. Related Issues:

Section 215.425, F.S., relates to the prohibition on extra compensation claims, bonuses, and severance pay for state employees. Subsection (1) stipulates that no extra compensation shall be made to any officer, agent, employee, or contractor after the service has been rendered or the contract made, nor shall any money be appropriated or paid on any claim the subject matter of which has not been provided for by preexisting laws, unless such compensation or claim is allowed by a law enacted by two-thirds of the members elected to each house of the Legislature. Given these statutory restrictions, the retroactive payment provisions of this bill may require a two-thirds vote of the Legislature in order to withstand a challenge under this statute.

VIII. Statutes Affected:

This bill substantially amends section 409.1664 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.)

CS by Education on March 21, 2017:

The committee substitute revises the definition of qualifying adoptive employee to include employees of charter schools and the Florida Virtual School (FLVS) for purposes of the State Employee Adoption Incentive Program. The committee substitute also authorizes qualifying employees of charter schools and the FLVS to apply for retroactive benefits under the program.

- B. **Amendments:**

None.

By the Committee on Education; and Senator Stargel

581-02685-17

2017780c1

A bill to be entitled

An act relating to adoption benefits; amending s. 409.1664, F.S.; revising the definition of the term "qualifying adoptive employee" to include persons employed by charter schools and the Florida Virtual School for the purpose of extending adoption benefits to those employees; authorizing such employees of charter schools and the Florida Virtual School to apply retroactively for the adoption benefit in certain circumstances; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1) and subsections (3) and (7) of section 409.1664, Florida Statutes, are amended, and paragraph (d) is added to subsection (2) of that section, to read:

409.1664 Adoption benefits for qualifying adoptive employees of state agencies.—

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

(b) "Qualifying adoptive employee" means a full-time or part-time employee of a state agency, a charter school as defined in s. 1002.33, or the Florida Virtual School established under s. 1002.37 who is paid from regular salary appropriations, or otherwise meets his or her ~~the state agency~~ employer's definition of a regular rather than temporary employee, and who adopts a child within the child welfare system pursuant to chapter 63 on or after July 1, 2015. The term includes instructional personnel, as defined in s. 1012.01, who are

Page 1 of 3

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

581-02685-17

2017780c1

employed by the Florida School for the Deaf and the Blind.

(2) A qualifying adoptive employee who adopts a child within the child welfare system who has special needs described in s. 409.166(2)(a)2. is eligible to receive a lump-sum monetary benefit in the amount of \$10,000 per such child, subject to applicable taxes. A qualifying adoptive employee who adopts a child within the child welfare system who does not have special needs described in s. 409.166(2)(a)2. is eligible to receive a lump-sum monetary benefit in the amount of \$5,000 per such child, subject to applicable taxes.

(d) A qualifying adoptive employee of a charter school or the Florida Virtual School may retroactively apply for the adoption benefit if he or she was employed by a charter school or the Florida Virtual School at the time of the adoption of a child from the child welfare system pursuant to chapter 63 and the adoption occurred on or after July 1, 2015.

(3) A qualifying adoptive employee must apply to his or her agency head or, in the case of an employee of a charter school or the Florida Virtual School, to the school director to obtain the monetary benefit provided in subsection (2). Applications must be on forms approved by the department and must include a certified copy of the final order of adoption naming the applicant as the adoptive parent. Monetary benefits shall be approved on a first-come, first-served basis based upon the date that each fully completed application is received by the department.

(7) The Chief Financial Officer shall disburse a monetary benefit to a qualifying adoptive employee upon the department's submission of a payroll requisition. The Chief Financial Officer

Page 2 of 3

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

581-02685-17

2017780c1

59 shall transfer funds from the department to a state university,
60 Florida College System institution, school district unit,
61 charter school, the Florida Virtual School, or water management
62 district, as appropriate, to enable payment to the qualifying
63 adoptive employee through the payroll systems as long as funds
64 are available for such purpose.

65 Section 2. This act shall take effect July 1, 2017.

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 804

INTRODUCER: Health Policy Committee and Senator Brandes

SUBJECT: Electronic Health Records

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Looke</u>	<u>Stovall</u>	<u>HP</u>	Fav/CS
2.	<u>Jones</u>	<u>Miller</u>	<u>TR</u>	Favorable
3.	<u>Forbes</u>	<u>Williams</u>	<u>AHS</u>	Pre-meeting
4.	_____	_____	<u>AP</u>	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 804 allows a patient, or the patient's health care surrogate or proxy, to donate the patient's electronic health records (EHR) and qualified electronic health records (QEHR)¹ to an approved² medical or dental school; college; university; hospital; or repository that collects, stores, and shares de-identified electronic health records with the public. The health records may be used for the purposes of educating or developing diagnoses, treatment choices, policies, health care system designs, and innovations in order to improve health outcomes and reduce health care costs.

To implement the provisions of this bill, the Agency for Health Care Administration will incur costs of \$438,000 annually and the Department of Highway Safety and Motor Vehicles will incur insignificant new costs.

The effective date of the bill is July 1, 2017.

¹ As defined in s. 408.051, F.S.

² By the Department of Health (DOH).

II. Present Situation:

The Florida Electronic Health Records Exchange Act

Section 408.051, F.S., establishes the Florida Health Records Exchange Act. The act requires a healthcare provider that receives an authorization form containing a request for the release of an identifiable health record to accept the form as a valid authorization to release the record.³ Any release of health information after the receipt of an authorization form completed and submitted as prescribed by the Agency for Health Care Administration (AHCA) creates a rebuttable presumption that the release was appropriate.⁴ For the purposes of the act, the term:

- “Electronic health record” means 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;⁵ and
- “Qualified electronic health record” means an electronic record of health-related information concerning an individual which includes patient demographic and clinical health information, such as medical history and problem lists, and which has the capacity to provide clinical decision support, to support physician order entry, to capture and query information relevant to health care quality, and to exchange electronic health information with, and integrate such information from, other sources.⁶

In addition to the provisions contained within the Florida Electronic Health Records Exchange Act, s. 408.062(5), F.S., requires the AHCA to develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the Authorization for Release of Protected Health Information

The HIPAA privacy rule is a federal rule that restricts the use and disclosure of individuals’ health information — called “protected health information”⁷ (PHI) by organizations subject to the Privacy Rule — called “covered entities,”⁸ as well as standards for individuals’ privacy rights to understand and control how their health information is used.⁹ In general, HIPAA grants an individual the right to access his or her own PHI. Included within this right is the right to:

- Ask to see and get a copy the individual’s own health records from most doctors, hospitals, and other health care providers;

³ Section 408.051(4)(c), F.S.

⁴ Section 408.051(4)(e), F.S.; however, pursuant to s. 408.051(4)(d), F.S., the use of the form adopted by the AHCA is not required to authorize release of protected health information.

⁵ Section 408.051(2)(a), F.S.

⁶ Section 408.051(2)(b), F.S.

⁷ Protected health information is all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

⁸ In general, covered entities are health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA.

⁹ U.S. Department of Health and Human Services, Health Information Privacy, *Summary of HIPAA Privacy Rule*, <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/> (last visited Mar. 8, 2017)

- Get either a paper or electronic copy, if the records are kept electronically, of the health records; and
- Have a copy of the records sent to someone else.¹⁰

HIPAA and De-Identified Health Information

For the purposes of HIPAA, protected health information is information, including demographic information, which relates to:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Protected health information includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above.

However, information that is not individually identifiable to a particular patient is not considered PHI and, therefore is not covered by HIPAA. For example, a health plan report that only noted the average age of health plan members was 45 years would not be PHI because that information, although developed by aggregating information from individual plan member records, does not identify any individual plan members and there is no reasonable basis to believe that it could be used to identify an individual.¹¹

Potential Rationale for Donation of Electronic Health Records

In addition to pure research related to specific medical conditions, recently, new technologies have been developed that are able to scan large amounts of data and apply the results to individual medical decisions. For example, IBM has begun using its computing system, Watson, within the healthcare field. IBM states that Watson's applications extend over many health fields including genomics, drug discovery, health patient engagement, oncology, and care management.¹² Watson is able to store significant amounts of data, analyze it, and find patterns and meaning within the data much quicker and more efficiently than any human. The abilities of Watson, and other computing systems like it, will be further enhanced by the availability of large amounts of data with which to work. Donating EHR and QEHR could help these future technologies become more effective in providing better overall outcomes within the healthcare system.

¹⁰ Message from Jocelyn Samuels, Director, Office of Civil Rights, U.S. Department of Health and Human Services, *Right to Access* (September 28, 2015) <https://www.hhs.gov/sites/default/files/righttoaccessmemo.pdf>, (last visited Mar. 3, 2017).

¹¹ U.S. Department of Health and Human Services, Health Information Privacy, *Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule* <https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#protected> (last visited Mar. 8, 2017).

¹² See IBM Watson Health, <https://www.ibm.com/watson/health/> (last visited Mar. 8, 2017).

Organ Donation Encouragement Program

Following direction from the Legislature¹³, the Department of Highway Safety and Motor Vehicles (DHSMV) and AHCA implemented a system to encourage potential donors of anatomical gifts (organ donors) through the process of issuing and renewing driver licenses or identification cards. The DHSMV includes “Organ Donor” notations on identification cards, driver licenses, and driver records to indicate an individual’s intent to be a donor. Donor registration cards are distributed by the DHSMV, with necessary supplies and forms provided by AHCA. The DHSMV is responsible for providing the necessary recordkeeping system. Additionally, the DHSMV is required to maintain an integrated link on its website referring individuals conducting business on the site to the donor registry.¹⁴ Approximately 98 percent of people who enroll in Florida’s registry do so while obtaining or renewing a driver license.¹⁵

III. Effect of Proposed Changes:

The bill amends ch. 765, F.S., relating to health care advance directives, to allow a patient, or the patient’s health care surrogate or proxy, to donate the patient’s Electronic Health Records (HER) and Qualified Electronic Health Records (QEHR)¹⁶ to an approved¹⁷ medical or dental school, college, university, hospital, or repository that collects, stores, and shares de-identified electronic health records with the public. The bill authorizes the donation of EHR and QEHR after the patient’s death.

Donations of EHR and QEHR by the Patient

Section 2 creates s. 765.114, F.S., to specify that a person may donate all or part of his or her EHR or QEHR by:

- Signing an EHR donor card;
- Indicating an intent to donate on his or her driver license or identification card issued by the DHSMV;
- Expressing the wish to donate in a living will or other advance directive;
- Expressing the wish to donate in a will;¹⁸ or
- Expressing a wish to donate in another document that has been signed by the donor (or his or her designee) and two witnesses.

This section provides a standard form that may be used to indicate the wish to donate EHR and QEHR.

De-identified EHR may be given to one or more donees that are accredited medical or dental schools, colleges, universities, hospitals, or repositories for the purpose of educating or

¹³ See Section 765.521, F.S.,

¹⁴ Section 765.521(2), F.S.

¹⁵ Donate Life Florida 2015 *Annual Report*, available at https://www.donateliflorida.org/files/53_file.pdf at p. 12.

¹⁶ The bill references the definitions of EHR and QEHR in s. 408.051, F.S. (See Present Situation for definitions of these terms).

¹⁷ By the DOH.

¹⁸ The bill specifies that, when a wish to donate is expressed in a will, the donation becomes effective upon the death of the testator without entering probate and that the donation is considered valid if made in good faith even if the will is found to be invalid for testamentary purposes.

developing diagnoses, treatment choices, policies, health care system designs, and innovations to improve health outcomes and reduce health care costs. Donees must be approved by the DOH and may be specified by name. The bill specifies that identified information may be donated with the written consent of the donor.

Additionally, a person may revoke or amend the terms of a donation of EHR by:

- The execution and delivery to the donee of a signed statement witnessed by at least two adults, one of whom is a disinterested witness;
- An oral statement made in the presence of two adult witnesses, one of whom is not a family member. The statement must be communicated to the donor's family, or to the donor's attorney, or to the donee and the donee must have actual notice of the revocation;
- An oral statement communicated during a terminal illness or injury to the primary physician who must communicate the revocation of the gift to the medical or dental school, college, university, hospital, or repository.
- A signed document found on or about the donor's person;
- A later-executed document of donation which amends or revokes a previous health records donation; or
- The destruction or cancellation, with the intent to revoke the donation, of the document, or portion of the document, that indicates the intent to donate.

Donation of EHR and QEHR by the Patient's Health Care Surrogate or Proxy

Section 1 amends s. 765.101, F.S., to allow a patient's health care surrogate or proxy to donate the patient's EHR and QEHR. This section amends the definition of "health care decision" in s. 765.101, F.S., to include the right of the health care surrogate or proxy to donate the principal's EHR and QEHR upon the principal's death and amends the suggested form of designation of a health care surrogate in s. 765.203, F.S., to include the authorization for the health care surrogate to donate the principal's EHR and QEHR. This section requires that information donated by a health care surrogate be de-identified.

Donation Encouragement Program

Section 3 creates s. 765.1141, F.S., to require the AHCA and the DHSMV to develop and implement a program to encourage and authorize persons to donate EHR and QEHR as part of the process of issuing and renewing identification cards and driver licenses. Donor cards distributed by the DHSMV must include the information and signatures necessary to authorize the donation of EHR and may include any additional information determined necessary by the DHSMV.

This section also requires the DHSMV to develop and implement a program to identify donors including notations on their identification cards or driver licenses to clearly indicate their intent to donate their EHR. The AHCA is required to provide necessary supplies and forms using appropriated funds or contributions from interested voluntary, nonprofit organizations, and the DHSMV is required to provide the necessary recordkeeping system using appropriated funds. The DHSMV is also required to maintain a link on its webpage referring visitors renewing identification cards and driver licenses to an electronic health records repository, if such repository is available.

This section exempts the DHSMV and the AHCA from liability in connection with the performance of any act regarding these programs, and requires the DHSMV, after consultation and concurrence with the AHCA, to adopt rules to implement the programs.

Section 4 amends s. 765.203, F.S., to expand the designation of health care surrogate to include the grant of authority to donate EHI.

The bill establishes an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may have a minor negative fiscal impact on health care facilities that are required to de-identify and electronically transfer records pursuant to a donation as detailed in the bill.

C. Government Sector Impact:

Under the provisions of the bill the AHCA and the DHSMV will incur new costs related to the implementation of the donation encouragement program.

The AHCA estimates costs will increase by \$447,318 annually.¹⁹ Of the \$438,432 recurring costs, the AHCA estimates an annual cost of \$300,000 for the production of supplies and forms. The remainder of the recurring costs (\$138,432) to the agency are associated with employing two full-time program staff to facilitate outreach with the DHSMV and to conduct training and education at each of the state's 67 county tax collector offices, and travel costs.

¹⁹ AHCA, *Senate Bill 804 Analysis* (Feb. 14, 2017) (on file with the Senate Committee on Health Policy).

The DHSMV will incur costs to develop and implement the EHR donor program. The bill requires the agency to:

- Identify donors and include notations on their identification cards or driver licenses;
- Provide the necessary recordkeeping system; and
- Maintain a link on the DHSMV webpage referring visitors to electronic health records repositories.

The DHSMV estimates programming and implementation costs to note such election on a driver license record or identification card record and to maintain a link on the DHSMV webpage is approximately \$16,522. Other costs associated with notating the driver license or identification card to indicate such election, staffing, and actual recordkeeping are unknown.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 765.101 and 765.203 of the Florida Statutes.

This bill creates sections 765.114 and 765.1141 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.)

CS by Health Policy Committee on March 14, 2017:

The CS amends SB 804 to specify that identified EHR and QEHR may be donated with the written consent of the donor and to make other technical changes.

- B. **Amendments:**

None.



218290

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Between lines 312 and 313
insert:

Section 5. The Office of Program Policy Analysis and
Government Accountability (OPPAGA) shall conduct a study of
current federal and state efforts on, and available
opportunities for, the collecting, sharing, and donating of
electronic health records before or after a patient's death for
the advancement of medical science. OPPAGA shall identify



218290

11 available options regarding databases or repositories that will
12 allow for the collection and distribution of donated electronic
13 health records for the purpose of advancing the current state of
14 medicine, including any existing public or private databases or
15 repositories and any available opportunities for public or
16 private funding to establish such a database or repository.
17 OPPAGA shall also study the donation of electronic health
18 records to identify any existing state or federal legislation or
19 programs that allow such donations and to identify the benefits
20 of, and barriers to, establishing such programs in the state of
21 Florida. OPPAGA shall report its findings and recommendations
22 for an electronic health records donation process to the
23 President of the Senate and the Speaker of the House of
24 Representatives no later than December 1, 2017.

25
26 ===== T I T L E A M E N D M E N T =====

27 And the title is amended as follows:

28 Delete line 42

29 and insert:

30 surrogate; directing the Office of Program Policy
31 Analysis and Government Accountability (OPPAGA) to
32 conduct a study of current federal and state efforts
33 on, and available opportunities for, the collecting,
34 sharing, and donating certain electronic health
35 records for the advancement of medical science;
36 requiring OPPAGA to identify available options
37 regarding databases or repositories; directing OPPAGA
38 to identify any existing state or federal legislation
39 or programs that allow such donations and identify the



218290

40 benefits of, and barriers to, establishing such
41 programs in the state; requiring OPPAGA to report its
42 findings and recommendations to the Legislature by a
43 specified date; providing an effective date.

By the Committee on Health Policy; and Senator Brandes

588-02407-17

2017804c1

1 A bill to be entitled
 2 An act relating to electronic health records; amending
 3 s. 765.101, F.S.; redefining the terms "health care
 4 decision" and "incapacity" or "incompetent"; creating
 5 s. 765.114, F.S.; authorizing a person to donate his
 6 or her electronic health records, subject to certain
 7 requirements; authorizing electronic health records
 8 and qualified electronic health records to be donated
 9 to specified entities for specified purposes;
 10 providing a form for a uniform donor card; requiring
 11 electronic health records and qualified electronic
 12 health records donated by a health care surrogate or
 13 proxy to be de-identified; authorizing electronic
 14 health records and qualified electronic health records
 15 to contain a donor's identifying information under
 16 certain conditions; authorizing a donor to amend the
 17 terms or revoke an electronic health records donation
 18 in specified manners; creating s. 765.1141, F.S.;
 19 requiring the Agency for Health Care Administration
 20 and the Department of Highway Safety and Motor
 21 Vehicles to develop and implement a program that
 22 encourages and authorizes persons to donate electronic
 23 health records and qualified electronic health records
 24 as part of a process of issuing and renewing
 25 identification cards and driver licenses; requiring
 26 specified information to be included in the donor
 27 registration card distributed by the department;
 28 requiring the agency and the department to develop and
 29 implement a program to identify donors through

Page 1 of 11

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

588-02407-17

2017804c1

30 notations on identification cards and driver licenses;
 31 requiring the agency to provide certain supplies and
 32 forms, and the department to provide a recordkeeping
 33 system; prohibiting the department and agency from
 34 incurring liability in connection with the performance
 35 of certain acts; requiring the department to maintain
 36 a link on its website referring visitors to an
 37 electronic health records repository under certain
 38 circumstances; requiring rulemaking; amending s.
 39 765.203, F.S.; revising the suggested form for
 40 designation of a health care surrogate to expand
 41 health care decision authority of the health care
 42 surrogate; providing an effective date.

43
 44 Be It Enacted by the Legislature of the State of Florida:

45
 46 Section 1. Paragraph (e) is added to subsection (6) of
 47 section 765.101, Florida Statutes, and subsection (10) of that
 48 section is amended, to read:

49 765.101 Definitions.—As used in this chapter:

50 (6) "Health care decision" means:

51 (e) The right of a health care surrogate or proxy to donate
 52 the principal's electronic health records and qualified
 53 electronic health records, as defined in s. 408.051, upon the
 54 principal's death to an approved medical or dental school,
 55 college, university, hospital, or repository that collects,
 56 stores, and shares de-identified electronic health records in
 57 the public domain for purposes of educating or developing
 58 diagnoses, treatment choices, policies, health care system

Page 2 of 11

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

588-02407-17

2017804c1

designs, and innovations in order to improve health outcomes and reduce health care costs. For purposes of this paragraph, the term "approved" means approved by the Department of Health.

(10) "Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift or donating electronic health records or qualified electronic health records, the term also includes a patient who is deceased.

Section 2. Section 765.114, Florida Statutes, is created to read:

765.114 Donating electronic health records and qualified electronic health records.—

(1) A person may donate all or part of his or her electronic health records or qualified electronic health records by doing any of the following:

(a) Signing an electronic health records donor card.

(b) Indicating an intent to donate on his or her driver license or identification card issued by the Department of Highway Safety and Motor Vehicles. Revocation, suspension, expiration, or cancellation of the driver license or identification card does not invalidate the intent to donate.

(c) Expressing a wish to donate in a living will or other advance directive.

(d) Expressing a wish to donate in a will. The donation becomes effective upon the death of the testator without waiting for probate. If the will is not probated or if it is declared invalid for testamentary purposes, the donation is nevertheless valid to the extent that it has been acted upon in good faith.

588-02407-17

2017804c1

(e) Expressing a wish to donate in a document other than a will. The document must be signed by the donor in the presence of two adult witnesses, who must sign the document in the donor's presence. If the donor cannot sign, the document may be signed by another person at the donor's direction and in his or her presence and in the presence of two witnesses, who must sign the document in the donor's presence. Delivery of the document during the donor's lifetime is not necessary to make the intent to donate valid. The following form of written document is sufficient for any person to make a donation of electronic health records or qualified electronic health records for the purposes of this part:

UNIFORM ELECTRONIC HEALTH RECORDS DONOR CARD

The undersigned hereby makes this health records donation, to take effect on death. The words and marks below indicate my desires:

I give:

1. all electronic health records;

2. only the following electronic health records:

...[Specify the health records]...

for the purpose of medical research or education.

Signed by the donor and the following witnesses in the presence of each other:

...(Signature of donor).....(Date of birth of donor)...

...(Date signed).....(City and State)...

588-02407-17

2017804c1

117
118 ... (Witness) ...
119 ... (Address) ...

121 (2) The de-identified electronic health records or
122 qualified electronic health records may be given to one or more
123 donees that are accredited medical or dental schools, colleges,
124 universities, hospitals, or repositories for the purposes of
125 educating or developing diagnoses, treatment choices, policies,
126 health care system designs, and innovations to improve health
127 outcomes and reduce health care costs. Electronic health records
128 or qualified electronic health records with a donor's
129 identifying information may be given to a donee upon written
130 consent of the donor. The donees must be approved by the
131 Department of Health and may be specified by name.

132 (3) Any electronic health records or qualified electronic
133 health records donated by a health care surrogate or proxy
134 designated by the decedent pursuant to part II of this chapter
135 must be de-identified, unless the donee provides written consent
136 stating that his or her identifying information may be included
137 with such records, and such donation must be made by a document
138 signed by that person or made by that person's witnessed
139 telephonic discussion, telegraphic message, or other recorded
140 message.

141 (4) A donor may amend the terms of or revoke a donation of
142 electronic health records or qualified electronic health records
143 by any of the following means:

144 (a) The execution and delivery to the donee of a signed
145 statement witnessed by at least two adults, one of whom is a

588-02407-17

2017804c1

146 disinterested witness.

147 (b) An oral statement that is made in the presence of two
148 adult witnesses, one of whom is not a family member, and
149 communicated to the donor's family or attorney or to the donee.
150 An oral statement is effective only if the medical or dental
151 school, college, university, hospital, or repository has actual
152 notice of the oral amendment or revocation.

153 (c) An oral statement made during a terminal illness or
154 injury addressed to the primary physician, who must communicate
155 the revocation of the gift to the medical or dental school,
156 college, university, hospital, or repository.

157 (d) A signed document found on or about the donor's person.

158 (e) A later-executed document of donation which amends or
159 revokes a previous health records donation or portion of a
160 health records donation, either expressly or by inconsistency.

161 (f) The destruction or cancellation, with the intent to
162 revoke the donation, of the document that indicates the intent
163 to donate or the destruction or cancellation of that portion of
164 the document which indicates the intent to donate.

165 Section 3. Section 765.1141, Florida Statutes, is created
166 to read:

167 765.1141 Electronic health records donations as part of
168 driver license or identification card process.—

169 (1) The Agency for Health Care Administration and the
170 Department of Highway Safety and Motor Vehicles shall develop
171 and implement a program encouraging and authorizing persons to
172 donate electronic health records and qualified electronic health
173 records, as defined in s. 408.051, as a part of the process of
174 issuing and renewing identification cards and driver licenses.

588-02407-17

2017804c1

175 The donor registration card distributed by the department must
 176 include the information and signatures required in the uniform
 177 electronic health records donor card under s. 765.114(1)(e) and
 178 such additional information as determined necessary by the
 179 department. The department shall also develop and implement a
 180 program to identify donors which includes notations on
 181 identification cards and driver licenses to clearly indicate the
 182 individual's intent to donate his or her electronic health
 183 records. The agency shall provide the necessary supplies and
 184 forms using appropriated funds or contributions from interested
 185 voluntary, nonprofit organizations. The department shall provide
 186 the necessary recordkeeping system using appropriated funds. The
 187 department and the agency do not incur liability in connection
 188 with the performance of any act authorized in this section.

189 (2) The department shall maintain an integrated link on its
 190 website referring a visitor renewing an identification card or a
 191 driver license or conducting other business to an electronic
 192 health records repository if available.

193 (3) The department, after consultation with and concurrence
 194 by the agency, shall adopt rules to implement this section
 195 pursuant to chapter 120.

196 Section 4. Section 765.203, Florida Statutes, is amended to
 197 read:

198 765.203 Suggested form of designation.—A written
 199 designation of a health care surrogate executed pursuant to this
 200 chapter may, but need not be, in the following form:

201
 202 DESIGNATION OF HEALTH CARE SURROGATE
 203

588-02407-17

2017804c1

204 I, ...(name)..., designate as my health care surrogate under s.
 205 765.202, Florida Statutes:

206
 207 Name: ...(name of health care surrogate)...

208 Address: ...(address)...

209 Phone: ...(telephone)...

210
 211 If my health care surrogate is not willing, able, or reasonably
 212 available to perform his or her duties, I designate as my
 213 alternate health care surrogate:

214
 215 Name: ...(name of alternate health care surrogate)...

216 Address: ...(address)...

217 Phone: ...(telephone)...

218 INSTRUCTIONS FOR HEALTH CARE

220
 221 I authorize my health care surrogate to:

222 ...(Initial here)... Receive any of my health information,
 223 whether oral or recorded in any form or medium, that:

224 1. Is created or received by a health care provider, health
 225 care facility, health plan, public health authority, employer,
 226 life insurer, school or university, or health care
 227 clearinghouse; and

228 2. Relates to my past, present, or future physical or
 229 mental health or condition; the provision of health care to me;
 230 or the past, present, or future payment for the provision of
 231 health care to me.

232 I further authorize my health care surrogate to:

588-02407-17

2017804c1

233 ...(Initial here)... Make all health care decisions for me,
234 which means he or she has the authority to:
235 1. Provide informed consent, refusal of consent, or
236 withdrawal of consent to any and all of my health care,
237 including life-prolonging procedures.
238 2. Apply on my behalf for private, public, government, or
239 veterans' benefits to defray the cost of health care.
240 3. Access my health information reasonably necessary for
241 the health care surrogate to make decisions involving my health
242 care and to apply for benefits for me.
243 4. Decide to make an anatomical gift pursuant to part V of
244 chapter 765, Florida Statutes.
245 5. Donate my electronic health records and qualified
246 electronic health records, as defined in s. 408.051, Florida
247 Statutes, to one or more accredited medical or dental schools,
248 colleges, universities, hospitals, or repositories, approved by
249 the Department of Health, to share my de-identified health
250 records for purposes of developing diagnoses, treatment choices,
251 policies, health care system designs, and innovations to improve
252 health outcomes and reduce health care costs.
253 ...(Initial here)... Specific instructions and
254 restrictions:
255
256
257
258 While I have decisionmaking capacity, my wishes are controlling
259 and my physicians and health care providers must clearly
260 communicate to me the treatment plan or any change to the
261 treatment plan prior to its implementation.

588-02407-17

2017804c1

262
263 To the extent I am capable of understanding, my health care
264 surrogate shall keep me reasonably informed of all decisions
265 that he or she has made on my behalf and matters concerning me.
266
267 THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY
268 SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA
269 STATUTES.
270
271 PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT
272 I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND
273 THIS DESIGNATION BY:
274 (1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES
275 MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
276 (2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN
277 ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY
278 DIRECTION;
279 (3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE
280 THIS DESIGNATION; OR
281 (4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT
282 FROM THIS DESIGNATION.
283
284 MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY
285 PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN
286 HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE
287 FOLLOWING BOXES:
288
289 IF I INITIAL THIS BOX [...], MY HEALTH CARE SURROGATE'S
290 AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT

588-02407-17

2017804c1

291 IMMEDIATELY.

292

293 IF I INITIAL THIS BOX [...], MY HEALTH CARE SURROGATE'S
294 AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT
295 IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES,
296 ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER
297 VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE
298 ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE
299 THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

300

301 SIGNATURES: Sign and date the form here:

```
302 | ... (date) ...                               ... (sign your name) ...
```

```
303 | ... (address) ...
```

```
304 ... (city) ... (state) ...
```

305

306 | SIGNATURES OF WITNESSES:

307	First witness	Second witness

```
308    ... (print name) ...                                ... (print name) ...
```

```
309 | ... (address) ...
```

```
310      ... (city) ...  ... (state) ...           ... (city) ...  ... (state) ...
```

311 | ... (signature of witness) (signature of witness) ...

```
312 | ... (date) ...
```

313 Section 5. This act shall take effect July 1, 2017.

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 876

INTRODUCER: Health Policy Committee and Senator Young and others

SUBJECT: Programs for Impaired Health Care Practitioners

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	Fav/CS
2.	Loe	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 876 revises multiple statutory provisions relating to treatment programs for impaired health care providers. Primarily, it clarifies in law the roles and responsibilities of the parties involved in the program, including the Department of Health (DOH), consultant, evaluator, treatment provider, and impaired practitioner. The bill removes the current authority granted to the DOH to specify by rule the manner in which consultants must work with DOH in intervening, evaluating, treating, monitoring, providing continuing care, or expelling a professional from the program. This will now be governed by a contract between the DOH and each consultant. The bill defines certain terms relating to impaired practitioner programs, and provides that a licensee may report an impaired practitioner to a consultant who operates an impaired practitioner program, rather than to the DOH, under certain circumstances.

The bill authorizes DOH to issue or renew a license for an individual convicted of, or entered a plea of guilty or nolo contendere to, a disqualifying offense before July 1, 2009, when the licensure disqualification law was enacted. The bill authorizes DOH to issue or renew the license of an individual convicted of, or enters a plea of guilty or nolo contendere to, a disqualifying felony if the applicant successfully completes a pretrial diversion program and the plea has been withdrawn or the charges have been dismissed.

The bill has no impact on state revenues or expenditures.

The bill takes effect upon becoming a law.

II. Present Situation:

Treatment Programs for Impaired Practitioners

Section 456.076, F.S., provides resources to assist licensees¹ in health care professions² who are impaired as a result of the misuse or abuse of alcohol or drugs, or as a result of any mental or physical condition, which could affect the licensees' ability to practice with skill and safety.³ For professions that do not have impaired practitioner programs provided for them in their practice acts, the DOH designates approved impaired practitioner programs.

The DOH is required to retain one or more impaired practitioner consultants licensed under the jurisdiction of the Division of Medical Quality Assurance (MQA) within the DOH and who is a licensed physician or nurse; or an entity that employs a medical director who is a licensed physician, or an executive director who is a licensed nurse.

There are currently two department-approved treatment consultants for the impaired practitioner programs in Florida: the Professionals Resource Network (PRN) and the Intervention Project for Nurses (IPN).⁴

The PRN provides evaluations, treatment referrals, and monitoring for all health professions, except nursing and certified nursing assistants.^{5,6} The IPN provides these services to nurses and certified nursing assistants.⁷ These consultants initiate interventions, recommend evaluations, and refer impaired licensees to treatment programs or treatment providers approved by the DOH, and monitor the progress of impaired licensees. The PRN and IPN do not provide medical services. They act as liaisons between the DOH and approved treatment programs and providers. The DOH is not responsible for paying for the care provided by approved treatment providers or a consultant.

A medical school, nursing program, or other health professional school may also contract with the PRN or IPN to provide services to an enrolled student if the student is allegedly impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition.⁸

¹ Licensee is defined in s. 456.001(6), F.S., to include any permit, registration, certificate, or license, including a provisional license, issued by the DOH.

² Profession is defined in s. 456.001(7), F.S., to include any activity, occupation, profession, or vocation regulated by the DOH in the Division of MQA. *See also* s. 20.43(1)(g), F.S.

³ The provisions of s. 456.076, F.S., also apply to veterinarians under s. 474.221, F.S., and radiological personnel under s. 468.315, F.S.

⁴ *See* Professionals Resource Network, available at <http://www.flprn.org/> and <http://www.ipnfl.org/> (last visited Mar. 7, 2017).

⁵ Professionals Resource Network, *About Us*, available at <http://www.flprn.org/about> (last visited Mar. 9, 2017).

⁶ The PRN also provides evaluations, treatment referrals, and monitoring for harbor pilots and deputy harbor pilots regulated by the Board of Pilot Commissioners in the Department of Business and Professional Regulation. *See* s. 310.102, F.S.

⁷ Intervention Project for Nurses, *IPN History*, available at <http://www.ipnfl.org/ipnhistory.html> (last visited Mar. 9, 2017)

⁸ Section 456.076(1)(c)2., F.S.

The IPN and PRN, if requested, also serve as consultants to the DOH in cases that come before the practice boards or the DOH, including credentialing and monitoring of applicants, and assisting in the development of plans for licensee practice in a structured environment. They must also be available to testify in administrative hearings and other legal proceedings on behalf of the DOH.

Whenever a consultant, licensee, or approved treatment provider makes a disclosure of confidential information regarding a licensee to the DOH pursuant to law, that individual is not subject to civil liability for such disclosure or its consequences. If the contract with the consultant contains specified provisions, the consultant, the consultant's officers and employees, and those acting at the direction of the consultant are considered agents of the DOH for purposes of s. 768.28, F.S., relating to sovereign immunity.

The Department of Financial Services is required to defend the consultant, its officers and employees, and those acting at the direction of the consultant for the limited purpose of an emergency intervention when the consultant is unable to perform the intervention, from any legal action brought as a result of the consultant's duties under the DOH contract.⁹

When the DOH receives a legally sufficient¹⁰ complaint alleging that a licensee is impaired, and no other complaint against the licensee exists, the reporting of such information does not constitute grounds for discipline if certain conditions are met.¹¹ Those conditions include findings by the appropriate board's probable cause panel,¹² or the DOH, if there is no board, that the licensee:

- Acknowledged the impairment problem;
- Enrolled in an appropriate, approved treatment program;
- Voluntarily withdrew from practice, or limited the scope of his or her practice, until he or she successfully completed the treatment program; and
- Released his or her medical records to the consultant.

If the DOH has not received a legally sufficient complaint, other than impairment, and the licensee agrees to withdraw from practice until such time as the consultant determines the licensee has satisfactorily completed an evaluation and approved treatment program, if appropriate, neither the probable cause panel nor the DOH will become involved in the case.¹³

If an impaired licensee fails to complete, or satisfactorily progress in, a treatment program, the consultant must follow specific procedures set forth in the contract with the DOH, up to and including, sending notification to the DOH of the dismissal of a licensee from the program and

⁹ Section 456.076(8), F.S.

¹⁰ A complaint is legally sufficient if it contains ultimate facts that show the occurrence of a violation of a practice act, ch. 456, F.S., or a rule adopted by the DOH or a board. *See* s. 456.073(1), F.S.

¹¹ Section 456.076(4)(a), F.S.

¹² A probable cause panel is a panel designated by rule of each regulatory board that reviews investigative information related to a complaint to determine whether probable cause exists that a health care practitioner violated statutes governing the practice of the licensee's profession. If probable cause exists, the probable cause panel will direct DOH to file a formal complaint against the licensee. *See* s. 456.073(4), F.S.

¹³ Section 456.076(4)(b), F.S.

for the DOH to initiate disciplinary action.¹⁴ When a licensee is dismissed from a treatment program, the consultant provides an evaluation of the licensee's impairment condition to the DOH. The evaluation is used by the DOH to determine if the licensee poses an immediate and serious danger to the public for the purpose of issuing an emergency order restricting or suspending his or her license to practice.

A licensee is required to report to the appropriate board or DOH, if there is no board, any person who the licensee knows is in violation of ch. 456, F.S., the chapter regulating the alleged violator, or the rules of the department or the board.¹⁵ This requirement also includes any person unable to practice with reasonable skill and safety to patients due to the misuse or abuse of alcohol or drugs, or as a result of any mental or physical condition.

Section 401.411, F.S., sets forth disciplinary guidelines for the DOH to take action against emergency medical technicians (EMTs), paramedics and emergency medical services (EMS) personnel. The guidelines include a penalty for failure to report any person known to be in violation of s. 401.411, F.S.¹⁶ The guidelines also include a penalty for practicing as an EMT, paramedic, or EMS personnel without reasonable skill and without regard for the safety of the public because of illness, drunkenness, or the use of drugs, narcotics, chemicals, or any other substance, or as a result of any mental or physical condition.¹⁷

In 2009, a law was enacted that prohibited DOH from issuing or renewing the license of an individual who was convicted of, or entered a plea of nolo contendere to, regardless of adjudication of certain felonies related to Medicaid, Medicare, fraud, or controlled substances.¹⁸ In 2012, the law was amended to create a tiered system of exclusions based on the severity of the crime and the amount of time elapsed between the crime and the application for licensure and provided an exception.¹⁹

Current law prohibits a board or DOH, if there is no board, from allowing a person to sit for an examination or issue a license, certificate, or registration, if the applicant has been convicted of a felony under ch. 409, F.S., relating to social and economic programs, including Medicaid; ch. 817, F.S., relating to fraud; or ch. 893, F.S., relating to controlled substances; or a similar felony offense committed in another jurisdiction unless the individual successfully completed a drug court program for the felony and the plea was withdrawn or the charges were dismissed. A board or DOH, if there is no board, may allow an applicant to sit for an examination or issue a license, certificate, or registration if the sentence or any related period of probation for a conviction ended:

- More than 15 years before the date of application for felonies of the first or second degree;

¹⁴ See s. 456.072(1)(hh), F.S.

¹⁵ Section 456.072(1)(i), F.S.

¹⁶ Section 401.411(1)(l), F.S.

¹⁷ Section 401.411(1)(k), F.S.

¹⁸ Chapter 2009-223, Laws of Florida, codified at s. 456.0635, F.S. If the sentences or any probation for a conviction ended more than 15 years before the date of application, DOH was not required to deny the license.

¹⁹ Chapter 2012-64, Laws of Florida.

- More than 10 years before the date of application for felonies of the third degree, except for those under s. 893.13(6)(a), F.S.,²⁰ or
- More than 5 years before the date of application for felonies of the third degree under s. 893.13(6)(a), F.S.

These exclusions also apply to an applicant who:

- Has been convicted of, or entered a plea of guilty or no contest to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such convictions or plea ended more than 15 years before the date of application; or
- Is listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

Additionally, a board or DOH is prohibited from renewing a license, certification, or registration if the applicant or candidate falls under the same restrictions established for initial licensure, certification, or registration. The same exceptions to the restrictions on initial licensure, certification, or registration apply for renewal applications; however, the renewal applicant or candidate must show that he or she is currently enrolled in a drug court program, rather than showing successful completion, as required of initial applicants. This disqualification from licensure – for felony convictions or pleas of guilty or no contest of the specified violations – did not apply until 2016 to applicants for initial licensure or certification, who were enrolled in a recognized training or education program as of July 1, 2009, and who applied for initial licensure after July 1, 2012. In 2016, this exception to the disqualification was repealed because individuals who were denied renewal based on one of the offenses, regardless of the date it was committed, were able to reapply and obtain new licenses based on the exemption.

III. Effect of Proposed Changes:

Section 1 amends s. 456.076(1), F.S., to define the terms: “impaired practitioner,” “impairment,” “inability to progress,” “material noncompliance,” and “practitioner.” Defining these terms provides clarification to the DOH for contractual purposes and in legal proceedings.

This section deletes the provisions authorizing the DOH to adopt, by rule, the manner in which consultants work with the DOH in interventions, in evaluating and treating professionals, in providing and monitoring continued care of impaired professionals, and in expelling professionals from the program.

This section requires that, if the DOH elects to retain one or more consultants to operate its impaired practitioner program, the terms and conditions of the impaired practitioner programs must be specified by the contract between the DOH and consultant, which must contain the following agreements:²¹

²⁰ Section 893.13(6)(a), F.S., makes it unlawful for a person to be in actual or constructive possession of a controlled substance unless such controlled substance was lawfully obtained from a practitioner or pursuant to a valid prescription, or order, of a practitioner while acting the course of his or her professional practice; or to be in actual or constructive possession of a controlled substance except as otherwise authorized under ch. 893, F.S. Any person who violates this provision commits a felony in the third degree.

²¹ See s. 456.076(3) F.S., of the bill.

- Accept referrals;
- Arrange for evaluation and treatment of impaired practitioners when the consultant deems it necessary;
- Monitor the impaired practitioner's recovery process until monitoring is no longer needed or the practitioner is terminated for material non-compliance²² or an inability to progress,²³ and
- Not directly evaluate, treat, or otherwise provide patient care to a practitioner in the program.

This section requires the consultant to execute a participant contract with an impaired practitioner that addresses, among other things, the terms of the monitoring. The consultant may modify the terms of the monitoring if the consultant concludes that extended, additional, or amended terms are needed to protect the health, safety, and welfare of the public.

This section provides that when the DOH receives a legally sufficient complaint alleging that a practitioner has an impairment, and no complaint exists other than impairment, the DOH must refer the practitioner to the consultant, along with all information in the DOH's possession relating to the impairment. The impairment does not constitute grounds for discipline pursuant to s. 456.072, F.S., or the applicable practice act, if the practitioner:

- Has acknowledged the impairment;
- Becomes a participant in an impaired practitioner program and successfully completes a participant contract;
- Has voluntarily withdrawn from practice, or has limited the scope of his or her practice, if required by the consultant;
- Has provided to the consultant, or has authorized the consultant to obtain, all records and information relating to the impairment from any source and all other medical records of the practitioner requested by the consultant; and
- Has authorized the consultant, in the event of the practitioner's termination from the impaired practitioner program, to report the termination to the DOH and provide the department with copies of all information in the consultant's possession relating to the practitioner.²⁴

Under current law, probable cause panels reviewing complaints against a licensee may work directly with a consultant to determine if an impairment played a role in the complaint against a licensee, and what, if any, disciplinary action needs to be taken. This section requires the consultant to assist DOH and licensure boards in matters involving impaired practitioners, including a determination of whether a practitioner is in fact impaired, rather than this process taking place before probable cause panels.

The mandatory requirement that the practitioner release all records and information relating to the impairment from any source, and all other medical records of the practitioner requested by the consultant, may be broader than the release requirement under current law.²⁵ Current law

²² The bill defines "Material noncompliance" to mean an act or omission by a participant in violation of his or her participant contract as determined by the department or consultant.

²³ "Inability to progress" means a determination by a consultant based on a participant's response to treatment and prognosis that the participant is unable to safely practice despite compliance with the treatment requirement and his or her participant contract.

²⁴ See s. 456.076(10)(a), F.S., of the bill.

²⁵ For example, in 2016, the Legislature enacted Senate Bill 964 authorizing, among other things, an impaired practitioner consultant indirect access to the Florida Prescription Drug Monitoring Program (PDMP) for the purpose of reviewing the

requires the practitioner to authorize the release of all records of evaluations, diagnoses and treatment of the licensee, including records of treatment for emotional or mental conditions, to the consultant.

This section modifies when a consultant must report an impaired practitioner in a treatment program to the DOH. Unless authorized by the participant, the consultant may not provide information to the DOH relating to a self-referring participant if the consultant has no knowledge of a pending DOH investigation, complaint, or disciplinary action against the participant, and if the participant is in compliance with the terms of the impaired practitioner program and contract.²⁶

When a referral or participant is terminated from the impaired practitioner program for a material noncompliance with a participant contract, an inability to progress, or any other reason than completion, the consultant is required to disclose all information in the consultant's possession relating to the practitioner to the DOH. Such disclosure constitutes a complaint that the DOH will then investigate. Whenever the consultant concludes that impairment affects a practitioner's practice and constitutes an immediate, serious danger to the public health, safety, or welfare, the consultant is required to immediately communicate such conclusion to the DOH and provide all information in the consultant's possession relating to the practitioner to the DOH.²⁷

A consultant may request of an approved evaluator, treatment program, or treatment provider, with the authorization of the practitioner when required by law, all information in its possession regarding a referral or participant. Failure to provide such information to the consultant is grounds for withdrawal of approval by the DOH of such evaluator, treatment program, or treatment provider.²⁸

The confidential or exempt information obtained by the consultant retains its confidential or exempt status.²⁹ However, the bill does not provide any protection for the information once sent to the DOH, or obtained by an evaluator or treatment provider, from a public records request.

This section protects the consultant, or a director, officer, employee, or agent of a consultant, from financial liability or any other cause of action for damages related to making a disclosure, or for any action or omission, against a license, registration, or certification.³⁰ Under current law a consultant, the consultant's officers and employees, and those acting at the direction of the

database information of an impaired practitioner program participant or a referral who has separately agreed in writing to the consultant's access to and review of such information. See ss. 893.055(7)(c)5 and 893.0551(3)(h), F.S. This potentially creates a coercive method of requiring the practitioner to give up his or her PDMP records to the consultant, and by extension, to the DOH for disciplinary action. In order to attempt to avoid discipline for the practitioner, the bill requires the practitioner to release any information that relates to the practitioner's impairment, and any other records the consultant requests. The PDMP records would be medical records related to the impairment that the consultant would request the practitioner to release. Were the practitioner then to be terminated from the impaired practitioner program for any reason, the consultant would be required to turn those records over to the DOH. The DOH does not have authority to access these PDMP records, either directly or indirectly.

²⁶ See s. 465.076(9)(b), F.S., of the bill

²⁷ See s. 456.076(11)(b), F.S., of the bill.

²⁸ See s. 456.076(11)(a), F.S., of the bill.

²⁹ See s. 456.016(2), F.S., of the bill.

³⁰ See s. 456.076(13), F.S., of the bill.

consultant are considered agents of the DOH, and have sovereign immunity while acting within the course and scope of their contract.³¹ The bill extends that protection to include directors, officers, employees or agents of a consultant.³² The provisions of s. 766.101, F.S., apply to any consultant and the consultant's directors, officers, employees, or agents in regards to providing information relating to a participant to a medical review committee if the participant authorizes such disclosure.³³

This section directs the Department of Financial Services to defend the consultant, consultant's directors, officers, employees and agents against any claim, suit, action, or proceeding for injunction, affirmative, or declaratory relief, as the result of any action or omission relating to the impaired practitioner program.³⁴

This section provides that, if another state agency retains a consultant under contract with DOH, the provisions of the contract between DOH and the consultant applies to the consultant's operation of an impaired practitioner program for that agency.

A consultant may disclose to a referral or participant, or to the legal representative of the referral or participant, the documents, records, or other information from the consultant's file, including information received by the consultant from other sources, and information on the terms required for the referral's or participant's monitoring contract, the referral's or participant's progress or inability to progress, the referral's or participant's discharge or termination, information supporting the conclusion of material noncompliance, or any other information required by law. If a consultant discloses information to the DOH in accordance with this program, a referral or participant, or his or her legal representative, may obtain a complete copy of the consultant's file from the consultant or the DOH.³⁵

Section 2 amends s. 401.411(1)(l), F.S., to authorize emergency medical personnel that become aware of an individual in their profession that is impaired due to illness, the use of alcohol or drugs, or as a result of a mental or physical condition, to report the individual to the consultant rather than DOH, as required under current law, without facing disciplinary action.

Section 4 amends s. 456.0635(2)-(3), F.S., to exempt individuals convicted of, or entered a plea of guilty or nolo contendere to, disqualifying offenses prior to July 1, 2009, from being disqualified for licensure, preventing retroactive applicability. This section also authorizes the DOH to allow an individual to sit for an examination or issue or renew a license, certificate, or registration for a person who is convicted of, or enters a plea of guilty or nolo contendere, to a disqualifying felony if the applicant successfully completes a pretrial diversion program and provides proof that the plea has been withdrawn or the charges have been dismissed.

³¹ See s. 456.076,(15)(a), F.S., of the bill.

³² *Supra* note 38.

³³ See s. 456.076, (14), F.S., of the bill.

³⁴ See s. 456.076, (15)(b), F.S., of the bill.

³⁵ See s. 456.076, (17), F.S., of the bill.

Sections 5 through 13, 15 through 18, 20, and 21 amend s. 456.072, F.S., and various statutes,³⁶ to authorize a practitioner to report another impaired professional to a consultant, rather than the DOH or applicable regulatory board, without facing disciplinary action.

Section 22 provides for the bill to take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The bill protects the confidential or exempt information obtained by the consultant from a public records request; but the bill does not protect any of the information sent to the DOH, or obtained by an evaluator or treatment provider, from a public records request.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill's definitions of, "inability to progress," and "material noncompliance," may create due process issues as conclusive presumptions.³⁷

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Due to the expansion of individuals who are afforded a defense by the Department of Financial Services for claims, actions, suits, or proceedings, there may be an insignificant indeterminate negative fiscal impact on the Risk Management Trust Fund.

³⁶ Section 457.109, F.S., (acupuncture); s. 458.331, F.S., (medical practice); s. 459.015, F.S., (osteopathic medicine); s. 460.413, F.S., (chiropractic medicine); s. 461.013, F.S., (podiatric medicine); s. 462.14, F.S., (naturopathy); s. 463.016, F.S., (optometry); s. 464.018, F.S., (nursing); s. 465.016, F.S., (pharmacy); s. 466.028, F.S., (dentistry, dental hygiene, and dental laboratories); s. 467.203, F.S., (midwifery); s. 468.217, F.S., (occupational therapy); s. 474.221, F.S., (veterinary medicine); and s. 483.825, F.S. (clinical laboratory personnel).

³⁷ A "conclusive presumption" is one in which proof of a basic fact renders the existence of the presumed fact conclusive and irrevocable regardless of any evidence to the contrary. Black's Law Dictionary, 6th Ed., 1992.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.076, 401.411, 455.227, 456.0635, 456.072, 457.109, 458.331, 459.015, 460.413, 461.013, 462.14, 463.016, 464.018, 464.204, 465.016, 466.028, 467.203, 468.217, 468.3101, 474.221, and 483.825.

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 March 14, 2017:

The CS:

- Amends the definition of referral to make clear that it includes self-referrals, referrals of one practitioner by another, and referrals reported by the DOH.
- Condenses and reorganizes the section which provides for contract terms and conditions with a consultant, but makes no substantive changes.
- Changes the terms “certify” and “decline to certify,” to “approve” and “deny,” respectively, to more accurately describe the actions.
- Clarifies that the consultant is not required to disclose information to the DOH on self-referring practitioners if the consultant has no knowledge of a complaint.
- Reinstates and amends the language that specifies that the consultant is an agent of the state for purposes of sovereign immunity when acting pursuant to its contract.
- Authorizes disclosure to the referral, participant or the legal representative of either, the documents and information received by the consultant pertaining to and supporting the participant’s discharge or termination from an impaired practitioner program; and any information the consultant discloses to the DOH.
- Amends the provisions relating to disqualification for licensure, and provides an exception for pretrial diversion.

B. Amendments:

None.



862134

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Between lines 73 and 74
insert:

Section 1. Section 456.0495, Florida Statutes, is created
to read:

456.0495 Reporting adverse incidents occurring in out-of-
hospital births.—

(1) A midwife licensed under chapter 467 or health care
provider, as applicable, shall report any adverse incident, as



862134

defined by department rule, occurring as a result of an attempted or completed, planned birthing center or out-of-hospital birth, along with a medical summary of events, to the department within 15 days after the adverse incident occurs.

(2) The department shall adopt rules establishing guidelines for reporting adverse incidents, including, but not limited to:

(a) Maternal deaths that occur during delivery or within 42 days after delivery.

(b) Transfers of maternal patients to a hospital intensive care unit.

(c) Maternal patients who experience hemorrhagic shock or who require a transfusion of more than 4 units of blood or blood products.

(d) Fetal or infant deaths, including stillbirths, associated with obstetrical deliveries.

(e) Transfers of infants to a neonatal intensive care unit due to a traumatic physical or neurological birth injury, including any degree of a brachial plexus injury.

(f) Transfers of infants to a neonatal intensive care unit within the first 72 hours after birth if the infant remains in such unit for more than 72 hours.

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

And the title is amended as follows:

Delete lines 2 - 3

and insert:

An act relating to health care practitioners; creating
s. 456.0495, F.S.; requiring licensed midwives and



862134

40 health care providers to report adverse incidents to
41 the Department of Health within a certain period;
42 requiring the department to adopt rules establishing
43 guidelines for reporting specified adverse incidents;
44 amending s. 456.076, F.S.; revising



419466

LEGISLATIVE ACTION

Senate

.
. .
. .
. .
. .

House

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

Senate Amendment

Delete lines 266 - 313
and insert:

(9) (a) - (4) (a) Except as provided in paragraph (b), when
~~Whenever~~ the department receives a ~~written or oral~~ legally
sufficient complaint alleging that a practitioner has an
impairment ~~licensee under the jurisdiction of the Division of~~
~~Medical Quality Assurance within the department is impaired as a~~
~~result of the misuse or abuse of alcohol or drugs, or both, or~~



419466

11 ~~due to a mental or physical condition which could affect the~~
12 ~~licensee's ability to practice with skill and safety, and no~~
13 ~~complaint exists~~ against the practitioner licensee other than
14 ~~impairment exists~~, the department shall refer the practitioner
15 to the consultant, along with all information in the
16 department's possession relating to the impairment. The
17 impairment does ~~reporting of such information shall~~ not
18 constitute grounds for discipline pursuant to s. 456.072 or ~~the~~
19 ~~corresponding grounds for discipline within the applicable~~
20 ~~practice act if the probable cause panel of the appropriate~~
21 ~~board, or the department when there is no board, finds:~~

22 1. The practitioner licensee has acknowledged the
23 impairment; ~~problem.~~

24 2. The practitioner becomes a participant licensee ~~has~~
25 ~~voluntarily enrolled in an impaired practitioner program and~~
26 successfully completes a participant contract under terms
27 established by the consultant; ~~appropriate, approved treatment~~
28 ~~program.~~

29 3. The practitioner licensee has voluntarily withdrawn from
30 practice or has limited the scope of his or her practice if as
31 ~~required by the consultant;~~ ~~in each case, until such time as~~
32 ~~the panel, or the department when there is no board, is~~
33 ~~satisfied the licensee has successfully completed an approved~~
34 ~~treatment program.~~

35 4. The practitioner licensee has provided to the
36 consultant, or has authorized the consultant to obtain, all
37 records and information relating to the impairment from any
38 source and all other medical records of the practitioner
39 requested by the consultant; and ~~executed releases for medical~~



419466

~~records, authorizing the release of all records of evaluations, diagnoses, and treatment of the licensee, including records of treatment for emotional or mental conditions, to the consultant. The consultant shall make no copies or reports of records that do not regard the issue of the licensee's impairment and his or her participation in a treatment program.~~

5. The practitioner has authorized the consultant, in the event of the practitioner's termination from the impaired practitioner program, to report the termination to the department and provide the department with copies of all information in the consultant's possession relating to the practitioner.

(b) For practitioners who are employed by governmental entities and who are also certified by the department pursuant to part III of chapter 401, the department may not refer the practitioner to the consultant if the practitioner is under a referral by the practitioner's employer to an employee assistance program through the governmental entity. If the practitioner fails to satisfactorily complete the employee assistance program or if his or her employment is terminated, his or her employer must immediately notify the department, which shall then refer the practitioner to the consultant as required in in paragraph (a). For purposes of this paragraph, the term "governmental entity" has the same meaning as provided in s. 70.001(3)(c).

(c) To encourage practitioners who are or may be impaired



794312

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment

Delete lines 618 - 664
and insert:
licensure, certification, or registration who was arrested for
or charged with a felony specified in paragraph (a) or paragraph
(b) before July 1, 2009.

(3) The department shall refuse to renew a license,
certificate, or registration of any applicant if the applicant
or any principal, officer, agent, managing employee, or



794312

11 affiliated person of the applicant:

12 (a) Has been convicted of, or entered a plea of guilty or
13 nolo contendere to, regardless of adjudication, a felony under
14 chapter 409, chapter 817, or chapter 893, or a similar felony
15 offense committed in another state or jurisdiction, unless the
16 applicant is currently enrolled in a pretrial diversion or drug
17 court program that allows the withdrawal of the plea for that
18 felony upon successful completion of that program. Any such
19 conviction or plea excludes the applicant from licensure renewal
20 unless the sentence and any subsequent period of probation for
21 such conviction or plea ended:

22 1. For felonies of the first or second degree, more than 15
23 years before the date of application.

24 2. For felonies of the third degree, more than 10 years
25 before the date of application, except for felonies of the third
26 degree under s. 893.13(6) (a).

27 3. For felonies of the third degree under s. 893.13(6) (a),
28 more than 5 years before the date of application.

29 (b) Has been convicted of, or entered a plea of guilty or
30 nolo contendere to, regardless of adjudication, a felony under
31 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396 since July 1,
32 2009, unless the sentence and any subsequent period of probation
33 for such conviction or plea ended more than 15 years before the
34 date of the application.

35 (c) Has been terminated for cause from the Florida Medicaid
36 program pursuant to s. 409.913, unless the applicant has been in
37 good standing with the Florida Medicaid program for the most
38 recent 5 years.

39 (d) Has been terminated for cause, pursuant to the appeals



794312

procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

This subsection does not apply to an applicant for renewal of licensure, certification, or registration who was arrested for or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

By the Committee on Health Policy; and Senators Young, Bean, and Rouson

588-02419-17

2017876c1

1 A bill to be entitled
 2 An act relating to programs for impaired health care
 3 practitioners; amending s. 456.076, F.S.; revising
 4 provisions related to impaired practitioner programs;
 5 providing definitions; deleting a requirement that the
 6 Department of Health designate approved programs by
 7 rule; deleting a requirement authorizing the
 8 department to adopt by rule the manner in which
 9 consultants work with the department in intervention,
 10 in evaluating and treating professionals, in providing
 11 and monitoring continued care of impaired
 12 professionals, and in expelling professionals from the
 13 program; authorizing, instead of requiring, the
 14 department to retain one or more consultants to
 15 operate its impaired practitioner program; requiring
 16 the department to establish the terms and conditions
 17 of the program by contract; providing contract terms;
 18 requiring consultants to establish the terms of
 19 monitoring impaired practitioners; authorizing
 20 consultants to consider the recommendations of certain
 21 persons in establishing the terms of monitoring;
 22 authorizing consultants to modify monitoring terms to
 23 protect the health, safety, and welfare of the public;
 24 requiring consultants to assist the department and
 25 licensure boards on matters relating to impaired
 26 practitioners; making technical changes; requiring the
 27 department to refer practitioners to consultants under
 28 certain circumstances; authorizing consultants to
 29 withhold certain information about self-reporting

Page 1 of 33

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

588-02419-17

2017876c1

30 participants from the department under certain
 31 circumstances to encourage self-reporting; requiring
 32 consultants to disclose all information relating to
 33 practitioners who are terminated from the program for
 34 material noncompliance; providing that all information
 35 obtained by a consultant retains its confidential or
 36 exempt status; providing that consultants, and certain
 37 agents of consultants, may not be held liable
 38 financially or have a cause of action for damages
 39 brought against them for disclosing certain
 40 information or for any other act or omission relating
 41 to the program; authorizing consultants to contract
 42 with a school or program to provide services to
 43 certain students; amending s. 401.411, F.S.; providing
 44 that an impaired practitioner may be reported to a
 45 consultant rather than the department under certain
 46 circumstances; amending s. 455.227, F.S.; conforming
 47 provisions to changes made by the act; amending s.
 48 456.0635, F.S.; providing that, under certain
 49 circumstances, a board or, if there is no board, the
 50 department, is not required to refuse to admit certain
 51 candidates to an examination, to issue a license,
 52 certificate, or registration to certain applicants, or
 53 to renew a license, certificate, or registration of
 54 certain applicants if they have successfully completed
 55 a pretrial diversion program; providing applicability;
 56 amending ss. 456.072, 457.109, 458.331, 459.015,
 57 460.413, 461.013, 462.14, 463.016, and 464.018, F.S.;
 58 providing that an impaired practitioner may be

Page 2 of 33

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

588-02419-17

2017876c1

59 reported to a consultant rather than the department
 60 under certain circumstances; amending s. 464.204,
 61 F.S.; conforming provisions to changes made by the
 62 act; amending ss. 465.016, 466.028, 467.203, 468.217,
 63 and 468.3101, F.S.; providing that an impaired
 64 practitioner may be reported to a consultant rather
 65 than the department under certain circumstances;
 66 amending s. 474.221, F.S.; conforming provisions to
 67 changes made by the act; amending s. 483.825, F.S.;
 68 providing that certain persons may be reported to a
 69 consultant rather than the department under certain
 70 circumstances; providing an effective date.

71
 72 Be It Enacted by the Legislature of the State of Florida:

73
 74 Section 1. Section 456.076, Florida Statutes, is amended to
 75 read:

76 456.076 Impaired practitioner programs ~~Treatment programs~~
 77 ~~for impaired practitioners.-~~

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

79 (a) "Consultant" means the individual or entity who
 80 operates an approved impaired practitioner program pursuant to a
 81 contract with the department and who is retained by the
 82 department as provided in subsection (2).

83 (b) "Evaluator" means a state-licensed or nationally
 84 certified individual who has been approved by a consultant or
 85 the department, who has completed an evaluator training program
 86 established by the consultant, and who is therefore authorized
 87 to evaluate practitioners as part of an impaired practitioner

588-02419-17

2017876c1

88 program.

89 (c) "Impaired practitioner" means a practitioner with an
 90 impairment.

91 (d) "Impaired practitioner program" means a program
 92 established by the department by contract with one or more
 93 consultants to serve impaired and potentially impaired
 94 practitioners for the protection of the health, safety, and
 95 welfare of the public.

96 (e) "Impairment" means a potentially impairing health
 97 condition that is the result of the misuse or abuse of alcohol,
 98 drugs, or both, or a mental or physical condition that could
 99 affect a practitioner's ability to practice with skill and
 100 safety.

101 (f) "Inability to progress" means a determination by a
 102 consultant based on a participant's response to treatment and
 103 prognosis that the participant is unable to safely practice
 104 despite compliance with treatment requirements and his or her
 105 participant contract.

106 (g) "Material noncompliance" means an act or omission by a
 107 participant in violation of his or her participant contract as
 108 determined by the department or consultant.

109 (h) "Participant" means a practitioner who is participating
 110 in the impaired practitioner program by having entered into a
 111 participant contract. A practitioner ceases to be a participant
 112 when the participant contract is successfully completed or is
 113 terminated for any reason.

114 (i) "Participant contract" means a formal written document
 115 outlining the requirements established by a consultant for a
 116 participant to successfully complete the impaired practitioner

588-02419-17

2017876c1

program, including the participant's monitoring plan.

(j) "Practitioner" means a person licensed, registered, certified, or regulated by the department under part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or an applicant for a license, registration, or certification under the same laws.

(k) "Referral" means a practitioner who has been referred, either as a self-referral or otherwise, or reported to a consultant for impaired practitioner program services, but who is not under a participant contract.

(l) "Treatment program" means a department- or consultant-approved residential, intensive outpatient, partial hospitalization or other program through which an impaired practitioner is treated based on the impaired practitioner's diagnosis and the treatment plan approved by the consultant.

(m) "Treatment provider" means a department- or consultant-approved state-licensed or nationally certified individual who provides treatment to an impaired practitioner based on the practitioner's individual diagnosis and a treatment plan approved by the consultant. ~~For professions that do not have impaired practitioner programs provided for in their practice acts, the department shall, by rule, designate approved impaired practitioner programs under this section. The department may adopt rules setting forth appropriate criteria for approval of treatment providers. The rules may specify the manner in which~~

588-02419-17

2017876c1

~~the consultant, retained as set forth in subsection (2), works with the department in intervention, requirements for evaluating and treating a professional, requirements for continued care of impaired professionals by approved treatment providers, continued monitoring by the consultant of the care provided by approved treatment providers regarding the professionals under their care, and requirements related to the consultant's expulsion of professionals from the program.~~

(2)(a) The department ~~may~~ shall retain one or more impaired practitioner consultants to operate its impaired practitioner program. Each consultant ~~who are each licensees under the jurisdiction of the Division of Medical Quality Assurance within the department and who must be:~~

(a)1- A practitioner ~~or recovered practitioner~~ licensed under chapter 458, chapter 459, or part I of chapter 464; or

(b)2- An entity that employs:

1.a- A medical director who ~~is~~ must be a practitioner or recovered practitioner licensed under chapter 458 or chapter 459; or

2.b- An executive director who ~~is~~ must be a registered nurse or a recovered registered nurse licensed under part I of chapter 464.

(3) The terms and conditions of the impaired practitioner program must be established by the department by contract with a consultant for the protection of the health, safety, and welfare of the public and must provide, at a minimum, that the consultant:

(a) Accepts referrals;

(b) Arranges for the evaluation and treatment of impaired

588-02419-17

2017876c1

practitioners by a treatment provider, when the consultant deems the evaluation and treatment necessary;

(c) Monitors the recovery progress and status of impaired practitioners to ensure that such practitioners are able to practice their profession with skill and safety. Such monitoring must continue until the consultant or department concludes that monitoring by the consultant is no longer required for the protection of the public or until the practitioner's participation in the program is terminated for material noncompliance or inability to progress; and

(d) Does not directly evaluate, treat, or otherwise provide patient care to a practitioner in the operation of the impaired practitioner program.

(4) The department shall specify, in its contract with each consultant, the types of licenses, registrations, or certifications of the practitioners to be served by that consultant.

(5) A consultant shall enter into a participant contract with an impaired practitioner and shall establish the terms of monitoring and shall include the terms in a participant contract. In establishing the terms of monitoring, the consultant may consider the recommendations of one or more approved evaluators, treatment programs, or treatment providers. A consultant may modify the terms of monitoring if the consultant concludes, through the course of monitoring, that extended, additional, or amended terms of monitoring are required for the protection of the health, safety, and welfare of the public.

~~(6)(b) A~~ An entity retained as an impaired practitioner

588-02419-17

2017876c1

~~consultant under this section which employs a medical director or an executive director~~ is not required to be licensed as a substance abuse provider or mental health treatment provider under chapter 394, chapter 395, or chapter 397 for purposes of providing services under this program.

~~(7)(e)1-~~ Each The consultant shall assist the department and licensure boards on matters of impaired practitioners, including the determination of probable cause panel and the department in carrying out the responsibilities of this section. This includes working with department investigators to determine whether a practitioner is, in fact, impaired, as specified in the consultant's contract with the department.

2. The consultant may contract with a school or program to provide services to a student enrolled for the purpose of preparing for licensure as a health care practitioner as defined in this chapter or as a veterinarian under chapter 474 if the student is allegedly impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition. The department is not responsible for paying for the care provided by approved treatment providers or a consultant.

~~(d) A medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or another school providing for the education of students enrolled in preparation for licensure as a health care practitioner as defined in this chapter or a veterinarian under chapter 474 which is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant retained by the department or for~~

588-02419-17

2017876c1

disciplinary actions that adversely affect the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provided by such consultant, if the school, in referring the student or taking disciplinary action, adheres to the due process procedures adopted by the applicable accreditation entities and if the school committed no intentional fraud in carrying out the provisions of this section.

(8)(3) Before issuing an approval of, or intent to deny, an application for licensure, each board and profession within the Division of Medical Quality Assurance may delegate to its chair or other designee its authority to determine, before certifying or declining to certify an application for licensure to the department, that an applicant for licensure under its jurisdiction may have an impairment be impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition that could affect the applicant's ability to practice with skill and safety. Upon such determination, the chair or other designee may refer the applicant to the consultant to facilitate for an evaluation before the board issues an approval of, certifies or intent to deny, declines to certify his or her application to the department. If the applicant agrees to be evaluated by the consultant, the department's deadline for approving or denying the application pursuant to s. 120.60(1) is tolled until the evaluation is completed and the result of the evaluation and recommendation by the consultant is communicated to the board by the consultant. If the applicant declines to be evaluated by the

588-02419-17

2017876c1

consultant, the board shall issue an approval of, or intent to deny, certify or decline to certify the applicant's application to the department notwithstanding the lack of an evaluation and recommendation by the consultant.

(9)(a)(4)(a) When ~~Whenever~~ the department receives a written or oral legally sufficient complaint alleging that a practitioner has an impairment licensee under the jurisdiction of the Division of Medical Quality Assurance within the department is impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental or physical condition which could affect the licensee's ability to practice with skill and safety, and no complaint exists against the practitioner licensee other than impairment exists, the department shall refer the practitioner to the consultant, along with all information in the department's possession relating to the impairment. The impairment does reporting of such information shall not constitute grounds for discipline pursuant to s. 456.072 or the corresponding grounds for discipline within the applicable practice act if the probable cause panel of the appropriate board, or the department when there is no board, finds:

1. The practitioner licensee has acknowledged the impairment; ~~problem.~~
2. The practitioner becomes a participant licensee has voluntarily enrolled in an impaired practitioner program and successfully completes a participant contract under terms established by the consultant; ~~appropriate, approved treatment program.~~
3. The practitioner licensee has voluntarily withdrawn from

588-02419-17

2017876c1

291 practice or has limited the scope of his or her practice if as
 292 required by the consultant;~~in each case, until such time as~~
 293 ~~the panel, or the department when there is no board, is~~
 294 ~~satisfied the licensee has successfully completed an approved~~
 295 ~~treatment program.~~

296 4. The practitioner licensee has provided to the
 297 consultant, or has authorized the consultant to obtain, all
 298 records and information relating to the impairment from any
 299 source and all other medical records of the practitioner
 300 requested by the consultant; and executed releases for medical
 301 records, authorizing the release of all records of evaluations,
 302 diagnoses, and treatment of the licensee, including records of
 303 treatment for emotional or mental conditions, to the consultant.
 304 The consultant shall make no copies or reports of records that
 305 do not regard the issue of the licensee's impairment and his or
 306 her participation in a treatment program.

307 5. The practitioner has authorized the consultant, in the
 308 event of the practitioner's termination from the impaired
 309 practitioner program, to report the termination to the
 310 department and provide the department with copies of all
 311 information in the consultant's possession relating to the
 312 practitioner.

313 (b) To encourage practitioners who are or may be impaired
 314 to voluntarily self-refer to a consultant, the consultant may
 315 not provide information to the department relating to a self-
 316 referring participant if the consultant has no knowledge of a
 317 pending department investigation, complaint, or disciplinary
 318 action against the participant and if the participant is in
 319 compliance and making progress with the terms of the impaired

588-02419-17

2017876c1

320 practitioner program and contract, unless authorized by the
 321 participant If, however, the department has not received a
 322 legally sufficient complaint and the licensee agrees to withdraw
 323 from practice until such time as the consultant determines the
 324 ~~licensee has satisfactorily completed an approved treatment~~
 325 ~~program or evaluation, the probable cause panel, or the~~
 326 ~~department when there is no board, shall not become involved in~~
 327 ~~the licensee's case.~~

328 ~~(c) Inquiries related to impairment treatment programs~~
 329 ~~designed to provide information to the licensee and others and~~
 330 ~~which do not indicate that the licensee presents a danger to the~~
 331 ~~public shall not constitute a complaint within the meaning of s.~~
 332 ~~456.073 and shall be exempt from the provisions of this~~
 333 ~~subsection.~~

334 ~~(d) Whenever the department receives a legally sufficient~~
 335 ~~complaint alleging that a licensee is impaired as described in~~
 336 ~~paragraph (a) and no complaint against the licensee other than~~
 337 ~~impairment exists, the department shall forward all information~~
 338 ~~in its possession regarding the impaired licensee to the~~
 339 ~~consultant. For the purposes of this section, a suspension from~~
 340 ~~hospital staff privileges due to the impairment does not~~
 341 ~~constitute a complaint.~~

342 ~~(e) The probable cause panel, or the department when there~~
 343 ~~is no board, shall work directly with the consultant, and all~~
 344 ~~information concerning a practitioner obtained from the~~
 345 ~~consultant by the panel, or the department when there is no~~
 346 ~~board, shall remain confidential and exempt from the provisions~~
 347 ~~of s. 119.07(1), subject to the provisions of subsections (6)~~
 348 ~~and (7).~~

588-02419-17

2017876c1

~~(f) A finding of probable cause shall not be made as long as the panel, or the department when there is no board, is satisfied, based upon information it receives from the consultant and the department, that the licensee is progressing satisfactorily in an approved impaired practitioner program and no other complaint against the licensee exists.~~

~~(10)(5)~~ In any disciplinary action for a violation other than impairment in which a practitioner licensee establishes the violation for which the practitioner licensee is being prosecuted was due to or connected with impairment and further establishes the practitioner licensee is satisfactorily progressing through or has successfully completed an impaired practitioner program ~~approved treatment program~~ pursuant to this section, such information may be considered by the board, or the department when there is no board, as a mitigating factor in determining the appropriate penalty. This subsection does not limit mitigating factors the board may consider.

~~(11)(a)(6)(a)~~ Upon request by the consultant, and with the authorization of the practitioner when required by law, an approved evaluator, treatment program, or treatment provider shall, ~~upon request,~~ disclose to the consultant all information in its possession regarding a referral or participant ~~the issue of a licensee's impairment and participation in the treatment program. All information obtained by the consultant and department pursuant to this section is confidential and exempt from the provisions of s. 119.07(1), subject to the provisions of this subsection and subsection (7).~~ Failure to provide such information to the consultant is grounds for withdrawal of approval of such evaluator, treatment program, or treatment

Page 13 of 33

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

588-02419-17

2017876c1

provider.

(b) When a referral or participant is terminated from the impaired practitioner program for material noncompliance with a participant contract, inability to progress, or any other reason than completion, the consultant shall disclose ~~if in the opinion of the consultant, after consultation with the treatment provider, an impaired licensee has not progressed satisfactorily in a treatment program,~~ all information regarding the issue of a licensee's impairment and participation in a treatment program in the consultant's possession relating to the practitioner ~~shall be disclosed~~ to the department. Such disclosure shall constitute a complaint pursuant to the general provisions of s. 456.073. In addition, whenever the consultant concludes that impairment affects a practitioner's licensee's practice and constitutes an immediate, serious danger to the public health, safety, or welfare, the consultant shall immediately communicate such that conclusion shall be communicated to the department and disclose all information in the consultant's possession relating to the practitioner to the department ~~State Surgeon General.~~

(12) All information obtained by the consultant pursuant to this section is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

~~(13)(7)~~ A consultant, or a director, officer, employee, or agent of a consultant, may not be held liable financially or may not have a cause of action for damages brought against him or her for making a disclosure pursuant to this section, for any other action or omission relating to the impaired practitioner program, or for the consequences of such disclosure or action or omission, including, without limitation, action by the

Page 14 of 33

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

588-02419-17

2017876c1

department against a license, registration, or certification licensee, or approved treatment provider who makes a disclosure pursuant to this section is not subject to civil liability for such disclosure or its consequences.

(14) The provisions of s. 766.101 apply to any consultant and the consultant's directors, officers, employees, or agents in regards to providing information relating to a participant to a medical review committee if the participant authorizes such disclosure officer, employee, or agent of the department or the board and to any officer, employee, or agent of any entity with which the department has contracted pursuant to this section.

(15) (a) (8) (a) A consultant retained pursuant to this section and subsection (2), a consultant's directors, officers, and employees, or agents and those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention shall be considered agents of the department for purposes of s. 768.28 while acting within the scope of the consultant's duties under the contract with the department ~~if the contract complies with the requirements of this section. The contract must require that:~~

~~1. The consultant indemnify the state for any liabilities incurred up to the limits set out in chapter 768.~~

~~2. The consultant establish a quality assurance program to monitor services delivered under the contract.~~

~~3. The consultant's quality assurance program, treatment, and monitoring records be evaluated quarterly.~~

~~4. The consultant's quality assurance program be subject to~~

588-02419-17

2017876c1

~~review and approval by the department.~~

~~5. The consultant operate under policies and procedures approved by the department.~~

~~6. The consultant provide to the department for approval a policy and procedure manual that comports with all statutes, rules, and contract provisions approved by the department.~~

~~7. The department be entitled to review the records relating to the consultant's performance under the contract for the purpose of management audits, financial audits, or program evaluation.~~

~~8. All performance measures and standards be subject to verification and approval by the department.~~

~~9. The department be entitled to terminate the contract with the consultant for noncompliance with the contract.~~

(b) In accordance with s. 284.385, the Department of Financial Services shall defend any claim, suit, action, or proceeding, including a claim, suit, action, or proceeding for injunctive, affirmative, or declaratory relief, against the consultant, or the consultant's directors, officers, or employees, and agents brought as the result of any action or omission relating to the impaired practitioner program or those acting at the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention, which claim, suit, action, or proceeding is brought as a result of an act or omission by any of the consultant's officers and employees and those acting under the direction of the consultant for the limited purpose of an emergency intervention on behalf of the licensee or student

588-02419-17

2017876c1

when the consultant is unable to perform such intervention, if the act or omission arises out of and is in the scope of the consultant's duties under its contract with the department.

~~(16)(e)~~ If ~~a~~ the consultant retained by the department pursuant to ~~this section subsection (2)~~ is also retained by another ~~any other~~ state agency to operate an impaired practitioner program for that agency, this section also applies to the consultant's operation of an impaired practitioner program for that agency, and if the contract between such state agency and the consultant complies with the requirements of this section, the consultant, the consultant's officers and employees, and those acting under the direction of the consultant for the limited purpose of an emergency intervention on behalf of a licensee or student as described in subsection (2) when the consultant is unable to perform such intervention shall be considered agents of the state for the purposes of this section while acting within the scope of and pursuant to guidelines established in the contract between such state agency and the consultant.

~~(17)(9)~~ A An impaired practitioner consultant is the official custodian of records relating to the referral of an impaired licensee or applicant to that consultant and any other interaction between the licensee or applicant and the consultant. The consultant may disclose to a referral or participant, or to the legal representative of the referral or participant, the documents, records, or other information from the consultant's file, including information received by the consultant from other sources, and information on the terms required for the referral's or participant's monitoring

588-02419-17

2017876c1

contract, the referral's or participant's progress or inability to progress, the referral's or participant's discharge or termination, information supporting the conclusion of material noncompliance, or any other information required by law the impaired licensee or applicant or his or her designee any information that is disclosed to or obtained by the consultant or that is confidential under paragraph (6)(a), but only to the extent that it is necessary to do so to carry out the consultant's duties under this section. The department, and any other entity that enters into a contract with the consultant to receive the services of the consultant, has direct administrative control over the consultant to the extent necessary to receive disclosures from the consultant as allowed by federal law. If a consultant discloses information to the department in accordance with this part, a referral or participant, or his or her legal representative, may obtain a complete copy of the consultant's file from the consultant or disciplinary proceeding is pending, an impaired licensee may obtain such information from the department under s. 456.073.

(18)(a) The consultant may contract with a school or program to provide impaired practitioner program services to a student enrolled for the purpose of preparing for licensure as a health care practitioner as defined in this chapter or as a veterinarian under chapter 474 if the student has or is suspected of having an impairment. The department is not responsible for paying for the care provided by approved treatment providers or approved treatment programs or for the services provided by a consultant to a student.

(b) A medical school accredited by the Liaison Committee on

588-02419-17

2017876c1

Medical Education or the Commission on Osteopathic College Accreditation, or another school providing for the education of students enrolled in preparation for licensure as a health care practitioner as defined in this chapter, or a veterinarian under chapter 474, which is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant retained by the department or for disciplinary actions that adversely affect the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provided by such consultant, if the school, in referring the student or taking disciplinary action, adheres to the due process procedures adopted by the applicable accreditation entities and if the school committed no intentional fraud in carrying out the provisions of this section.

Section 2. Paragraph (1) of subsection (1) of section 401.411, Florida Statutes, is amended to read:

401.411 Disciplinary action; penalties.—

(1) The department may deny, suspend, or revoke a license, certificate, or permit or may reprimand or fine any licensee, certificateholder, or other person operating under this part for any of the following grounds:

(1) The failure to report to the department any person known to be in violation of this part. However, a professional known to be operating under this part without reasonable skill and without regard for the safety of the public by reason of illness, drunkenness, or the use of drugs, narcotics, chemicals,

588-02419-17

2017876c1

or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 3. Paragraph (u) of subsection (1) of section 455.227, Florida Statutes, is amended to read:

455.227 Grounds for discipline; penalties; enforcement.—

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

(u) Termination from an impaired practitioner program ~~a treatment program for impaired practitioners~~ as described in s. 456.076 for failure to comply, without good cause, with the terms of the monitoring or participant treatment ~~treatment~~ contract entered into by the licensee or failing to successfully complete a drug or alcohol treatment program.

Section 4. Subsections (2) and (3) of section 456.0635, Florida Statutes, are amended to read:

456.0635 Health care fraud; disqualification for license, certificate, or registration.—

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the candidate or applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony

588-02419-17

2017876c1

offense committed in another state or jurisdiction, unless the candidate or applicant has successfully completed a pretrial diversion or drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application;

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application;

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the candidate or applicant has been in

588-02419-17

2017876c1

good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application; or

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

This subsection does not apply to an applicant for initial licensure, certification, or registration who was enrolled on or before July 1, 2009, in an educational or training program that was recognized by a board or, if there was no board, recognized by the department, and was arrested or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

(3) The department shall refuse to renew a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the applicant is currently enrolled in a pretrial diversion or drug court program that allows the withdrawal of the plea for that felony upon successful completion of that program. Any such conviction or plea excludes the applicant from licensure renewal unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

588-02419-17

2017876c1

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396 since July 1, 2009, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application. However, if the applicant was arrested or charged with such felony before July 1, 2009, he or she is not excluded from licensure renewal under this paragraph.

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years.

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

Section 5. Paragraphs (i) and (hh) of subsection (1) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

588-02419-17

2017876c1

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

(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board. However, a person who the licensee knows is unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

(hh) Being terminated from an impaired practitioner program that a treatment program for impaired practitioners, which is overseen by a an impaired practitioner consultant as described in s. 456.076, for failure to comply, without good cause, with the terms of the monitoring or participant treatment contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

Section 6. Paragraph (f) of subsection (1) of section 457.109, Florida Statutes, is amended to read:

457.109 Disciplinary actions; grounds; action by the board.—

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

(f) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department. However, a person who the licensee knows is

588-02419-17

2017876c1

697 unable to practice acupuncture with reasonable skill and safety
 698 to patients by reason of illness or use of alcohol, drugs,
 699 narcotics, chemicals, or any other type of material, or as a
 700 result of a mental or physical condition, may be reported to a
 701 consultant operating an impaired practitioner program as
 702 described in s. 456.076 rather than to the department.

703 Section 7. Paragraph (e) of subsection (1) of section
 704 458.331, Florida Statutes, is amended to read:

705 458.331 Grounds for disciplinary action; action by the
 706 board and department.—

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

709 (e) Failing to report to the department any person who the
 710 licensee knows is in violation of this chapter or of the rules
 711 of the department or the board. However, a person who the
 712 licensee knows is unable to practice medicine with reasonable
 713 skill and safety to patients by reason of illness or use of
 714 alcohol, drugs, narcotics, chemicals, or any other type of
 715 material, or as a result of a mental or physical condition, may
 716 be reported to a consultant operating an impaired practitioner
 717 program as described in s. 456.076 rather than to the department
 718 ~~A treatment provider approved pursuant to s. 456.076 shall~~
 719 ~~provide the department or consultant with information in~~
 720 ~~accordance with the requirements of s. 456.076(4), (5), (6),~~
 721 ~~(7), and (9).~~

722 Section 8. Paragraph (e) of subsection (1) of section
 723 459.015, Florida Statutes, is amended to read:

724 459.015 Grounds for disciplinary action; action by the
 725 board and department.—

588-02419-17

2017876c1

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

728 (e) Failing to report to the department or the department's
 729 impaired professional consultant any person who the licensee or
 730 certificateholder knows is in violation of this chapter or of
 731 the rules of the department or the board. However, a person who
 732 the licensee knows is unable to practice osteopathic medicine
 733 with reasonable skill and safety to patients by reason of
 734 illness or use of alcohol, drugs, narcotics, chemicals, or any
 735 other type of material, or as a result of a mental or physical
 736 condition, may be reported to a consultant operating an impaired
 737 practitioner program as described in s. 456.076 rather than to
 738 the department ~~A treatment provider, approved pursuant to s.~~
 739 ~~456.076, shall provide the department or consultant with~~
 740 ~~information in accordance with the requirements of s.~~
 741 ~~456.076(4), (5), (6), (7), and (9).~~

742 Section 9. Paragraph (g) of subsection (1) of section
 743 460.413, Florida Statutes, is amended to read:

744 460.413 Grounds for disciplinary action; action by board or
 745 department.—

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

748 (g) Failing to report to the department any person who the
 749 licensee knows is in violation of this chapter or of the rules
 750 of the department or the board. However, a person who the
 751 licensee knows is unable to practice chiropractic medicine with
 752 reasonable skill and safety to patients by reason of illness or
 753 use of alcohol, drugs, narcotics, chemicals, or any other type
 754 of material, or as a result of a mental or physical condition,

588-02419-17

2017876c1

may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 10. Paragraph (f) of subsection (1) of section 461.013, Florida Statutes, is amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.—

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

(f) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows is unable to practice podiatric medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 11. Paragraph (f) of subsection (1) of section 462.14, Florida Statutes, is amended to read:

462.14 Grounds for disciplinary action; action by the department.—

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

(f) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department. However, a person who the licensee knows is unable to practice naturopathic medicine with reasonable skill

588-02419-17

2017876c1

and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 12. Paragraph (1) of subsection (1) of section 463.016, Florida Statutes, is amended to read:

463.016 Grounds for disciplinary action; action by the board.—

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

(1) Willfully failing to report any person who the licensee knows is in violation of this chapter or of rules of the department or the board. However, a person who the licensee knows is unable to practice optometry with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

Section 13. Paragraph (k) of subsection (1) of section 464.018, Florida Statutes, is amended to read:

464.018 Disciplinary actions.—

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

(k) Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department or the board. However, a person who the licensee knows is unable to practice nursing with reasonable skill and

588-02419-17

2017876c1

813 safety to patients by reason of illness or use of alcohol,
 814 drugs, narcotics, chemicals, or any other type of material, or
 815 as a result of a mental or physical condition, may be reported
 816 to a consultant operating an impaired practitioner program as
 817 described in s. 456.076 rather than to the department, however,
 818 if the licensee verifies that such person is actively
 819 participating in a board-approved program for the treatment of a
 820 physical or mental condition, the licensee is required to report
 821 such person only to an impaired professionals consultant.

822 Section 14. Paragraph (c) of subsection (2) of section
 823 464.204, Florida Statutes, is amended to read:

824 464.204 Denial, suspension, or revocation of certification;
 825 disciplinary actions.—

826 (2) When the board finds any person guilty of any of the
 827 grounds set forth in subsection (1), it may enter an order
 828 imposing one or more of the following penalties:

829 (c) Imposition of probation or restriction of
 830 certification, including conditions such as corrective actions
 831 as retraining or compliance with the department's impaired
 832 practitioner program operated by a consultant as described in s.
 833 456.076 an approved treatment program for impaired
 834 practitioners.

835 Section 15. Paragraph (o) of subsection (1) of section
 836 465.016, Florida Statutes, is amended to read:

837 465.016 Disciplinary actions.—

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

840 (o) Failing to report to the department any licensee under
 841 chapter 458 or under chapter 459 who the pharmacist knows has

588-02419-17

2017876c1

842 violated the grounds for disciplinary action set out in the law
 843 under which that person is licensed and who provides health care
 844 services in a facility licensed under chapter 395, or a health
 845 maintenance organization certificated under part I of chapter
 846 641, in which the pharmacist also provides services. However, a
 847 person who the licensee knows is unable to practice medicine or
 848 osteopathic medicine with reasonable skill and safety to
 849 patients by reason of illness or use of alcohol, drugs,
 850 narcotics, chemicals, or any other type of material, or as a
 851 result of a mental or physical condition, may be reported to a
 852 consultant operating an impaired practitioner program as
 853 described in s. 456.076 rather than to the department.

854 Section 16. Paragraph (f) of subsection (1) of section
 855 466.028, Florida Statutes, is amended to read:

856 466.028 Grounds for disciplinary action; action by the
 857 board.—

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

860 (f) Failing to report to the department any person who the
 861 licensee knows, or has reason to believe, is clearly in
 862 violation of this chapter or of the rules of the department or
 863 the board. However, a person who the licensee knows, or has
 864 reason to believe, is clearly unable to practice her or his
 865 profession with reasonable skill and safety to patients by
 866 reason of illness or use of alcohol, drugs, narcotics,
 867 chemicals, or any other type of material, or as a result of a
 868 mental or physical condition, may be reported to a consultant
 869 operating an impaired practitioner program as described in s.
 870 456.076 rather than to the department.

588-02419-17

2017876c1

871 Section 17. Paragraph (h) of subsection (1) of section
 872 467.203, Florida Statutes, is amended to read:
 873 467.203 Disciplinary actions; penalties.—
 874 (1) The following acts constitute grounds for denial of a
 875 license or disciplinary action, as specified in s. 456.072(2):
 876 (h) Failing to report to the department any person who the
 877 licensee knows is in violation of this chapter or of the rules
 878 of the department. However, a person who the licensee knows is
 879 unable to practice midwifery with reasonable skill and safety to
 880 patients by reason of illness or use of alcohol, drugs,
 881 narcotics, chemicals, or any other type of material, or as a
 882 result of a mental or physical condition, may be reported to a
 883 consultant operating an impaired practitioner program as
 884 described in s. 456.076 rather than to the department.
 885 Section 18. Paragraph (f) of subsection (1) of section
 886 468.217, Florida Statutes, is amended to read:
 887 468.217 Denial of or refusal to renew license; suspension
 888 and revocation of license and other disciplinary measures.—
 889 (1) The following acts constitute grounds for denial of a
 890 license or disciplinary action, as specified in s. 456.072(2):
 891 (f) Failing to report to the department any person who the
 892 licensee knows is in violation of this part or of the rules of
 893 the department or of the board. However, a person who the
 894 licensee knows is unable to practice occupational therapy with
 895 reasonable skill and safety to patients by reason of illness or
 896 use of alcohol, drugs, narcotics, chemicals, or any other type
 897 of material, or as a result of a mental or physical condition,
 898 may be reported to a consultant operating an impaired
 899 practitioner program as described in s. 456.076 rather than to

Page 31 of 33

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

588-02419-17

2017876c1

900 the department.
 901 Section 19. Paragraph (n) of subsection (1) of section
 902 468.3101, Florida Statutes, is amended to read:
 903 468.3101 Disciplinary grounds and actions.—
 904 (1) The department may make or require to be made any
 905 investigations, inspections, evaluations, and tests, and require
 906 the submission of any documents and statements, which it
 907 considers necessary to determine whether a violation of this
 908 part has occurred. The following acts shall be grounds for
 909 disciplinary action as set forth in this section:
 910 (n) Being terminated from an impaired practitioner program
 911 operated by a consultant as described in s. 456.076 for failure
 912 to comply, without good cause, with the terms of monitoring or a
 913 participant contract entered into by the licensee, or for not
 914 successfully completing a drug treatment or alcohol treatment
 915 program ~~Failing to comply with the recommendations of the~~
 916 ~~department's impaired practitioner program for treatment,~~
 917 ~~evaluation, or monitoring. A letter from the director of the~~
 918 ~~impaired practitioner program that the certificateholder is not~~
 919 ~~in compliance shall be considered conclusive proof under this~~
 920 ~~part.~~
 921 Section 20. Section 474.221, Florida Statutes, is amended
 922 to read:
 923 474.221 Impaired practitioner provisions; applicability.—
 924 Notwithstanding the transfer of the Division of Medical Quality
 925 Assurance to the Department of Health or any other provision of
 926 law to the contrary, veterinarians licensed under this chapter
 927 shall be governed by the ~~treatment~~ of impaired practitioner
 928 program provisions of s. 456.076 as if they were under the

Page 32 of 33

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

588-02419-17

2017876c1

jurisdiction of the Division of Medical Quality Assurance,
except that for veterinarians the Department of Business and
Professional Regulation shall, at its option, exercise any of
the powers granted to the Department of Health by that section,
and "board" shall mean board as defined in this chapter.

Section 21. Paragraph (o) of subsection (1) of section
483.825, Florida Statutes, is amended to read:

483.825 Grounds for disciplinary action.—

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

(o) Failing to report to the department a person or other
licensee who the licensee knows is in violation of this chapter
or the rules of the department or board adopted hereunder.
However, a person or other licensee who the licensee knows is
unable to perform or report on clinical laboratory examinations
with reasonable skill and safety to patients by reason of
illness or use of alcohol, drugs, narcotics, chemicals, or any
other type of material, or as a result of a mental or physical
condition, may be reported to a consultant operating an impaired
practitioner program as described in s. 456.076 rather than to
the department.

Section 22. This act shall take effect upon becoming a law.

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 888

INTRODUCER: Senator Bean

SUBJECT: Prescription Drug Price Transparency

DATE: April 17, 2017

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Looke	Stovall	HP	Favorable
2. Forbes	Williams	AHS	Pre-meeting
3. _____	_____	AP	_____

I. Summary:

Currently, the Agency for Health Care Administration (AHCA) lists 150 medications on its website for retail drug prices, although current statute only requires 100 medications to be listed. SB 888 requires the AHCA to list on its website retail drug prices, by pharmacy, for a 30-day supply of the 300 most frequently prescribed medications. The bill requires the AHCA to update the prices monthly.

The bill does not impact of state revenues or expenditures.

This bill takes effect upon becoming law.

II. Present Situation:

Currently, s. 408.062, F.S., requires that the AHCA collect quarterly a statistically valid sample of data on the retail prices charged by pharmacies for the 100 most frequently prescribed medicines from any pharmacy licensed by this state as a special study authorized by the Legislature to be performed by the agency quarterly. If the drug is available generically, price data must be reported for both the generic drug and brand-named drug for which the generic drug is the equivalent. The AHCA is required to make available on its Internet website, for each pharmacy, drug prices for a 30-day supply at a standard dose.

AHCA's website implementing s. 408.062, F.S., is MyFloridaRx.¹ The AHCA established the webpage in 2005 in collaboration with the Attorney General's Office. Currently, the AHCA

¹ See <http://www.myfloridarx.com/>

collects and provides retail pricing information² for the 150 most commonly prescribed medications and the website is updated on a monthly basis. The source of the data is the usual and customary price³ as reported to the AHCA on Medicaid fee-for-service pharmacy claims and Medicaid HMO encounters. Visitors to the website can search for pricing information by county, city, or name of the medication they need. The search output displays pharmacy name, address, and telephone number; pharmacy zip code; drug name and strength; most commonly dispensed quantity; and price.⁴

III. Effect of Proposed Changes:

SB 888 enhances price transparency for consumers of prescription medications by increasing the number of commonly prescribed medications for which the retail price is disclosed on the AHCA website to help consumers shop for the lowest price in their area for their prescription drugs.

The bill amends s. 408.062, F.S., to require the AHCA to list on its website retail drug prices, by pharmacy, for a 30-day supply of the 300 most frequently prescribed medications and to update the prices monthly.

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

² Prices that reflect what an uninsured consumer would pay.

³ Usual and customary price in this context means the average charge to all other customers during the same calendar quarter for the same drug, quantity, and strength.

⁴ Agency for Health Care Administration, *Senate Bill 888 Analysis* (Feb. 3, 2017) (on file with the Senate Committee on Health Policy Committee).

C. Government Sector Impact:

The bill does not impact state revenues or expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 408.062 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.)

None.

B. Amendments:

None.

By Senator Bean

4-01279-17

2017888__

A bill to be entitled

An act relating to prescription drug price transparency; amending s. 408.062, F.S.; requiring the Agency for Health Care Administration to collect data on the retail prices charged by pharmacies for the 300 most frequently prescribed medicines; requiring the agency to update its website monthly; providing an effective date.

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

Section 1. Paragraph (h) of subsection (1) of section 408.062, Florida Statutes, is amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(h) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the 300 ~~100~~ most frequently prescribed medicines from any pharmacy licensed by this state ~~as a special study authorized by the Legislature to be performed by the agency quarterly~~. If the drug is available generically, price data shall be reported for the generic drug and price data of a brand-named drug for which the generic drug is the equivalent shall be reported. The agency shall make available on its Internet website for each pharmacy, ~~no later than October 1, 2006,~~ drug prices for a 30-day supply at a

Page 1 of 2

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

4-01279-17

2017888__

standard dose. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region and updated monthly ~~quarterly~~.

Section 2. This act shall take effect upon becoming a law.

Page 2 of 2

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

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 1130

INTRODUCER: Health Policy Committee and Senators Bean and Mayfield

SUBJECT: Pregnancy Support Services

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Lloyd</u>	<u>Stovall</u>	<u>HP</u>	Fav/CS
2.	<u>Loe</u>	<u>Williams</u>	<u>AHS</u>	Pre-meeting
3.	<u> </u>	<u> </u>	<u>AP</u>	<u> </u>

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 1130 creates s. 381.96, F.S., to codify the existing Pregnancy Support Services Program (program) which has been funded by the state since the 2005-2006 fiscal year. A nonprofit corporation provides pregnancy support and wellness support services, such as direct client services, program awareness activities, and communication activities, through a statewide alliance of community organizations. The bill directs the Department of Health (DOH) to specify contract deliverables with the program, including financial reports, staffing requirements, and timeframes for achieving obligations. The program is to contract only with providers that exclusively promote and support childbirth.

The bill has no impact on state revenues or expenditures.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Florida's Birth Rate

In 2015, over 214,000 women aged 15 to 50 in Florida had a birth in the past 12 months.¹ Unlike the national trend that shows an upward tick in the birth rate, Florida's birth rate has slowly

¹ United States Census Bureau, *American Fact Finder - Selected Characteristics in the United States, 2011-2015 American Community Survey 5-Year Estimates*,

trended downward for several years.² Of Florida's total births, 42 percent of all births are to unwed mothers with 86 percent of the fathers acknowledged on the birth certificate.³

The state's infant mortality rate decreased to 6.0 infant deaths per 1,000 live births in 2014, the lowest rate in Florida's history. The department conducted an annual analysis through 2015 of expected infant mortality rates and low birth rates by county based on unique demographics of the area. Variables that were identified included the mother's race, marital status, and educational attainment.⁴ Higher fluctuations in expected versus actual rates were seen in the smaller, rural counties compared to the larger, urban counties across the multi-year time period.

The Florida Pregnancy Care Network

The Florida Pregnancy Care Network (network) is a private 501(c)(3)⁵ nonprofit organization that provides financial and other support to pregnant women and their families through an alliance of pregnancy support organizations. The network includes 74 resource organizations throughout the state that provide counseling, referral, material support, training, and education to pregnant mothers as they prepare to parent or place their babies for adoption.⁶

Florida Pregnancy Support Services Program

The network administers the Florida Pregnancy Support Services Program (program) through a contract with the DOH. The program has received state funding since the 2005-2006 fiscal year, including \$4 million in general revenue funds for the 2016-2017 fiscal year.⁷

Proviso language in the Fiscal Year 2016-2017 General Appropriations Act (GAA) permits the funds to be used for wellness services, including but not limited to, high blood pressure screening, flu vaccines, anemia testing, thyroid screening, cholesterol, diabetes screening, assistance with smoking cessation, and tetanus vaccines.⁸ The GAA also requires that at least 85 percent of the funds appropriated be used for direct client services such as life skills, program awareness, and communications.⁹ The department is directed to specifically contract with the program's current contract management provider and to provide the contractual oversight. The department is authorized by the Fiscal Year 2016-2017 GAA to spend no more than \$50,000 for administrative oversight activities. Similar proviso language has been included in the GAA since the 2009-2010 fiscal year.

https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_5YR_DP02&src=pt (last visited Mar. 10, 2017).

² *Id.*

³ Department of Health, *FL Health Charts, Pregnancy and Young Child Profile*,

<http://www.flhealthcharts.com/charts/MICProfile.aspx?county=1&profileyear=2015&tn=30>, (last visited: Mar. 10, 2017).

⁴ Daniel Thompson and Cheryl Clark, Department of Health, Division of Community Health Promotion, Bureau of Family Health Services, *Infant Mortality and Low Birth Weight Actual Rates Compared to Expected Rates by County for Florida 2014*, <http://www.floridahealth.gov/diseases-and-conditions/infant-mortality-and-adverse-birth-outcomes/documents/expected-rates-by-county-2014.pdf> (last visited Mar. 10, 2017).

⁵ Section 501(c)(3) of the Internal Revenue Code. Organizations described in this section are commonly referred to as charitable organizations.

⁶ Florida Pregnancy Care Network, *Introduction*, <http://myfpcn.com/>, (last visited Mar. 10, 2017).

⁷ Chapter 2016-66, Specific Appropriation 464, Laws of Fla.

⁸ *Id.*

⁹ *Id.*

Financial reimbursement through this contract is made to local pregnancy resource organizations for services to pregnant women and their families by the program.¹⁰ While many participating organizations may be faith-based, they are not permitted to share religious information and contracting entities must ensure that they will strictly adhere to this regulation.¹¹

The program also provides a statewide toll free number¹² that is available 24/7 via phone or text message, a helpline via email,¹³ and a website that can also connect women and their families to available resources.¹⁴ All services are available to women and their families free of charge and can continue for up to 12 months after the birth of the child.

Pregnant women and their families may use the program to prepare for pregnancy, childbirth, and parenting. The program offers free counseling and classes that cover these topics as well as nutrition and infant care. Participants may also receive items such as maternity and baby clothing, diapers, formula and baby food, baby bath items, cribs and infant carriers by participating in on-site classes and training.¹⁵ For Fiscal Year 2015-2016, the program served 24,184 clients and has served 16,448 clients through January 2017 of the 2016-2017 fiscal year.¹⁶

Background Screenings for Qualified Entities

Under s. 943.0542, F.S., certain business and organizations that provide care or care placement services, or licenses or certifies to provide care or care placement services, may have access to criminal history information from the Florida Department of Law Enforcement (FDLE) after registering with the FDLE and payment of any fees. The qualified entity must submit fingerprints to the FDLE with its request for screening and maintain a signed waiver allowing the release of the state and national criminal history record to the qualified entity. The amount of the fee is set by the Federal Bureau of Investigation for the national criminal history check in compliance with the National Child Protection Act of 1993, as amended.

The national criminal history data is available to qualified entities to use only for the purpose of screening employees and volunteers or persons applying to be employees or volunteers. The FDLE will provide the information directly to the qualified entity as permitted by the written waiver. Whether the individual is fit to be an employee or volunteer around children or the elderly is for the qualified entity to determine; the FDLE will not make that determination. The qualified entity must notify the screened individual of his or her right to obtain a copy of the screening report as well as any criminal records.

¹⁰ Florida Pregnancy Care Network, *Florida Pregnancy Support Services Program*, <http://myfpcn.com/about.html> (last visited Mar. 10, 2017).

¹¹ *Id.*

¹² The toll-free number is 1-866-673-4673 or participants can text the word “choice” to 313131.

¹³ The helpline via email is floridapregnancy@optionline.org.

¹⁴ Florida Pregnancy Support Services, *I Might Be Pregnant* <http://www.floridapregnancysupportservices.com/i-might-be-pregnant/> (last visited Mar. 10, 2017).

¹⁵ Florida Pregnancy Support Services, *I Am Pregnant and Considering Terminating My Pregnancy*, <http://www.floridapregnancysupportservices.com/i-am-pregnant-and-need-help/> (last visited Mar. 10, 2017).

¹⁶ Email from Bryan Wendel, Florida Department of Health, (Mar. 13, 2017) (on file with the Senate Committee on Health Policy).

III. Effect of Proposed Changes:

Section 1 creates s. 381.96, F.S., to codify the Pregnancy Support Services Program, a program that has been funded through the General Appropriations Act since the 2005-2006 fiscal year. The bill implements most of the provisions from the prior years' proviso language with a few exceptions and additions as noted below:

- A specific directive to spend at least 90 percent of the contract funds on pregnancy support and wellness services rather than 85 percent of appropriated funds on direct client services, including life skills, program awareness, and communications.
- A specific requirement for background screening under s. 943.0542, F.S., for all paid staff and volunteers of a subcontractor if those individuals provide direct client services to a client who is a minor or an elderly person who has a disability.

The bill directs the DOH to specify the contract deliverables with the program, including requirements to:

- Establish the financial deliverables and delivery dates, the timeframes for achieving the contractual obligations, and any other requirements deemed necessary by the DOH, such as staffing and location requirements;
- Monitor subcontractors annually and to specify the sanctions that shall be imposed for noncompliance with the terms of a subcontract;
- Establish and manage the subcontracts with a sufficient number of networks to ensure availability of pregnancy support and wellness services and to maintain delivery of those services throughout the contract term;
- Offer wellness services or vouchers or other appropriate payment arrangements that allow for the purchase of services from providers;
- Subcontract only with providers that exclusively promote and support childbirth; and
- Ensure that informational materials provided to eligible clients is accurate, current, and cites a reference source of medical statement.

Section 2 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

Either the individual resource organizations or the program will be paying the costs of the criminal background checks at the cost of \$36.00 per employee or \$28.75 per volunteer.¹⁷ The current contract between the program and the department requires the program's subcontractors to follow these same screening requirements.¹⁸ The current contract places this responsibility on the individual subcontractors.

C. Government Sector Impact:

The DOH is responsible for the contractual oversight of the state's funding of the program. Proviso language included in the Fiscal Year 2016-2017 GAA places a cap of \$50,000 on DOH administrative costs.¹⁹ The bill does not place a maximum or minimum funding amount for the DOH's administrative oversight functions.

The FDLE will be processing additional background checks for the program employees and volunteers. It is unknown at this time how many employees or volunteers will be processed under this new requirement. The background check will cost \$36.00 for employees and \$28.75 for volunteers.²⁰

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.96 of the Florida Statutes.

¹⁷ Florida Department of Law Enforcement, *Criminal History Record Check Fee Schedule* (October 1, 2016) https://www.fdle.state.fl.us/cms/Criminal-History-Records/Documents/BackgroundChecks_FAQ.aspx, p. 8, (last visited Mar. 10, 2017)

¹⁸ State of Florida, Department of Health and Florida Pregnancy Care Network, Inc. (Contract #COHD2), (Feb. 2, 2017) (on file with the Senate Committee on Health Policy).

¹⁹ *Supra* note 8.

²⁰ *Supra* note 19.

IX. Additional Information:

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

CS by Health Policy Committee on March 13, 2017:

The CS corrects a technical issue as the bill contemplated the inclusion of both pregnancy support services and wellness services. For consistency, the CS added “wellness services,” as appropriate to address the deficiency.

- B. **Amendments:**

None.



698954

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Between lines 95 and 96
insert:

Section 2. (1) The Office of Program Policy Analysis and
Government Accountability (OPPAGA) shall conduct a study of the
pregnancy support services program to evaluate the effectiveness
and cost efficiency of the program and provide recommendations
on whether the program should be continued or eliminated. The
report must include information about the Florida Pregnancy Care



698954

Network, its affiliated pregnancy support and resource organizations, and any other subcontractors to whom state funds are expended for pregnancy support services. The report must also include the total amount of state funds appropriated and expended by fiscal year for the pregnancy support services program since its inception.

(2) As part of the study, OPPAGA must assess the effectiveness of the Department of Health's financial and administrative oversight and monitoring of the network.

(3) As part of determining the effectiveness of the program, the study must include, but need not be limited to, gathering information pertaining to:

(a) The use of state funding by the department, the network, and subcontractors, and how expenditures are tracked and accounted for through items such as financial statements or expenditure reports.

(b) The percentage of funding used for:

1. Direct client services, including the average amount of a voucher provided to eligible clients for services;

2. Wellness services;

3. Program awareness activities; and

4. Communication activities.

(c) The performance and outcome measures used by the department and the network to ensure quality of care, client satisfaction, and positive health outcomes for eligible clients, including the most recent results.

(d) The methods used by the department and the network to ensure that eligible clients receive accurate medical information.



698954

40 (e) The methods used by the department and the network to
41 resolve complaints and grievances, including information about
42 the number of complaints and grievances received and their
43 disposition.

44 (f) Network adequacy standards used to ensure the
45 availability of pregnancy support and wellness services for
46 eligible clients.

47 (g) Fraud and abuse measures implemented by the department
48 and the network to ensure program accountability and to prevent
49 waste of state funds.

50 (h) For the most recently completed fiscal year, if a
51 corrective action plan or sanction was imposed on the network or
52 its subcontractors, a description, the outcome, and the amount
53 of monetary fines or penalties, if any.

54 (i) The controls used by the department to ensure that
55 services provided by the network and its subcontractors are
56 provided in a noncoercive manner and do not include any
57 religious content. Such services may include client interviews
58 or surveys.

59 (j) The educational and medical qualifications of the
60 network's staff or the staff of the subcontractors who interact
61 with eligible clients.

62 (k) Citations of any medical statements included in
63 informational materials provided by the network or its
64 subcontractors to an eligible client.

65 (l) Information about the ownership of each subcontractor
66 and any financial or ownership interests with providers who
67 receive vouchers to provide services to eligible clients.

68 (m) Other audits, evaluative reports, or information



698954

pertaining to the pregnancy support services program to ensure the delivery of high-quality, cost-effective services to eligible clients.

(4) If OPPAGA recommends program continuation, it shall include recommendations for program improvement and methods to ensure that eligible clients have access to the full range of referral information to make reproductive health decisions.

(5) OPPAGA shall submit a report with its findings and recommendations to the President of the Senate, the Speaker of the House of Representatives, and the standing legislative committees that have substantive jurisdiction over health care services by January 1, 2018.

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

And the title is amended as follows:

Delete line 16
and insert:

religious content; requiring the Office of Program Policy Analysis and Government Accountability to conduct a study to evaluate the effectiveness and cost efficiency of the pregnancy support services program and provide recommendations on whether the program should be continued; providing criteria to be included in the study and in a report; requiring the report to be submitted to the Legislature by a specified date; providing an effective date.

By the Committee on Health Policy; and Senator Bean

588-02414-17

20171130c1

A bill to be entitled

An act relating to the pregnancy support services; creating s. 381.96, F.S.; providing definitions; requiring the Department of Health to contract with a not-for-profit statewide alliance of organizations to provide pregnancy support services through subcontractors; providing duties of the department; providing contract requirements; requiring the contractor to spend a specified percentage of funds on direct client services; requiring the contractor to annually monitor subcontractors; providing for subcontractor background screenings under certain circumstances; specifying the entities eligible for a subcontract; requiring services to be provided in a noncoercive manner and forbidding the inclusion of religious content; providing an effective date.

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

Section 1. Section 1. Section 381.96, Florida Statutes, is created to read:

381.96 Pregnancy support services.—

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

(a) "Department" means the Department of Health.

(b) "Eligible client" means a pregnant woman or a woman who suspects she is pregnant, and the family of such woman, who voluntarily seeks pregnancy support services. The woman and her family shall continue to be eligible clients for no more than 12 months after the birth of the child.

Page 1 of 4

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

588-02414-17

20171130c1

(c) "Florida Pregnancy Care Network, Inc.," or "network" means the not-for-profit statewide alliance of pregnancy support organizations that provide pregnancy support services and wellness services through a comprehensive system of care to women and their families.

(d) "Pregnancy support services" means services that promote and encourage childbirth, including, but not limited to:

1. Direct client services, such as pregnancy testing, counseling, referral, training, and education for pregnant women and their families.

2. Program awareness activities, including a promotional campaign to educate the public about the pregnancy support services offered by the network and a website that provides information on the location of providers in the user's area, as well as other available community resources.

3. Communication activities, including the operation and maintenance of a hotline or call center with a single statewide toll-free number which is available 24 hours a day for an eligible client to obtain the location and contact information for a pregnancy center located in his or her area.

(e) "Wellness services" means services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to, high blood pressure screening, flu vaccinations, anemia testing, thyroid screening, cholesterol screening, diabetes screening, assistance with smoking cessation, and tetanus vaccinations.

(2) DEPARTMENT DUTIES.—The department shall contract with the network for the management and delivery of pregnancy support services and wellness services to eligible clients.

Page 2 of 4

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

588-02414-17

20171130c1

(3) CONTRACT REQUIREMENTS.—The department contract shall specify the contract deliverables, including financial reports and other reports due to the department, timeframes for achieving contractual obligations, and any other requirements the department determines are necessary, such as staffing and location requirements. The contract shall require the network to:

(a) Establish, implement, and monitor a comprehensive system of care through subcontractors to meet the pregnancy support and wellness needs of eligible clients.

(b) Establish and manage subcontracts with a sufficient number of providers to ensure the availability of pregnancy support and wellness services for eligible clients, and maintain and manage the delivery of such services throughout the contract period.

(c) Spend at least 90 percent of the contract funds on pregnancy support and wellness services.

(d) Offer wellness services through vouchers or other appropriate arrangements that allow the purchase of services from qualified health care providers.

(e) Require a background screening under s. 943.0542 for all paid staff and volunteers of a subcontractor if such staff or volunteers provide direct client services to an eligible client who is a minor or an elderly person or who has a disability.

(f) Annually monitor its subcontractors and specify the sanctions that shall be imposed for noncompliance with the terms of a subcontract.

(g) Subcontract only with providers that exclusively

588-02414-17

20171130c1

promote and support childbirth.

(h) Ensure that informational materials provided to an eligible client by a provider are current and accurate and cite the reference source of any medical statement included in such materials.

(4) SERVICES.—Services provided pursuant to this section must be provided in a noncoercive manner and may not include any religious content.

Section 2. This act shall take effect July 1, 2017.

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 1144

INTRODUCER: Health Policy Committee and Senator Montford

SUBJECT: Laboratory Screening

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	Fav/CS
2.	Loe	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1144 amends the powers and duties of the Department of Health (DOH) pertaining to:

- Human Immunodeficiency Virus (HIV) - The bill requires providers in only nonhealth care settings to inform persons to be tested that a positive test result will be reported to the county health department (CHD) and the CHD will provide that person with locations for anonymous testing.
- Laboratory Screening for Other States - The bill authorizes the DOH to perform public health laboratory testing for other states on a fee-for-service basis.
- Lead Poison Screening - The bill revises the Lead Poisoning Prevention Screening and Educational Act to conform to federal guidelines and modifies the scope of responsibilities required of the DOH.
- Newborn Screening - The bill revises the composition of the Genetics and Newborn Screening Advisory Council (GNSAC), adds eligible individuals who may receive test results from the Newborn Screening Program (NSP), and expands the responsibility of the NSP to screen for genetic disorders even when treatment is not currently available.

The bill has no impact on state revenues or expenditures.

The bill provides an effective date of July 1, 2017.

II. Present Situation:

Human Immunodeficiency Virus (HIV)

HIV is an immune system virus that can lead to acquired immunodeficiency syndrome, or AIDS. HIV affects specific cells in the immune system and, over time, the virus can destroy so many of those cells that the body cannot fight off infections and disease.¹ There is no cure for HIV but it can be controlled with proper medical care, including antiretroviral therapy (ART). If taken properly, ART can dramatically prolong the lives of people infected with HIV, keep them healthy, and greatly lower the chance of infecting others.² A person diagnosed with HIV and treated, before the disease advances, can live nearly as long as someone who does not have HIV. If left untreated, HIV is almost always fatal.³

In the U.S., HIV is spread mainly through unprotected sex with someone who has HIV or by sharing needles, syringes, or other equipment used to inject drugs with someone who has HIV. HIV can also be spread from mother to baby during pregnancy, birth or breastfeeding.⁴ The Centers for Disease Control and Prevention (CDC) estimated that in 2013, the most recent year for which the information is available, more than 1.2 million persons in the U.S. were living with HIV, including 13 percent (one in eight) who were unaware they were infected. However, the annual number of new HIV cases declined by 19 percent from 2005 to 2014. In 2015, approximately 39,513 persons were diagnosed with HIV; and gay and bisexual African American men were the population group most affected.⁵

HIV Testing

An HIV test is a medical test ordered to determine the presence or absence of antibodies or antigens to the human immunodeficiency virus, or the presence or absence of human immunodeficiency virus itself.⁶ The CDC supports HIV testing that occurs during an individual's routine health care visit.⁷ This is especially important for people who may not consider themselves at risk for HIV.⁸

The most common test for HIV is an HIV antibody test, where blood or saliva are checked for specific HIV fighting proteins known as HIV antibodies.⁹ This test is considered "preliminary"

¹ Centers for Disease Control and Prevention, *About HIV/AIDS* (updated November 30, 2016), available at <http://www.cdc.gov/hiv/basics/whatishiv.html>, (last visited March 20, 2017).

² *Id.*

³ *Id.*

⁴ Centers for Disease Control and Prevention, *HIV Transmission*, (updated December 21, 2016), available at <http://www.cdc.gov/hiv/basics/transmission.html>, (last visited March 20, 2017).

⁵ Centers for Disease Control and Prevention, *HIV in the United States: At A Glance* (updated December 2, 2016), available at <http://www.cdc.gov/hiv/statistics/basics/ataglance.html>, (last visited March 20, 2017).

⁶ Section 381.004(1)(b), F.S.

⁷ Centers for Disease Control and Prevention, *State HIV Testing Laws: Consent and Counseling Requirements* (updated March 18, 2015), available at <http://www.cdc.gov/hiv/policies/law/states/testing.html>, (last visited March 20, 2017).

⁸ In Florida, only 42.2 percent of adults reported having ever been tested for HIV; Florida Department of Health, *Florida Charts*, available at <http://www.flhealthcharts.com/charts/Brfss/StateDataViewer.aspx?bid=119> (last visited March 20, 2017).

⁹ The U.S. Department of Health and Human Services, *Types of HIV Tests*, (updated Mar. 7, 2017) available at <http://aids.gov/hiv-aids-basics/prevention/hiv-testing/hiv-test-types/index.html>, (last visited March 20, 2017).

because it can take between three to 12 weeks for the body to produce sufficient HIV antibodies for the test to detect the presence of the antibodies.¹⁰ If the test result is positive, follow-up diagnostic testing is required to confirm the presence of the HIV.

Follow-up HIV testing detects both antibodies and antigens. The antibody-antigen test can find a recent HIV infection earlier than tests that detect only antibodies, but antibody-antigen tests are only available for blood, not other body fluids.¹¹

HIV in Florida

The DOH estimates that approximately 127,589 persons living in Florida are infected with HIV.¹² In 2016, Florida ranked first in the nation in the number of new HIV cases, with over 5,300 new cases; however, this was down from 2014, when there were more than 6,000 newly reported HIV infections in Florida.¹³

HIV Testing in Florida

Section 381.004, F.S., governs HIV testing in Florida. It creates a statewide network of confidential and anonymous HIV testing and counseling sites, and establishes procedures for HIV testing, informed consent, and reporting requirements. The DOH CHDs are the primary source for state-sponsored HIV programs and provide testing, counseling, prevention outreach, and education to the public. The CHDs, and any other person conducting an AIDS or HIV testing program, must register with the DOH and meet necessary requirements.¹⁴ The statute was enacted to create an environment in which people would agree to seek out HIV testing because they would be sufficiently informed about the infection and assured about the privacy of a decision to be tested.¹⁵

Notification and Informed Consent

Section 381.004(2), F.S., differentiates between a “health care setting” and a “nonhealth care setting” when delineating the procedures required to obtain a person’s consent to perform an HIV test.

In the health care setting, the person to be tested must be notified, either orally or in writing, that the test is planned and that he or she has a right to refuse. If the person consents and has a current, signed general medical consent form, no separate consent form is required for the HIV test. If the person refuses the HIV test, it must be documented in their medical records.¹⁶ A

¹⁰ Id.

¹¹ Centers for Disease Control and Prevention, *Testing* (updated December 6, 2016), available at <http://www.cdc.gov/hiv/basics/testing.html>, (last visited March 20, 2017).

¹² Department of Health, *HIV Data Center*, available at <http://www.floridahealth.gov/%5C/diseases-and-conditions/aids/surveillance/index.html>, (last visited March 20, 2017).

¹³ Department of Health, *HIV Disease: United States vs. Florida*, available at http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/2014/2014-us-vs-fl-fact-sheet.pdf, (last visited March 20, 2017).

¹⁴ Section 381.004(1), F.S.

¹⁵ Florida Department of Health, “*Florida’s Omnibus AIDS Act: A Brief Legal Guide for Health Care Professionals*,” Jack P. Hartog, Esq., (August 2013), available at http://www.floridahealth.gov/diseases-and-conditions/aids/administration/_documents/Omnibus-booklet-update-2013.pdf, (last visited March 20, 2017).

¹⁶ Section 381.004(2), F.S.

“health care setting” is defined as a setting devoted to the diagnosis and care of persons or the provision of medical services to persons.

In a “nonhealth care setting,” a provider is required to obtain a subject’s informed consent before performing an HIV test. Informed consent must be preceded by an explanation of the subject’s right to confidential treatment of the test results and the information identifying him or her as the test subject.¹⁷ A “nonhealth care setting” is defined as a site that conducts HIV testing for the sole purpose of identifying HIV infection, but does not provide medical treatment.

In either the healthcare or nonhealth care setting, every person tested for HIV must first give his or her informed consent, except as specified in s. 381.004(2)(h), F.S. Informed consent for HIV testing requires:

- An explanation that the identity of the person to be tested, and the results of the test, are confidential and protected from disclosure to the extent permitted by law;
- Notice that persons with a positive HIV test will be reported to the local CHD; and
- Notice that anonymous testing is available and the locations of the anonymous testing sites.¹⁸

Informed consent must be in writing when it is:

- From the potential donor, or donor’s legal representative, prior to donating blood, blood components, organs, skin, semen, or other human tissue or body part;
- For insurance purposes; and
- For contract purposes in a health maintenance organization.¹⁹

Currently, test results contained in medical records of hospitals licensed under ch. 395, F.S., can be released under s. 395.3025, F.S., if the hospital has obtained written informed consent for the HIV test. Informed consent is not required in numerous situations, including when a significant exposure has occurred.²⁰

The DOH Laboratory Testing for Other States

Section 381.0202, F.S., directs the DOH to establish and maintain laboratories in the state for microbiological and chemical analysis and any other purpose it determines necessary for the protection of public health, safety, and welfare. The DOH operates the Bureau of Public Health Laboratories that provides diagnostic screening, monitoring, reference, research, and emergency public health laboratory services to CHDs and other official agencies, physicians, hospitals, and private laboratories.²¹

Due to costs and resource limitations, it is not feasible for all 50 states to maintain public health testing infrastructure.²² Furthermore, reagents to test for rare or emerging pathogens are often

¹⁷ *Supra* note 17.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ See s. 381.004(2)(e)14., F.S.

²¹ Department of Health, *Bureau of Public Health Laboratories*, available at <http://www.floridahealth.gov/programs-and-services/public-health-laboratories/index.html>, (last visited Mar. 21, 2017).

²² Department of Health, *House Bill 1041 Analysis (identical to SB 1144)*, (March 1, 2017) (on file with the Senate Committee on Health Policy).

only available in limited quantities from the CDC.²³ In response, the CDC advocates for the establishment of regional testing centers to perform specialized testing for multiple states.²⁴

Current statutory language does not give the DOH authority to perform public health laboratory testing for samples from other states.

Lead Poison Screening and Education

“Lead poisoning” or “lead toxicity” are both defined as high levels of lead, which is a heavy metal, typically associated with severe health effects. The amount of lead in the body and tissues, as well as the length of time of the exposure, determines the toxicity level and the signs and symptoms exhibited by a person.²⁵ The CDC has termed excessive absorption to lead as one of the most common pediatric health problems in the U.S. today, and it is entirely preventable.²⁶ Enough is known about lead poisoning to prevent lead exposure and permanently eradicate this condition. This makes the persistence of lead poisoning in the U.S. a singular and direct challenge to public health authorities, clinicians, regulatory agencies, and society.²⁷ While the U.S. has not eradicated lead poisoning completely, it has made tremendous progress in reducing lead exposure.²⁸

Adult Lead Poisoning

Lead poisoning in adults is a medical condition caused by increased BLLs in the body that can be from, among other things, food, water, soil, home building materials including lead paint, exhaust fumes, and industrial and recycling waste. Lead interferes with a variety of biologic processes and is toxic to many organs and tissues, including the heart, bones, intestines, kidneys, and reproductive and nervous systems. The CDC states that a BLL of five micrograms per deciliter (5 µg/dL) or above for an adult is cause for concern; however, lead may impair development and have harmful health effects at even lower levels. There is no known safe level of lead exposure.²⁹ In 2015, the National Institute for Occupational Safety and Health also designated five micrograms per deciliter (5 µg/dL) or above from whole blood, in a venipuncture blood sample, as an elevated BLL for adults.

Childhood Lead Poisoning

In the U.S. today, there are approximately 3.6 million families with a child under six years of age who live in homes with one or more conditions that can expose a child to lead levels that the U.S. Environmental Protection Agency (EPA) considers hazardous. The CDC recognizes a reference level of five micrograms of lead per deciliter (5 µg/dL) of blood to identify children

²³ *Id.*

²⁴ *Id.*

²⁵ Department of Health, *Adult Lead Poisoning*, available at http://www.floridahealth.gov/environmental-health/lead-poisoning/adults.html#heading_2, (last visited March 21, 2017).

²⁶ Centers for Disease Control and Prevention, *Preventing Lead Poisoning in Young Children, Chapter 1*, (last updated October 1991) available at <https://www.cdc.gov/nceh/lead/publications/books/plpyc/Chapter1.htm>, (last visited March 21, 2017).

²⁷ *Id.*

²⁸ See *Supra* note 28.

²⁹ *Id.*

whose BLLs are high enough for the CDC to recommend public health actions be initiated. Approximately 500,000 children each year ages one to five years of age exceed the reference level, which is based on an extrapolation of the U.S. population of children ages one to five who are tested for BLLs. The median concentration of BLLs for U.S. children one to five years of age has declined from 15 µg/dL in 1976-1980 to 0.7 µg/dL in 2013-2014 - a decrease of 95 percent;³⁰ however, there is no safe BLL for children that has been identified.³¹ The largest decline occurred between 1970 and 1990 following the elimination of lead in motor vehicle gasoline, the ban on lead paint for residential use, the removal of lead from food cans, bans on the use of lead pipes and plumbing fixtures, and other limitations on lead uses.³²

Signs and Symptoms of Lead Poisoning

Lead poisoning is classified acute or chronic depending upon the length of time the individual has been exposed to the source of the lead.³³ Signs and symptoms of acute lead poisoning include abdominal pain, nausea, diarrhea, and poor appetite.

Chronic lead poisoning usually presents itself with symptoms affecting multiple body systems. It is associated with three main types of symptoms: gastrointestinal, neuromuscular, and neurological. Central nervous system and neuromuscular symptoms usually result from intense exposure while gastrointestinal symptoms usually result from exposure over longer periods of time.

Lead Toxicity Testing

In 2012, the CDC adopted the BLL as its preferred method of testing children and adults for elevated levels of lead in the body, and five micrograms per deciliter (5 µg/dL) as the level where environmental or educational public health intervention is required.³⁴ While testing is available to detect lead in any body tissue, the primary tests used in the last 30 years to evaluate lead exposure that are readily available to practitioners to determine lead exposure levels in the human body are:

³⁰ Supra note 33, at p. 6, citing Centers for Disease Control and Prevention, National Center for Health Statistics, *National Health and Nutrition Examination Survey* (updated January 25, 2017) available at <https://www.cdc.gov/nchs/nhanes.htm>, (last visited March 21, 2017); See also U.S. Environmental Protection Agency, *America's Children and the Environment (ACE)* available at <https://www.epa.gov/ace>, (last visited March 21, 2017).

³¹ President's Task Force on Environmental Health Risks and Safety Risks to Children, *Key Federal Program to Reduce Childhood Lead Exposures and Eliminate Associated Health Impacts* (November 2016) available at https://ptfceh.niehs.nih.gov/features/assets/files/key_federal_programs_to_reduce_childhood_lead_exposures_and_eliminate_associated_health_impacts/presidents_508.pdf, (last visited March 21, 2017).

³² *Id.* at p. 5.

³³ Supra note 28.

³⁴ U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry, Environmental and Health Medicine Education, *Lead Toxicity: What Tests Can Assist with Diagnosis and Treatment of Lead Toxicity?* available at: <https://www.atsdr.cdc.gov/cssem/cssem.asp?csem=7&po=12>, (last visited March 21, 2017).

- Venipuncture³⁵ - BLL, Complete Blood Count, or EP and ZPP³⁶ blood levels;³⁷
- Capillary stick^{38,39} - for BLLs;
- Radiographs - Abdominal radiographs to detect the presence of radio-dense lead foreign bodies in the gastrointestinal tract, or long bone radiographs to detect the presence of lead lines;⁴⁰ and
- Hair and fingernail scrapings.⁴¹

Lead Poisoning Prevention Screening and Education Act

In 2006, the Florida Legislature created the Lead Poisoning Prevention Screening and Education Act (Act). The Act requires the DOH to establish a program for the early identification of persons at risk for having elevated BLLs. Section 381.985(1), F.S., requires the program to systematically screen children under the age of six in certain targeted populations for the presence of elevated BLLs. The DOH is required to consult with professional medical groups and other sources, and adopt rules that establish procedural guidelines for the screening of children under six, the appropriate intervals for re-screening, and the follow-up for children found to have elevated BLLs.⁴² The Act defines “elevated blood-lead level” as a quantity of lead in whole venous blood that exceeds ten micrograms per deciliter (10 µg/dL) or such other level as provided in the Act.⁴³

The Act requires the DOH to establish a statewide, multifaceted, ongoing educational program designed to meet the needs of tenants, property owners, health care providers, early childhood educators, care providers, and realtors concerning lead poisoning prevention.⁴⁴ This educational program requires the DOH to:

- Sponsor public service announcements on radio, television, print media, and the internet about the nature of lead-based paint hazards, the importance of standards for lead poisoning prevention, and the purposes and responsibilities of the Act; and

³⁵ Medicare defines venipuncture, for purposes of reimbursement using CPT code 36415, as the process of puncturing a vein and withdrawing a blood sample for purposes of analysis for testing. The most common method and site of venipuncture is the insertion of a needle into the cubital vein of the anterior forearm at the elbow fold. It is fee scheduled at \$3.10, the same as a capillary stick. See Medicare Fee, Payment, Procedure code, ICD, Denial, *CPT code venipuncture - 36415 and 36416 - Billing Tips - Not separately paid*, available at: <http://www.medicarepaymentandrebimbursement.com/2010/06/cpt-venipuncture-36415-not-seperately.html>, (last visited March 22, 2017).

³⁶ *Id.* Erythrocyte protoporphyrin (EP), commonly assayed as zinc protoporphyrin (ZPP), was previously considered the best test for screening for asymptomatic children; however, is not sufficiently sensitive at lower BLLs and therefore is not as useful a screening test for lead exposure as previously thought.

³⁷ *Id.* For individuals with high or chronic past exposure; however, BLLs often under-represent the total body burden because most lead is stored in the bone and may have “normal” levels in the blood.

³⁸ *Id.* The CDC recommends, that given the greater risk of contamination using the capillary stick method, an elevated BLL obtained through a capillary stick should always be confirmed through venipuncture.

³⁹ *Supra* note 43. Medicare defines a capillary stick, for purposes of reimbursement using CPT code 36416, as the collection of a blood specimen from the stick of the finger, heel, or ear. It is fee scheduled at \$3.10, the same as venipuncture.

⁴⁰ *Id.* These are lines of increased density on the metaphysis growth plate of the bone, showing radiological growth retardation. This is not a routine procedure to identify lead poisoning, but a radiological finding of chronic exposure.

⁴¹ *Id.* to detect their lead content is an uncertain estimate of body burden and is not recommended.

⁴² Section 381.985(1), F.S.

⁴³ Section 381.983(3), F.S.

⁴⁴ Section 381.984(1), F.S.

- Develop culturally and linguistically appropriate information pamphlets regarding lead poisoning, testing, prevention, treatment, and the purposes of the Act.⁴⁵

The DOH previously had federal funding to conduct a lead poisoning prevention program, including funding for a large media campaign; however, the federal funding for this program ended in 2012.⁴⁶

The Act also requires the DOH to maintain records of all screenings conducted, indexed geographically and by owner, to determine the location of areas with relatively high incidence of lead poisoning and elevated BLLs. All confirmed and probable cases of lead poisoning found in the course of screening must be reported to the affected individual, his or her parent or legal guardian if he or she is a minor, and the State Surgeon General.⁴⁷

Florida Newborn Screening Program

The Newborn Screening Program (NSP) screens all newborns for hearing impairment and to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.⁴⁸

The Florida Genetics and Newborn Screening Advisory Council (GNSAC) advises the DOH on which disorders should be added to the panel of screening for disorders, and the procedures for collecting and transmitting specimens.⁴⁹ The GNASC is made up of 15 members, including consumer members, various state agency representatives and health care providers, and one representative from each of the four medical schools in the state.⁵⁰ When the GNSAC was created, the state only had four medical schools. Currently there are ten medical schools in Florida.

The NSP currently screens for 31 core conditions and 22 secondary conditions,⁵¹ and 50 of these conditions are included in the 58 disorders listed in the federal Recommended Uniform

⁴⁵ Sections 381.984(2) and (3), F.S.

⁴⁶ *Supra* note 25.

⁴⁷ Section 381.985(3), F.S.

⁴⁸ Department of Health, *Florida Newborn Screening Guidelines* (2012), available at https://www.peds.ufl.edu/divisions/genetics/programs/newborn_screening/2012%20newborn%20screening%20guidelines%20FL.pdf, (last visited March 21, 2017).

⁴⁹ Section 383.14(5), F.S.

⁵⁰ *Id.*

⁵¹ Department of Health, *Disorder List* (December 17, 2013), available at <http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/documents/newborn-screening-disorders.pdf>, (last visited March 21, 2017); this list is also maintained by the DOH as a Rule. See also Rule 64C-7.002, F.A.C.

Screening Panel (RUSP).⁵² Currently, every disorder screened⁵³ on the NSP panel has known treatment options.

The NSP involves coordination among several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory in Jacksonville (state laboratory), Children's Medical Services (CMS) Newborn Screening Follow-up Program, and referral centers, birthing centers, and physicians throughout the state.⁵⁴

Currently, the state laboratory is only authorized to release the results of a newborn's metabolic tests or screenings to the newborn's health care practitioner.⁵⁵ Federal regulations require public health laboratories to release screening results, upon request, to the patient, the patient's parent or legal guardian, the patient's personal representative, or person designated by the patient or legal guardian.⁵⁶

III. Effect of Proposed Changes:

Human Immunodeficiency Virus (HIV)

Section 1 amends s. 381.004(2)(a), F.S., to remove the requirement on a provider in health care settings to inform a person seeking an HIV test that a positive test result will be reported to the CHD and the CHD will provide information on the availability and locations for anonymous testing. This section requires only providers in nonhealth care settings to inform persons seeking HIV testing of those facts.

Providers in health care settings will still be required to report positive HIV test results to the DOH. This section does not remove the reporting requirement, only the requirement for providers to provide the person seeking the HIV test the information that a positive result will be reported to the CHD and the CHD will provide information on the availability and locations for anonymous testing.

The DOH Laboratory Testing for Other States

Section 2 amends s. 381.0202, F.S., to authorize the DOH to perform laboratory testing related to public health for other states on a fee-for-service basis.

⁵² The federal Advisory Committee on Heritable Disorders in Newborns and Children (committee) advises the Secretary of the U.S. Department of Health and Human Services on the most appropriate application of universal newborn screening tests, technologies, policies, guidelines, and standards. The committee established the Recommended Uniform Screening Panel (RUSP), and periodically updates it. See U.S. Department of Health and Human Services, *Advisory Committee on Heritable Disorders in Newborns and Children*, available at <https://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/>, (last visited March 23, 2017).

⁵³ X-Linked Adrenoleukodystrophy (X-ALD) was recommended by the GNSAC on February 19, 2016, for inclusion to the NSP panel; however, screening for the disorder is not expected to begin until at least early 2018 when a test kit approved by the federal Food and Drug Administration is anticipated to be available.

⁵⁴ Department of Health, *Newborn Screening*, available at <http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/> (last visited March 21, 2017).

⁵⁵ Section 383.14(1)(c), F.S.

⁵⁶ 42 C.F.R. s. 493.1291(l) (2016).

Lead Poison Screening and Education

Section 3 s. 381.983(3), F.S., to revise the definition of an “elevated blood-lead level.” This section removes the requirement that, in determining a person’s BLL, the blood sample tested must be only whole venous blood. This section broadens the permissible test samples for BLLs to include blood from a capillary draw, but does not define the term “draw”. The use of a capillary sample to test for an elevated BLL might increase the cost of testing as, according to the CDC, all elevated BLLs from a capillary stick should be confirmed by secondary testing with a whole blood sample.⁵⁷

Section 3 eliminates the specific, numerical level of 10 µg/dL as the quantity of lead in the blood which constitutes an “elevated blood-lead level.” This section requires the DOH to specify by rule the test result level defining an elevated BLL based on national recommendations developed by the Council of State and Territorial Epidemiologists and the CDC. This change allows for the adjustment of reporting and screening requirements as the science relating to BLLs changes.

Section 4 amends s. 381.984(2)-(3), F.S., to revise the required media options for the DOH to use as it sponsors public service announcements regarding lead based paint hazards, lead poisoning prevention and the purposes and responsibilities set out in the Lead Poisoning Prevention Screening and Education Act.⁵⁸ This creates flexibility and may result in a cost savings for the distribution of educational materials regarding lead poisoning.

Section 5 amends s. 381.985, F.S., to require the DOH to establish guidelines for the early identification of persons at risk of having elevated BLLs and for the systematic screening of children under age six in targeted populations. This replaces the responsibility for the DOH to establish a program for the early identification of persons at risk for having elevated BLLs, which shall systematically screen children under the age of six in certain targeted populations for the presence of elevated BLLs.

Section 5 reduces the DOH reporting and record keeping requirements regarding BLLs. This section requires the DOH to only maintain records of screenings with an elevated BLL rather than all screenings, and removes the requirement to report all screening results to affected individuals and maintain geographically indexed records. This section places the requirement to notify the individual tested, or the individual’s parent or legal guardian if he or she is a minor, on the provider conducting or ordering the lead level screening.

Newborn Screening for Metabolic, Hereditary or Congenital Disorders

Section 6 amends s. 383.14(1)(c), F.S., to allow the state laboratory to release metabolic tests or screenings to a newborn’s parent or legal guardian, the newborn’s personal representative, or a person designated by the newborn’s parent or legal guardian. This change aligns state law with federal regulations relating to public health laboratories.

⁵⁷ *Supra* note 48.

⁵⁸ Sections 381.982 - 381.985, F.S.

Section 6 amends s. 383.14(3)(f), F.S., to expand the DOH's duties in the newborn screening program to also promote the availability of genetic services, in addition to the availability of genetic studies and counseling, so that family members may benefit from detection and available knowledge of conditions even when no treatment is currently available.

Section 6 amends s. 383.14(5), F.S. to update the composition of the GNSAC to include a representative from four of the 10 medical schools in the state. The number of medical school representatives remains the same, but this change allows representatives from all medical schools in the state the potential to be appointed to the GNSAC, not just those medical schools in existence when the GNSAC was created.

Section 7: The effective date of the bill is July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has no impact on state revenues or expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.004, 381.0202, 381.983, 381.984, 381.985, and 383.14.

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 March 27, 2017:

The CS reinstates the requirement for the DOH to sponsor and seek participation from the private sector for public service announcements about lead poisoning prevention but adds a choice of media for the announcements including radio, television, the internet, or in print media, rather than requiring the use of all methods.

- B. **Amendments:**

None.

By the Committee on Health Policy; and Senator Montford

588-02964A-17

20171144c1

1 A bill to be entitled
 2 An act relating to laboratory screening; amending s.
 3 381.004, F.S.; clarifying that certain requirements
 4 related to the reporting of positive HIV test results
 5 to county health departments apply only to testing
 6 performed in a nonhealth care setting; amending s.
 7 381.0202, F.S.; authorizing the Department of Health
 8 to perform laboratory testing for other states;
 9 amending s. 381.983, F.S.; redefining the term
 10 "elevated blood-lead levels"; amending s. 381.984,
 11 F.S.; revising requirements of a public information
 12 initiative on lead-based-paint hazards; revising
 13 requirements on the distribution of information on
 14 childhood lead poisoning developed by the State
 15 Surgeon General or his or her designee; amending s.
 16 381.985, F.S.; revising requirements for the State
 17 Surgeon General's program for early identification of
 18 persons at risk of having elevated blood-lead levels;
 19 requiring the department to maintain records showing
 20 elevated blood-lead levels; requiring that health care
 21 providers report to the individual who was screened
 22 the results that indicate elevated blood-lead levels;
 23 amending s. 383.14, F.S.; authorizing the State Public
 24 Health Laboratory to release the results of a
 25 newborn's hearing and metabolic tests to certain
 26 individuals; requiring the department to promote the
 27 availability of services to promote detection of
 28 genetic conditions; clarifying that the membership of
 29 the Genetics and Newborn Screening Advisory Council

588-02964A-17

20171144c1

30 must include one member each from four of the medical
 31 schools in this state; providing an effective date.
 32
 33 Be It Enacted by the Legislature of the State of Florida:
 34
 35 Section 1. Paragraph (a) of subsection (2) of section
 36 381.004, Florida Statutes, is amended to read:
 37 381.004 HIV testing.—
 38 (2) HUMAN IMMUNODEFICIENCY VIRUS TESTING; INFORMED CONSENT;
 39 RESULTS; COUNSELING; CONFIDENTIALITY.—
 40 (a) Before performing an HIV test:
 41 1. In a health care setting, the person to be tested shall
 42 be notified orally or in writing that the test is planned and
 43 that he or she has the right to decline the test. If the person
 44 to be tested declines the test, such decision shall be
 45 documented in the medical record. A person who has signed a
 46 general consent form for medical care is not required to sign or
 47 otherwise provide a separate consent for an HIV test during the
 48 period in which the general consent form is in effect.
 49 2. In a nonhealth care setting, a provider shall obtain the
 50 informed consent of the person upon whom the test is to be
 51 performed. Informed consent shall be preceded by an explanation
 52 of the right to confidential treatment of information
 53 identifying the subject of the test and the results of the test
 54 as provided by law. The provider shall also inform the test
 55 subject that a positive HIV test result will be reported to the
 56 county health department with sufficient information to identify
 57 the test subject and provide him or her with information on the
 58 availability and location of sites where anonymous testing is

588-02964A-17

20171144c1

performed. As required in paragraph (3)(c), each county health department shall maintain a list of sites where anonymous testing is performed which includes site locations, telephone numbers, and hours of operation.

~~The test subject shall also be informed that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject and of the availability and location of sites at which anonymous testing is performed. As required in paragraph (3)(c), each county health department shall maintain a list of sites at which anonymous testing is performed, including the locations, telephone numbers, and hours of operation of the sites.~~

Section 2. Section 381.0202, Florida Statutes, is amended to read:

381.0202 Laboratory services.—

(1) The department shall establish and maintain, in suitable and convenient places in the state, laboratories for microbiological and chemical analyses and any other purposes it determines necessary for the protection of the public health.

(2) The department may contract or agree with any person or public or private agency to provide laboratory services relating to or having potential impact on the public health or relating to the health of clients directly under the care of the state.

(3) The department is authorized to establish and collect reasonable fees and charges for laboratory services provided. Such fees and charges shall be deposited in a trust fund administered by the department and shall be used solely for this purpose.

588-02964A-17

20171144c1

(4) The department may perform laboratory testing related to public health for other states on a fee-for-service basis.

Section 3. Subsection (3) of section 381.983, Florida Statutes, is amended to read:

381.983 Definitions.—As used in this act, the term:

(3) "Elevated blood-lead level" means a quantity of lead in the whole venous blood, measured from a venous or capillary draw expressed in micrograms per deciliter (ug/dL), which exceeds the cutpoint specified in department rule. The determination of elevated blood-lead level must be based on national recommendations developed by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention. 10 ug/dL or such other level as specifically ~~provided in this act.~~

Section 4. Subsections (2) and (3) of section 381.984, Florida Statutes, are amended to read:

381.984 Educational programs.—

(2) PUBLIC INFORMATION INITIATIVE.—The Governor, in conjunction with the State Surgeon General and his or her designee, shall sponsor a series of public service announcements on radio, television, or the Internet, or in ~~and~~ print media about the nature of lead-based-paint hazards, the importance of standards for lead poisoning prevention in properties, and the purposes and responsibilities set forth in this act. In developing and coordinating this public information initiative, the sponsors shall seek the participation and involvement of private industry organizations, including those involved in real estate, insurance, mortgage banking, or ~~and~~ pediatrics.

(3) DISTRIBUTION OF INFORMATION ~~LITERATURE~~ ABOUT CHILDHOOD

588-02964A-17

20171144c1

LEAD POISONING. ~~By January 1, 2007,~~ The State Surgeon General or his or her designee shall develop culturally and linguistically appropriate information and distribution methods ~~pamphlets~~ regarding childhood lead poisoning, the importance of testing for elevated blood-lead levels, prevention of childhood lead poisoning, treatment of childhood lead poisoning, and, as where appropriate, the requirements of this act. ~~This~~ These information ~~pamphlets~~ shall be distributed to parents or the ~~other~~ legal guardians of children 6 years of age or younger on the following occasions:

(a) By a health care provider at the time of a child's birth and at the time of any childhood immunization or vaccination unless it is established that such information ~~pamphlet~~ has been provided ~~previously~~ to the parent or legal guardian by the health care provider within the prior 12 months.

(b) By the owner or operator of any child care facility or preschool or kindergarten class on or before each October 15 ~~of the calendar year.~~

Section 5. Section 381.985, Florida Statutes, is amended to read:

381.985 Screening program.—

(1) The State Surgeon General shall establish guidelines ~~a program~~ for early identification of persons at risk of having elevated blood-lead levels and for the systematic screening of ~~Such program shall systematically screen~~ children under 6 years of age in the target populations identified in subsection (2) for the presence of elevated blood-lead levels. Children within the specified target populations shall be screened with a blood-lead test at age 12 months and age 24 months, or between the

588-02964A-17

20171144c1

ages of 36 months and 72 months if they have not previously been screened. The State Surgeon General shall, after consultation with recognized professional medical groups and such other sources as the State Surgeon General deems appropriate, adopt rules to follow established national guidelines or recommendations such as those issued by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention related to reporting elevated blood-lead levels and screening results to the department pursuant to this section. ~~promulgate rules establishing:~~

~~(a) The means by which and the intervals at which such children under 6 years of age shall be screened for lead poisoning and elevated blood lead levels.~~

~~(b) Guidelines for the medical followup on children found to have elevated blood-lead levels.~~

(2) In developing screening programs to identify persons at risk with elevated blood-lead levels, priority shall be given to persons within the following categories:

(a) All children enrolled in the Medicaid program at ages 12 months and 24 months, or between the ages of 36 months and 72 months if they have not previously been screened.

(b) Children under the age of 6 years exhibiting delayed cognitive development or other symptoms of childhood lead poisoning.

(c) Persons at risk residing in the same household, or recently residing in the same household, as another person at risk with an elevated ~~a~~ blood-lead level ~~of 10 ug/dl or greater.~~

(d) Persons at risk residing, or who have recently resided, in buildings or geographical areas in which significant numbers

588-02964A-17

20171144c1

of cases of lead poisoning or elevated blood-lead levels have recently been reported.

(e) Persons at risk residing, or who have recently resided, in an affected property contained in a building that during the preceding 3 years has been subject to enforcement for violations of lead-poisoning-prevention statutes, ordinances, rules, or regulations ~~as specified by the State Surgeon General.~~

(f) Persons at risk residing, or who have recently resided, in a room or group of rooms contained in a building whose owner also owns a building containing affected properties which, during the preceding 3 years, has been subject to an enforcement action for a violation of lead-poisoning-prevention statutes, ordinances, rules, or regulations.

(g) Persons at risk residing in other buildings or geographical areas in which the State Surgeon General reasonably determines there is to be a significant risk of affected individuals having an elevated blood-lead level. ~~a blood-lead level of 10 ug/dL or greater.~~

(3) The ~~department~~ State Surgeon General shall maintain comprehensive records of all screenings indicating an elevated blood-lead level. ~~conducted pursuant to this section. Such records shall be indexed geographically and by owner in order to determine the location of areas of relatively high incidence of lead poisoning and other elevated blood-lead levels.~~

~~All cases or probable cases of lead poisoning found in the course of screenings conducted pursuant to this section shall be reported to the affected individual, to his or her parent or legal guardian if he or she is a minor, and to the State Surgeon~~

588-02964A-17

20171144c1

~~General.~~

(4) The results of screenings conducted pursuant to this section shall be reported by the health care provider who conducted or ordered the screening to the individual who was screened, or to the individual's parent or legal guardian if he or she is a minor.

Section 6. Paragraph (c) of subsection (1), paragraph (f) of subsection (3), and subsection (5) of section 383.14, Florida Statutes, are amended to read:

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

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. The department shall also promote the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin prior to and immediately following the birth of the child by the attending health care

588-02964A-17

20171144c1

provider. Such efforts shall be conducted in hospitals, perinatal centers, county health departments, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.

(c) *Release of screening results.*—Notwithstanding any law to the contrary, the State Public Health Laboratory may release, directly or through the Children's Medical Services program, the results of a newborn's hearing and metabolic tests or screenings to the newborn's health care practitioner, the newborn's parent or legal guardian, the newborn's personal representative, or a person designated by the newborn's parent or legal guardian. As used in this paragraph, the term "health care practitioner" means a physician or physician assistant licensed under chapter 458; an osteopathic physician or physician assistant licensed under chapter 459; an advanced registered nurse practitioner, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a midwife licensed under chapter 467; a speech-language pathologist or audiologist licensed under part I of chapter 468; or a dietician or nutritionist licensed under part X of chapter 468.

(3) DEPARTMENT OF HEALTH; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(f) Promote the availability of genetic studies, services, and counseling in order that the parents, siblings, and affected newborns may benefit from detection and available knowledge of the condition.

All provisions of this subsection must be coordinated with the

588-02964A-17

20171144c1

provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

(5) ADVISORY COUNCIL.—There is established a Genetics and Newborn Screening Advisory Council made up of 15 members appointed by the State Surgeon General. The council shall be composed of two consumer members, three practicing pediatricians, at least one of whom must be a pediatric hematologist, ~~one member representative from each from of the~~ four of the medical schools in this ~~the~~ state, the State Surgeon General or his or her designee, one representative from the Department of Health representing Children's Medical Services, one representative from the Florida Hospital Association, one individual with experience in newborn screening programs, one individual representing audiologists, and one representative from the Agency for Persons with Disabilities. All appointments shall be for a term of 4 years. The chairperson of the council shall be elected from the membership of the council and shall serve for a period of 2 years. The council shall meet at least semiannually or upon the call of the chairperson. The council may establish ad hoc or temporary technical advisory groups to assist the council with specific topics which come before the council. Council members shall serve without pay. Pursuant to the provisions of s. 112.061, the council members are entitled to be reimbursed for per diem and travel expenses. It is the purpose of the council to advise the department about:

(a) Conditions for which testing should be included under the screening program and the genetics program.

(b) Procedures for collection and transmission of specimens and recording of results.

588-02964A-17

20171144c1

291 (c) Methods whereby screening programs and genetics
292 services for children now provided or proposed to be offered in
293 the state may be more effectively evaluated, coordinated, and
294 consolidated.

295 Section 7. This act shall take effect July 1, 2017.

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's 1318 & 1454

INTRODUCER: Children, Families, and Elder Affairs Committee and Senators Garcia and Broxson

SUBJECT: Child Protection

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	Fav/CS Combined
2.	Sneed	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1318 and 1454 makes a number of changes to provisions relating to Child Protection Teams (CPT) in the Department of Health (DOH). The bill:

- Changes the limitation on physicians who can be CPT medical directors to allow a board-certified physician in family medicine (rather than pediatrics) to be hired as a medical director. Physicians employed as CPT medical directors must, within two years after their date of employment, obtain either a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to s. 39.303(2)(d), F.S.
- Requires the State Surgeon General and Deputy Secretary for Children's Medical Services to consult with the Statewide Medical Director for Child Protection on decisions regarding screening, employment, and termination of child protection team medical directors at headquarters and within all circuits statewide.
- Revises the group of persons who are authorized to complete the required review of all suspected abuse and neglect reports submitted to the Department of Children and Families (DCF) Florida Abuse Hotline, to determine if a face-to-face medical evaluation by a child protection team is necessary.
- Changes CPT districts to circuits to align the CPT and the DCF service areas.
- Codifies the requirements for Sexual Abuse Treatment Programs (SATP) that provide children alleged to have been sexually abused, their siblings, and their non-offending caretakers with specialized therapeutic treatment to assist in recovery from sexual abuse.

- Requires the Children's Medical Services (CMS) Division in the DOH to convene a task force to develop a standardized protocol for forensic interviewing for children suspected of having been abused and provide staff to support the task force, as needed. The task force must include various representatives from the disciplines of law enforcement, child welfare, and mental health treatment. The bill requires the DOH to provide the protocol to the Legislature by January 1, 2018.
- Expands the cases in which an expert witness certificate may be used, to include cases involving abandonment, dependency, and sexual abuse.

The bill has no impact on state revenues or expenditures.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Child Protection Teams

A child protection team (CPT) is a medically directed, multidisciplinary team that works with local Sheriff's offices and the DOH in cases of child abuse and neglect to supplement investigation activities.¹ Current law governs CPTs, and requires the Children's Medical Services Program (CMS) in the DOH to develop, maintain, and coordinate the services of the CPTs in each of the service districts of the DCF. Child protection team medical directors are responsible for oversight of the teams.²

Specifically, CPTs help assess risk and protective factors, and provide recommendations for interventions that protect children.³ Child abuse, abandonment, and neglect reports to the DCF Florida Abuse Hotline that must be referred to child protection teams include cases involving:

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
- Bruises anywhere on a child 5 years of age or younger.
- Any report alleging sexual abuse of a child.
- Any sexually transmitted disease in a prepubescent child.
- Reported malnutrition or failure of a child to thrive.
- Reported medical neglect of a child.
- A sibling or other child remaining in a home where one or more children have been - pronounced dead on arrival or have been injured and later died as a result of suspected abuse, abandonment, or neglect.
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.⁴

¹ Children's Medical Services, Child Protection Teams, (Aug. 30, 2012) *available at*: http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html. (last visited March 20, 2017).

² Section 39.303, F.S.

³ Children's Medical Services, Child Protection Team Brochure, *available at* http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/documents/child_protection_brochure.pdf. (last visited March 20, 2017).

⁴ Section 39.303, F.S..

Qualifications for Child Protection Team Medical Directors

Currently, district medical directors are required to be a physician licensed under ch. 458 or ch. 459, F.S., who is a board-certified pediatrician and, within 4 years after the date of his or her employment as a district medical director, either obtain a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to s. 39.303(2)(d), F.S.

While child protection teams are required to be medically directed by at least one board-certified pediatrician, despite active recruitment efforts, three of the 22 child protection team medical director positions have been vacant for more than a year. Child Protection Team medical directors are state employees and currently, three are employed by state universities and the remaining 19 are employed by the DOH.⁵

Specialty Certification for Child Abuse Pediatrics

The American Board of Medical Specialties approved the child abuse pediatrics specialty in 2006 and administered the first certification exams in late 2009.⁶ Eligibility for the Child Abuse Pediatric certification exam requires a person to have completed both a 3-year residency in pediatrics and a 3-year fellowship in child abuse pediatrics at an accredited program.⁷ Fellowship training includes medical evaluations of children with manifestations of acute and chronic child maltreatment, as well as children with a broad range of other diagnoses. The trainee develops expertise in determining non-accidental trauma and other forms of maltreatment by developing excellent diagnostic expertise and knowledge of various disorders which may mimic child maltreatment. Training will include mandatory reporting laws, legal proceedings, child abuse and family violence prevention, teaching opportunities, and clinical research.⁸

As of December 31, 2015, Florida has 12 physicians certified in Child Abuse Pediatrics through the American Board of Pediatrics.⁹

Third-Party Credentialing Entity

The Florida Certification Board offers the Child Protection Team Medical Provider (CPTMP) credential to eligible members of the Florida Department of Health's Child Protection Teams. This program was developed in response to the requirement that each DOH district medical director obtain a subspecialist certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity. The DOH has expanded eligibility for this credential to specified members of Florida's Child Protection

⁵ Department of Health, 2017 Agency Legislative Bill Analysis, SB 1318, March 1, 2017.

⁶ HealthLeaders Media, New Specialty Certification for Child Abuse Pediatrics, Nov. 6, 2009, *available at*: <http://www.healthleadersmedia.com/content/PHY-241751/New-Specialty-Certification-for-Child-Abuse-Pediatrics.html>. (last visited Mar. 20, 2017).

⁷ Council of Pediatric Subspecialties, Pediatric Child Abuse, Nov. 5, 2013. *available at*: <http://pedsubs.org/SubDes/ChildAbuse.cfm>. (last visited Mar. 20, 2017).

⁸ *Id.*

⁹ American Board of Pediatrics Inc., 2015-2016 Workforce Data, *available at*: <https://www.abp.org/sites/abp/files/pdf/workforcebook.pdf>. (last visited March 20, 2017)

Teams. To be eligible to take the exam, applicants must either be a board certified pediatrician, a board certified advanced registered nurse practitioner, or another board certified medical professional.¹⁰

Sexual Abuse Treatment Programs (SATP)

In 1986, the legislature required the department to develop a model plan for community intervention and treatment of intrafamily sexual abuse in conjunction with the Department of Law Enforcement, the DOH, the Department of Education, the Office of Attorney General (OAG), the state Guardian Ad Litem Program, the Department of Corrections, representatives of the judiciary, and professionals and advocates from the mental health and child welfare community.¹¹ As a result, children alleged to have been sexually abused, their siblings, and their non-offending caretakers are currently served by 14 sexual abuse treatment programs statewide. The programs are a partnership between the DOH, the OAG, and the DCF. The DOH contracts with local programs to provide administrative and clinical oversight, OAG pays for therapeutic services, and the DOH and the DCF have an interagency agreement for the operation of the program. This program provided therapeutic counseling services to 3,400 child victims of sexual abuse and their non-offending family members during Fiscal Year 2015-2016.¹²

Forensic Interviewing of Child Victims

Forensic interviewing began after several high-profile cases in the 1980s involving allegations of daycare providers sexually abusing multiple children in their care became the subject of analysis based on the interview techniques that were used.¹³ Law enforcement had relied on mental health practitioners because of their ability to establish and build rapport with children. However, these mental health practitioners used therapeutic techniques that were later deemed inappropriate for forensic purposes due to concerns of suggestibility and the encouragement of make-believe and pretend. Three specific criticisms of these methods were that:

- Investigation activities and decision-making were not coordinated across the multiple agencies involved;
- Children were interviewed too many times by too many interviewers and had to tell their story over and over again; and
- Children were interviewed in stressful or compromising locations that disturbed them further and made it difficult to talk.¹⁴

¹⁰ Florida Certification Board, Child Protection Team Medical Provider Certification, *available at*: <http://flcertificationboard.org/certification/childprotectionteam-credential/> (last visited March 22, 2017).

¹¹ Chapter 85-54, Laws of Florida. The provision was created as s. 415.5095, it was transferred and renumbered as s.39.305 in 1998 (Chapter 98-403, Laws of Florida) and subsequently repealed in 2011 (Chapter 2011-213, Laws of Florida).

¹² Department of Health, 2017 Agency Legislative Bill Analysis, SB 1318, March 1, 2017.

¹³ Walker, N., *Forensic Interviews of Children: The Components of Scientific Validity and Legal Admissibility*, 2002, *available at*: <http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1241&context=lcp&sei-redir=1&referer=http%3A%2F%2Fwww.bing.com%2Fsearch%3Fq%3Dforensic%2Binterviewing%2Bchildren%26src%3DI-E-SearchBox%26FORM%3DIENSR#search=%22forensic%20interviewing%20children%22>. (last visited March 23, 2017).

¹⁴ Cross, T., Jones, L., et al, *Child forensic interviewing in Children's Advocacy Centers: Empirical data on a practice model*, *Child Abuse & Neglect* 31 (2007), *available from*: <http://www.unh.edu/ccrc/pdf/cv108.pdf>. (last visited March 23, 2017).

A forensic interview, however, is a structured conversation with a child intended to elicit detailed information about a possible event that the child may have experienced or witnessed. The purposes of a forensic interview are:

- To obtain information from a child that may be helpful in a criminal investigation;
- To assess the safety of the child's living arrangements;
- To obtain information that will either corroborate or refute allegations or suspicions of abuse and neglect; and
- To assess the need for medical treatment and psychological care.¹⁵

People from multiple disciplines attend, or later review, the forensic interview including child protective investigators, police officers and other law enforcement officials, child protection attorneys, victim advocates, and medical and mental health care practitioners. The interview provides facts and direction for those involved with the investigation and provision of services.¹⁶

Child Advocacy Centers have taken the lead in the development of forensic interviewing protocols for children and one of their primary functions is to conduct forensic interviews in a non-threatening, child-friendly environment. Florida law provided standards for child advocacy centers in 1998¹⁷ and Florida currently has 27 Child Advocacy Centers that serve an estimated 85 percent of children in need of services statewide.¹⁸

The DOH reports that a variety of forensic interview protocols exist and vary from being very structured (scripted), less structured (semi-scripted) to flexible (not scripted but includes guidelines for interviewing). Agencies and entities providing forensic interviews can choose from a variety of well-known and established protocols, most of which provide structured training for forensic interviewers.¹⁹ One of these existing protocols is the internationally recognized National Children's Advocacy Center Child Forensic Interview Structure that is flexible, can be adapted to children of all ages and cultural backgrounds, and is appropriate for interviewing children who may have experienced sexual or physical abuse or who may be a witness to violence.²⁰

Expert Witness Certificates and Expert Testimony in Child Abuse Cases

Current law authorizes the DOH to issue a certificate authorizing a physician who holds an active and valid license to practice medicine or osteopathic medicine in another state or a province of Canada to provide expert testimony in this state, if the physician applies and pays for the certificate.²¹ An expert witness certificate authorizes the physician to whom the certificate is issued to do only the following:

¹⁵ *Id.*

¹⁶ U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin, *Child Forensic Interviewing: Best Practices*, September 2015, available at: <https://www.ojjdp.gov/pubs/248749.pdf>. (last visited March 22, 2017).

¹⁷ Chapter 98-403, F.S.

¹⁸ Florida Network of Child Advocacy Centers, available at: <http://www.fncac.org/about-us>. (last visited March 23, 2017).

¹⁹ Florida Department of Health, 2017 Agency Legislative Bill Analysis, SB 1454, March 6, 2017.

²⁰ National Child Advocacy Center, Forensic Interviewing of Children, available at: <http://www.nationalcac.org/forensic-interviewing-of-children-training/>. (last visited March 23, 2017).

²¹ Sections 458.3175 and 459.0066, F.S.

- Provide a verified written medical expert opinion as provided in s. 766.203, F.S.;
- Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed under chapter 458 or this chapter; and
- Provide expert testimony in criminal child abuse and neglect cases in this state.²²

Currently, expert testimony requirements in chapter 827, relating to abuse of children that rises to the level of criminal abuse, are restricted only to criminal child abuse cases and not family or dependency court.²³

III. Effect of Proposed Changes:

Section 1 amends s. 39.303, F.S., relating to child protection teams, to change the limitation on physicians who can be CPT medical directors to allow a board-certified physician in family medicine (rather than pediatrics) to be hired as a medical director. Physicians employed as CPT medical directors would, within two years after their date of employment, obtain either a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to s. 39.303(2)(d), F.S.

This section includes the CPT medical director in the list of persons who can complete the required review of all suspected abuse and neglect reports called to the DCF Florida Abuse Hotline to determine if a face-to-face medical evaluation by a child protection team is necessary.

This section changes references to CPT districts to “circuits”, to align the CPT and the DCF service areas.

This section requires the Children’s Medical Services (CMS) within the DOH to convene a task force to develop a standardized protocol for forensic interviewing for children suspected of having been abused and provide staff to support the task force, as needed. The task force must include various representatives from the disciplines of law enforcement, child welfare, and mental health treatment. The bill requires the DOH to provide the protocol to the legislature by January 1, 2018.

This section also codifies the requirements for Sexual Abuse Treatment Programs (SATP) that provide children alleged to have been sexually abused, their siblings, and their non-offending caretakers with specialized therapeutic treatment to assist in recovery from sexual abuse.

Section 2 amends s. 39.3031, F.S., relating to rules for the implementation of s. 39.303, F.S., to conform provisions to changes made by the bill.

Section 3 amends s. 458.3175, F.S., relating to expert witness certificates, to allow a physician who holds an active and valid license to practice medicine in another state or a province of

²² *Id.*

²³ Section 827.03, F.S.

Canada and holds an expert witness certificate to provide expert testimony in neglect, abandonment, dependency and sexual abuse cases.

Section 4 amends s. 459.0066, F.S., relating to expert witness certificates, to allow a physician who holds an active and valid license to practice osteopathic medicine in another state or a province of Canada and holds an expert witness certificate to provide expert testimony in neglect, abandonment, dependency and sexual abuse cases.

Section 5 amends s. 827.03, F.S., relating to abuse, aggravated abuse, and neglect of a child, to expand the expert testimony requirements of subsection (3) to include neglect, abandonment, dependency and sexual abuse cases.

Section 6 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill does not impact state revenues or expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill substantially amends ss. 39.303, 39.3031, 458.3175, 459.0066, and 827.03 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 Committee on Children, Families, and Elder Affairs on March 27, 2017:

- No longer limits physicians who could be CPT medical directors to only those board certified in pediatrics, but would allow a board-certified physician in family medicine to be hired as a medical director. Physicians employed as CPT medical directors must, within two years after their date of employment, obtain either a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to s. 39.303(2)(d), F.S.
- Requires the Children's Medical Services (CMS) within the DOH to convene a task force to develop a standardized protocol for forensic interviewing for children suspected of having been abused and provide staff to support the task force, as needed. The task force must include various representatives from the disciplines of law enforcement, child welfare, and mental health treatment. The bill requires the DOH to provide the protocol to the legislature by January 1, 2018.
- Expands the cases in which an expert witness certificate may be used, to include cases involving abandonment, dependency, and sexual abuse.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and
Senators Garcia and Broxson

586-02923A-17

20171318c1

A bill to be entitled

An act relating to child protection; amending s. 39.303, F.S.; revising the entities responsible for screening, employing, and terminating child protection team medical directors to include the Statewide Medical Director for Child Protection; revising the term "district medical director" to "child protection team medical director"; revising references to subdivisions of the state from "districts" to "circuits"; revising the required board certifications for child protection team medical directors and reviewing physicians; revising the timeframe in which child protection team medical directors must obtain certification; requiring Children's Medical Services to convene a task force to develop a protocol for forensic interviewing of children suspected of having been abused; specifying membership of the task force; requiring Children's Medical Services to develop, maintain, and coordinate one or more sexual abuse treatment programs; amending s. 39.3031, F.S.; requiring the Department of Health, in consultation with the Department of Children and Families, to adopt rules regarding sexual abuse treatment programs; amending ss. 458.3175, 459.0066, and 827.03, F.S.; revising provisions regarding expert testimony provided by certain entities to include criminal cases involving child abuse and neglect, dependency cases, and cases involving sexual abuse of a child; providing an effective date.

Page 1 of 13

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

586-02923A-17

20171318c1

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

Section 1. Section 39.303, Florida Statutes, is amended to read:

39.303 Child protection teams and sexual abuse treatment programs; services; eligible cases.—

(1) The Children's Medical Services Program in the Department of Health shall develop, maintain, and coordinate the services of one or more multidisciplinary child protection teams in each of the service circuits ~~districts~~ of the Department of Children and Families. Such teams may be composed of appropriate representatives of school districts and appropriate health, mental health, social service, legal service, and law enforcement agencies. The Department of Health and the Department of Children and Families shall maintain an interagency agreement that establishes protocols for oversight and operations of child protection teams and sexual abuse treatment programs. The State Surgeon General and the Deputy Secretary for Children's Medical Services, in consultation with the Secretary of Children and Families and the Statewide Medical Director for Child Protection, shall maintain the responsibility for the screening, employment, and, if necessary, the termination of child protection team medical directors, ~~at headquarters and~~ in the 15 circuits ~~districts~~.

(2) (a) The Statewide Medical Director for Child Protection must be a physician licensed under chapter 458 or chapter 459 who is a board-certified pediatrician with a subspecialty certification in child abuse from the American Board of

Page 2 of 13

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

586-02923A-17

20171318c1

59 Pediatrics.

60 (b) Each child protection team ~~district~~ medical director
 61 must be a physician licensed under chapter 458 or chapter 459
 62 who is a board-certified physician in pediatrics or family
 63 medicine ~~pediatrician~~ and, within 2 ~~4~~ years after the date of
 64 ~~his or her~~ employment as a child protection team ~~district~~
 65 medical director, obtains ~~either obtain~~ a subspecialty
 66 certification in child abuse from the American Board of
 67 Pediatrics or within 2 years meet the minimum requirements
 68 established by a third-party credentialing entity recognizing a
 69 demonstrated specialized competence in child abuse pediatrics
 70 pursuant to paragraph (d). Each child protection team ~~district~~
 71 medical director employed on July 1, 2015, must, by July 1, 2019
 72 ~~within 4 years~~, either obtain a subspecialty certification in
 73 child abuse from the American Board of Pediatrics or meet the
 74 minimum requirements established by a third-party credentialing
 75 entity recognizing a demonstrated specialized competence in
 76 child abuse pediatrics pursuant to paragraph (d). Child
 77 protection team medical directors shall be responsible for
 78 oversight of the teams in the circuits ~~districts~~.

79 (c) All medical personnel participating on a child
 80 protection team must successfully complete the required child
 81 protection team training curriculum as set forth in protocols
 82 determined by the Deputy Secretary for Children's Medical
 83 Services and the Statewide Medical Director for Child
 84 Protection.

85 (d) Contingent on appropriations, the Department of Health
 86 shall approve one or more third-party credentialing entities for
 87 the purpose of developing and administering a professional

586-02923A-17

20171318c1

88 credentialing program for child protection team ~~district~~ medical
 89 directors. Within 90 days after receiving documentation from a
 90 third-party credentialing entity, the department shall approve a
 91 third-party credentialing entity that demonstrates compliance
 92 with the following minimum standards:

93 1. Establishment of child abuse pediatrics core
 94 competencies, certification standards, testing instruments, and
 95 recertification standards according to national psychometric
 96 standards.

97 2. Establishment of a process to administer the
 98 certification application, award, and maintenance processes
 99 according to national psychometric standards.

100 3. Demonstrated ability to administer a professional code
 101 of ethics and disciplinary process that applies to all certified
 102 persons.

103 4. Establishment of, and ability to maintain, a publicly
 104 accessible Internet-based database that contains information on
 105 each person who applies for and is awarded certification, such
 106 as the person's first and last name, certification status, and
 107 ethical or disciplinary history.

108 5. Demonstrated ability to administer biennial continuing
 109 education and certification renewal requirements.

110 6. Demonstrated ability to administer an education provider
 111 program to approve qualified training entities and to provide
 112 precertification training to applicants and continuing education
 113 opportunities to certified professionals.

114 (3) The Department of Health shall use and convene the
 115 child protection teams to supplement the assessment and
 116 protective supervision activities of the family safety and

586-02923A-17

20171318c1

preservation program of the Department of Children and Families. This section does not remove or reduce the duty and responsibility of any person to report pursuant to this chapter all suspected or actual cases of child abuse, abandonment, or neglect or sexual abuse of a child. The role of the child protection teams ~~is shall be~~ to support activities of the program and to provide services deemed by the child protection teams to be necessary and appropriate to abused, abandoned, and neglected children upon referral. The specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services that a child protection team must ~~shall~~ be capable of providing include, but are not limited to, the following:

(a) Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services, as needed, and documentation of related findings.

(b) Telephone consultation services in emergencies and in other situations.

(c) Medical evaluation related to abuse, abandonment, or neglect, as defined by policy or rule of the Department of Health.

(d) Such psychological and psychiatric diagnosis and evaluation services for the child or the child's parent or parents, legal custodian or custodians, or other caregivers, or any other individual involved in a child abuse, abandonment, or neglect case, as the team may determine to be needed.

(e) Expert medical, psychological, and related professional testimony in court cases.

586-02923A-17

20171318c1

(f) Case staffings to develop treatment plans for children whose cases have been referred to the team. A child protection team may provide consultation with respect to a child who is alleged or is shown to be abused, abandoned, or neglected, which consultation shall be provided at the request of a representative of the family safety and preservation program or at the request of any other professional involved with a child or the child's parent or parents, legal custodian or custodians, or other caregivers. In every such child protection team case staffing, consultation, or staff activity involving a child, a family safety and preservation program representative shall attend and participate.

(g) Case service coordination and assistance, including the location of services available from other public and private agencies in the community.

(h) Such training services for program and other employees of the Department of Children and Families, employees of the Department of Health, and other medical professionals as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases.

(i) Educational and community awareness campaigns on child abuse, abandonment, and neglect in an effort to enable citizens more successfully to prevent, identify, and treat child abuse, abandonment, and neglect in the community.

(j) Child protection team assessments that include, as appropriate, medical evaluations, medical consultations, family psychosocial interviews, specialized clinical interviews, or forensic interviews.

586-02923A-17

20171318c1

175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203

A child protection team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child shall consult with a physician who has experience in treating children with the same condition.

(4) The child abuse, abandonment, and neglect reports that must be referred by the department to child protection teams of the Department of Health for an assessment and other appropriate available support services as set forth in subsection (3) must include cases involving:

(a) Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.

(b) Bruises anywhere on a child 5 years of age or under.

(c) Any report alleging sexual abuse of a child.

(d) Any sexually transmitted disease in a prepubescent child.

(e) Reported malnutrition of a child and failure of a child to thrive.

(f) Reported medical neglect of a child.

(g) Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home.

(h) Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.

(5) All abuse and neglect cases transmitted for investigation to a circuit district by the hotline must be simultaneously transmitted to the ~~Department of Health~~ child

586-02923A-17

20171318c1

204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232

protection team for review. For the purpose of determining whether a face-to-face medical evaluation by a child protection team is necessary, all cases transmitted to the child protection team which meet the criteria in subsection (4) must be timely reviewed by:

(a) A physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team;

(b) A physician licensed under chapter 458 or chapter 459 who holds board certification in a specialty other than pediatrics, who may complete the review only when working under the direction of the child protection team medical director or a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team;

(c) An advanced registered nurse practitioner licensed under chapter 464 who has a specialty in pediatrics or family medicine and is a member of a child protection team;

(d) A physician assistant licensed under chapter 458 or chapter 459, who may complete the review only when working under the supervision of the child protection team medical director or a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team; or

(e) A registered nurse licensed under chapter 464, who may complete the review only when working under the direct supervision of the child protection team medical director or a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child

586-02923A-17

20171318c1

protection team.

(6) A face-to-face medical evaluation by a child protection team is not necessary when:

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

(b) The child protective investigator, with supervisory approval, has determined, after conducting a child safety assessment, that there are no indications of injuries as described in paragraphs (4) (a)-(h) as reported; or

(c) The child protection team medical director or a child protection team board-certified pediatrician, as authorized in subsection (5), determines that a medical evaluation is not required.

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

(7) In all instances in which a child protection team is

586-02923A-17

20171318c1

providing certain services to abused, abandoned, or neglected children, other offices and units of the Department of Health, and offices and units of the Department of Children and Families, shall avoid duplicating the provision of those services.

(8) The Department of Health child protection team quality assurance program and the Family Safety Program Office of the Department of Children and Families shall collaborate to ensure referrals and responses to child abuse, abandonment, and neglect reports are appropriate. Each quality assurance program shall include a review of records in which there are no findings of abuse, abandonment, or neglect, and the findings of these reviews shall be included in each department's quality assurance reports.

(9) (a) Children's Medical Services shall convene a task force to develop a standardized protocol for forensic interviewing of children suspected of having been abused. The Department of Health shall provide staff to the task force as necessary. The task force must include:

1. A representative from the Florida Prosecuting Attorneys Association.

2. A representative from the Florida Psychological Association.

3. The Statewide Medical Director for Child Protection.

4. A representative from the Florida Public Defender Association.

5. The executive director of the Statewide Guardian Ad Litem Office.

6. A representative from a community-based care lead

586-02923A-17

20171318c1

291 agency.

292 7. A representative from Children's Medical Services.

293 8. A representative from the Florida Sheriffs Association.

294 9. A representative from the Florida Chapter of the
 295 American Academy of Pediatrics.

296 10. A representative from the Florida Network of Children's
 297 Advocacy Centers.

298 11. Other representatives designated by Children's Medical
 299 Services.

300 (b) Children's Medical Services must provide the
 301 standardized protocol to the President of the Senate and the
 302 Speaker of the House of Representatives by July 1, 2018.

303 (c) Members of the task force are not entitled to per diem
 304 or other payment for service on the task force.

305 (10) The Children's Medical Services program in the
 306 Department of Health shall develop, maintain, and coordinate the
 307 services of one or more sexual abuse treatment programs.

308 (a) A child under the age of 18 who is alleged to be a
 309 victim of sexual abuse, his or her siblings, non-offending
 310 caregivers, and family members who have been impacted by sexual
 311 abuse are eligible for services.

312 (b) Sexual abuse treatment programs must provide
 313 specialized therapeutic treatment to victims of child sexual
 314 abuse, their siblings, nonoffending caregivers, and family
 315 members to assist in recovery from sexual abuse, to prevent
 316 developmental impairment, to restore the children's pre-abuse
 317 level of developmental functioning, and to promote healthy, non-
 318 abusive relationships. Therapeutic intervention services must
 319 include crisis intervention, clinical treatment, and individual,

586-02923A-17

20171318c1

320 family, and group therapy.

321 (c) The sexual abuse treatment programs and child
 322 protection teams must provide referrals for victims of child
 323 sexual abuse and their families, as appropriate.

324 Section 2. Section 39.3031, Florida Statutes, is amended to
 325 read:

326 39.3031 Rules for implementation of s. 39.303.—The
 327 Department of Health, in consultation with the Department of
 328 Children and Families, shall adopt rules governing the child
 329 protection teams and sexual abuse treatment programs pursuant to
 330 s. 39.303, including definitions, organization, roles and
 331 responsibilities, eligibility, services and their availability,
 332 qualifications of staff, and a waiver-request process.

333 Section 3. Paragraph (c) of subsection (2) of section
 334 458.3175, Florida Statutes, is amended to read:

335 458.3175 Expert witness certificate.—

336 (2) An expert witness certificate authorizes the physician
 337 to whom the certificate is issued to do only the following:

338 (c) Provide expert testimony in criminal child abuse and
 339 neglect cases pursuant to chapter 827, dependency cases pursuant
 340 to chapter 39, and cases involving sexual battery of a child
 341 pursuant to chapter 794 in this state.

342 Section 4. Paragraph (c) of subsection (2) of section
 343 459.0066, Florida Statutes, is amended to read:

344 459.0066 Expert witness certificate.—

345 (2) An expert witness certificate authorizes the physician
 346 to whom the certificate is issued to do only the following:

347 (c) Provide expert testimony in criminal child abuse and
 348 neglect cases pursuant to chapter 827, dependency cases pursuant

586-02923A-17

20171318c1

349 to chapter 39, and cases involving sexual battery of a child
350 pursuant to chapter 794 in this state.

351 Section 5. Paragraph (d) of subsection (3) of section
352 827.03, Florida Statutes, is amended to read:

353 827.03 Abuse, aggravated abuse, and neglect of a child;
354 penalties.—

355 (3) EXPERT TESTIMONY.—

356 (d) The expert testimony requirements of this subsection
357 apply only to criminal child abuse and neglect cases pursuant to
358 chapter 827, dependency cases pursuant to chapter 39, and cases
359 involving sexual battery of a child pursuant to chapter 794 and
360 not to family court ~~or dependency court~~ cases.

361 Section 6. This act shall take effect July 1, 2017.

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 1756

INTRODUCER: Children, Families, and Elder Affairs Committee and Senator Garcia

SUBJECT: Examination and Treatment of Individuals with Mental Illness

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	Fav/CS
2.	Sneed	Williams	AHS	Pre-meeting
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1756 provides responsibilities to the Department of Children and Families (DCF) for a comprehensive statewide mental health and substance abuse program. The bill revises the rights of individuals receiving mental health services to use surrogates or proxies to act as decision makers. Additionally, the definition of a service provider's employee is expanded to include contractors and volunteers for the purpose of reporting sexual misconduct.

The bill revises the list of people eligible for designation as representative for an individual admitted to a facility for involuntary examination or services to include a guardian advocate, health care surrogate, or proxy. Persons ineligible for designation as representative of an individual admitted to a facility for involuntary examination or services include non-clinical people providing substantial professional services to the individual. A designated representative is given certain rights, authority, and responsibility concerning the individual.

The list of professionals allowed to execute a certificate to initiate an involuntary examination is expanded to include an advanced registered nurse practitioner and a physician assistant. The professionals allowed to discharge an individual if an involuntary examination occurred in a hospital, removes psychiatric nurses performing within a framework of an established protocol with a psychiatrist and an emergency department physician with experience in the diagnosis and treatment of mental illness and limits such discharge responsibilities to an attending emergency department physician.

The bill provides that hearings on involuntary services must be held within 5 court working days after the petition is filed and the hearing must be held in the receiving or treatment facility where the individual is located unless certain conditions apply.

The bill allows law enforcement to transport an individual eligible to receive services from the United States Department of Veterans' Affairs (USDVA) to a USDVA facility to conduct involuntary examinations, provide voluntary admission and treatment, and petition for involuntary services for the individual.

According to DCF, modifications to the department's acute care database to report public receiving facility and treatment facility encounter data by "Payor class" is estimated to cost \$140,000. Although there is a sufficient trust fund cash balance in the department's Operations and Maintenance Trust Fund, additional budget authority would be needed to expend the funds.

This bill provides an effective date of July 1, 2017.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.¹ Unemployment rates for persons with mental disorders are high relative to the overall population.² People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.³ Mental illness increases a person's risk of homelessness in America threefold.⁴ Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.⁵ Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chances of receiving proper treatment and leads to future re-offenses.⁶

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are also affected by substance abuse.⁷ NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.⁸ When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the

¹ Mental Illness: The Invisible Menace, *Economic Impact* <http://www.mentalmenace.com/economicimpact.php>

² Mental Illness: The Invisible Menace, *More impacts and facts* <http://www.mentalmenace.com/impactsfacts.php>

³ *Id.*

⁴ Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) available at <http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/>

⁵ *Id.*

⁶ *Id.*

⁷ Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders*, (October 2, 2013) available at <http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/>

⁸ *Id.*

contra-indications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.⁹

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.¹⁰ The Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Mental illness creates enormous social and economic costs.¹¹ Unemployment rates for persons having mental disorders are high relative to the overall population.¹² Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.¹³ Mental illness increases a person's risk of homelessness in America threefold.¹⁴ Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.¹⁵ Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future recidivism.¹⁶

Involuntary Examination to under the Baker Act

Criteria for Involuntary Examination

The Baker Act provides that a person meets the criteria for involuntary examination if a court finds by clear and convincing evidence that he or she has a mental illness and because of this mental illness:

- Has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purposes of inpatient placement for treatment; or
- Is unable to determine whether inpatient placement is necessary; and
- Is incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services. Without treatment, he or she is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

⁹ *Id.*

¹⁰ Chapter 71-131, L.O.F.; The Baker Act is contained in ch. 394, F.S.

¹¹ MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact*, <http://www.mentalmenace.com/economicimpact.php> (last visited Jan. 11, 2016).

¹² MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts*, <http://www.mentalmenace.com/impactsfacts.php> (last visited Jan. 11, 2016).

¹³ *Id.*

¹⁴ Family Guidance Center for Behavioral Health Care, *How does Mental Illness Impact Rates of Homelessness?*, (February 4, 2014), <http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/>.

¹⁵ *Id.*

¹⁶ *Id.*

- There is substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.¹⁷

Initiation of involuntary examinations

Courts, law enforcement officers, and certain health care practitioners are authorized to initiate such involuntary examinations.¹⁸ A circuit court may enter an *ex parte* order stating a person meets the criteria for involuntary examination. A law enforcement officer may take a person into custody who appears to meet the criteria and transport them to a receiving facility for examination. Health care practitioners may initiate an involuntary examination by executing the *Certificate of Professional Initiating an Involuntary Examination*, an official form adopted in rule by DCF. The health care practitioner must have examined the person within the preceding 48 hours and state that the person meets the criteria for involuntary examination.¹⁹ The Baker Act currently authorizes the following health care practitioners to initiate an involuntary examination by certificate:

- A physician licensed under ch. 458, F.S., or ch. 459, F.S., who has experience in the diagnosis and treatment of mental and nervous disorders.
- A clinical psychologist, as defined in s. 490.003(7), F.S., with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure.
- A physician or psychologist employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense that qualifies as a receiving or treatment facility.
- A psychiatric nurse who is certified as an advanced registered nurse practitioner under s. 464.012, F.S., who has a master's degree or a doctorate in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advance practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.
- A mental health counselor, marriage and family therapist, or clinical social worker licensed under ch. 491, F.S.²⁰

Time Limits

The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.²¹ Within that 72-hour examination period, or no later than the next working day if the 72 hours ends on a weekend or holiday, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;

¹⁷ Section 394.467(1), F.S.

¹⁸ Section 394.463(2)(a), F.S.

¹⁹ Section 394.463(2)(a)3., F.S.

²⁰ *Id.*

²¹ Section 394.463(2)(f), F.S.

- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.²²

Physician Assistants

Physician assistant (PA) licensure in Florida is governed by ss. 458.347(7) and 459.022(7), F.S. The Department of Health (DOH) licenses PAs and the Florida Council on Physician Assistants (Council) regulates them.²³ PAs are also regulated by either the Florida Board of Medicine for PAs licensed under ch. 458, F.S., or the Florida Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S. The duty of the board and its members is to make disciplinary decisions concerning whether a doctor or PA has violated the provisions of his or her practice act.²⁴

PAs may only practice under the direct or indirect supervision of a medical doctor or doctor of osteopathic medicine with whom they have a clinical relationship.²⁵ A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.²⁶ The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.²⁷

To be licensed as a PA in Florida, an applicant must demonstrate to the Council:

- Satisfactory passage of the National Commission on Certification of Physician Assistant exam;
- Completion of the application and remittance of the application fee;²⁸
- Completion of an approved PA training program;
- Acknowledgement of any prior felony convictions;
- Acknowledgement of any previous revocation or denial of licensure in any state;
- Submission of two letters of recommendation; and
- If the applicant wishes to apply for prescribing authority, a copy of the course transcripts and course description from a PA training program describing the course content in pharmacotherapy.²⁹

Licenses are renewed biennially. At the time of renewal, a PA must demonstrate that he or she has met the continuing education requirements and must submit an acknowledgement that he or she has not been convicted of any felony in the previous two years.³⁰

²² Section 394.463(2)(i)4., F.S.

²³ The Council consists of three physicians who are members of the Board of Medicine; one member who is a member of the Board of Osteopathic Medicine, and a physician assistant appointed by the State Surgeon General. (Sections 458.347(9) and 459.022(8), F.S.)

²⁴ Sections 458.347(12) and 459.022(12), F.S.

²⁵ Sections 485.347(2)(f) and 459.022(2)(f), F.S.

²⁶ Rules 64B8-30.012 and 64B15-6.010, F.A.C.

²⁷ Sections 458.347(15) and 459.022(15), F.S.

²⁸ The application fee is \$100 and the initial license fee is \$205. See <http://flboardofmedicine.gov/licensing/physician-assistant-licensure/> (last visited March 31, 2017).

²⁹ Sections 458.347(7) and 459.022(7), F.S.

³⁰ Sections 458.347(7)(b)-(c) and 459.022(7)(b)-(c), F.S.

Current Florida law does not expressly allow PAs to provide referrals for or initiate involuntary examinations under the Baker Act; however, in 2008, Attorney General Bill McCollum issued an opinion stating:

A physician assistant pursuant to Chapter 458 or 459, Florida Statutes, may refer a patient for involuntary evaluation pursuant to section 394.463, Florida Statutes, provided that the physician assistant has experience regarding the diagnosis and treatment of mental and nervous disorders and such tasks are within the supervising physician's scope of practice.³¹

PAs are not required by law to have experience in the diagnosis and treatment of mental and nervous disorders.

Advanced Registered Nurse Practitioners

Nurse licensure is governed by part I of ch. 464, F.S. Nurses are licensed by the DOH and regulated by the Board of Nursing. Licensure requirements to practice nursing include completion of an approved educational course of study, passage of an examination approved by the DOH, acceptable criminal background screening results, and payment of applicable fees.³²

A nurse who holds a current license to practice professional nursing may apply to be certified as an Advanced Registered Nurse Practitioner (ARNP), under s. 464.012, F.S., if the nurse meets one or more of the following requirements:

- Satisfactory completion of a formal postbasic educational program of at least one academic year that prepares nurses for advanced or specialized practice;
- Certification by a specialty board; or
- Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.

Current law defines three categories of ARNPs: certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.³³ All ARNPs, regardless of practice category, may only practice within the framework of an established protocol and under the supervision of an allopathic or osteopathic physician or dentist.³⁴ ARNPs may carry out treatments as specified in statute, including:³⁵

- Prescribing, dispensing, administering, or ordering any drug;³⁶
- Initiating appropriate therapies for certain conditions;

³¹ Op. Att'y Gen. Fla. 08-31 (2008), available at <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/agopinion.pdf> (last visited March 31, 2017).

³² Sections 464.008 and 424.009, F.S.

³³ Section 464.012(2), F.S.

³⁴ Section 464.012(3), F.S.

³⁵ *Id.*

³⁶ Section 464.012(3)(a), F.S., provides that an ARNP may only prescribe controlled substances if he or she has graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills. An ARNP is limited to prescribing a 7-day supply of Schedule II controlled substances. Only a psychiatric nurse may prescribe psychotropic controlled substances for the treatment of mental disorders and psychiatric mental health controlled substance for children younger than 18.

- Ordering diagnostic tests and physical and occupational therapy;
- Ordering any medication for administration to patients in certain facilities; and
- Performing additional functions as may be determined by rule in accordance with s. 464.003(2), F.S.³⁷

An ARNP may also perform other acts as authorized by statute and within his or her specialty.³⁸ Further, if it is within an ARNP's established protocol, the ARNP may ascertain behavioral problems and diagnosis and make treatment recommendations.³⁹

Currently, only ARNPs who are "psychiatric nurses" may initiate involuntary examinations under the Baker Act.⁴⁰ To qualify as a psychiatric nurse, an ARNP must have a master's or doctoral degree in psychiatric nursing, hold a national advance practice certification as a psychiatric mental health advanced practice nurse, and two years post-master's clinical experience.

III. Effect of Proposed Changes:

Section 1 amends s. 394.453, F.S., to authorize DCF to include substance abuse impairment in its evaluation, research and recommendations of programs designed to reduce occurrence, severity, duration, and disabling aspects of mental, emotional and behavioral disorders.

Section 2 amends s. 394.455, F.S., to add or revise terms to the definitions.

Section 3 amends s. 394.457, F.S., to add substance abuse to DCF's comprehensive statewide program of mental health. DCF is permitted to distribute its information handbook of policies and procedures for mental health and substance abuse online.

Section 4 amends s. 394.4573, F.S., to change the term "patient" to "individual".

Section 5 amends s. 394.4574, F.S., to allow mental health counselors, marriage and family therapists or qualified professionals to conduct evaluations of individuals residing in assisted living facilities that hold limited mental health licenses.

Section 6 amends s. 394.458, F.S., to provide that it is unlawful to knowingly and intentionally bring certain items or articles into any facility providing mental health or substance abuse services.

Section 7 amends s. 394.459, F.S., to provide that a person shall be given, in addition to a physical examination, a mental health examination within 24 hours of admission to a facility by a psychiatrist, psychologist, or psychiatric nurse. The examinations must be documented in the clinical record. The facility, within 72 hours after admission of an individual, must provide the individual with an individualized treatment plan in writing.

³⁷ Section 464.003(2), F.S.

³⁸ Section 464.012(4), F.S.

³⁹ Section 464.012(4)(c)1, F.S.

⁴⁰ Section 394.463(2)(a), F.S.

This section also directs receiving and treatment facilities to have written procedures for reporting events that place individuals receiving services at risk of harm, including, but not limited to, death, injury, unauthorized departure or absence of the individual, a disaster or crisis situation or allegation of sexual battery upon an individual examined or treated in the facility. Facilities are directed to ensure that all staff, including contractors and volunteers, receive the written procedures.

This section provides additional individuals who may deny or withdraw consent at any time on behalf of the individual, to receive notices on behalf and to receive custody of personal effects of the individual to include a health care surrogate or proxy.

Additionally, this section directs all service providers to provide information concerning advance directives and assist individuals who are competent and willing to complete advance directives. The directive may include instructions regarding mental health or substance abuse treatment.

Section 8 amends s. 394.4593, F.S., to change the term “patient” to “individual”.

Section 9 repeals s. 394.4595, F.S., relating to statewide and local advocacy councils.

Section 10 creates s. 394.4596, F.S., to allow the agency designated by the Governor as the federally mandated protection and advocacy system for individuals with disabilities to have specific access under federal law to facilities, individuals, information and records.

Section 11 amends s. 394.4597, F.S., to add the name, address and telephone number of a guardian advocate, health care surrogate or proxy to the list of individuals entered into the patient’s clinical record.

Additionally, this section adds volunteers and contractors to the list of individuals ineligible to serve as a representative of the patient. The person selected as representative by the individual or designated by the facility has the right to receive notices, have immediate access to the individual, receive a copy of the individual’s inventory of clothing and personal effects, petition on behalf of the individual for a writ of habeas corpus, apply for a change in venue for the involuntary placement hearing, and receive notice of release of the individual from a facility.

Section 12 amends s. 394.4598, F.S., to prohibit a contractor or a volunteer of a facility from being appointed as a guardian advocate of an individual in a facility for involuntary examination.

Section 13 amends s. 394.4599, F.S., to reinstate the requirement that a notice for the petition for involuntary outpatient services be filed with the criminal county court or the circuit court in the county in which the individual is hospitalized and to correct a cross-reference.

Section 14 repeals s. 394.460, F.S., relating to rights of professionals.

Section 15 amends s. 394.461, F.S., to provide that only governmental facilities and facilities designated by DCF may hold or treat individuals on an involuntary basis. Governmental facilities are authorized to provide voluntary and involuntary mental health or substance abuse examination and treatment.

Section 16 amends s. 394.4615, F.S., to add certain individuals that may allow for the release and/or inspection of an individual's clinical record to include the individual's guardian advocate, health care surrogate or proxy.

Section 17 amends s. 394.462, F.S., to allow law enforcement to transport an individual eligible for services provided by the United States Department of Veterans' Affairs to a facility operated by the United States Department of Veterans' Affairs.

This section allows a law enforcement officer who has custody of an individual based on a misdemeanor or a felony, other than a forcible felony as defined in s. 776.08, F.S., to transport the individual to an appropriate facility. The facility is not required to admit an individual charged with a forcible felony as defined in s. 766.08, F.S., if it determines it cannot provide adequate security.

This section allows a law enforcement officer to transport an individual who appears to meet the criteria for voluntary admission to a receiving facility upon the individual's request.

Section 18 amends s. 394.4625, F.S., to provide criteria for examination and treatment of voluntary admissions of individuals to facilities. A minor may only be admitted on the basis of express and informed consent of the minor's guardian in conjunction with the assent of the minor. Unless the minor's assent is verified, a petition for involuntary services must be filed with the court within 24 hours or the minor must be released to his or her guardian.

This section provides that a facility may not admit an individual on voluntary status or transfer an individual to voluntary status who has been adjudicated incapacitated except when a court provides authorization to a legal guardian.

This section also provides that an individual on voluntary status charged with a crime is to be discharged into the custody of law enforcement unless the individual has been released from law enforcement custody by posting a bond, pretrial conditional release or other judicial release.

Section 19 amends s. 394.463, F.S., to add an advanced registered nurse practitioner and a physician assistant to the list of professionals that may complete a certificate to initiate involuntary examination of an individual. A law enforcement officer or professional who initiates an involuntary examination of an individual may notify the individual's guardian, representative, health care surrogate or proxy of such examination.

Section 20 amends s. 394.467, F.S., to direct the Division of Administrative Hearings to ensure that individuals who are the subject of a petition for continued involuntary services or his or her guardian, guardian advocate, health care surrogate or proxy are informed of the individual's right to an independent expert examination.

Section 21 amends s. 394.46715, F.S., to provide the department rulemaking authority.

Section 22 amends s. 394.4672, F.S., to include a facility owned, operated, or administered by the United States Department of Veterans' Affairs that provides mental health services the

authority to initiate and conduct involuntary examinations, provide voluntary services, and provide voluntary admission and treatment.

Section 23 amends s. 394.4685, F.S., to allow a private facility to request an individual be transferred to another private facility upon the acceptance of the transfer by the facility to which the individual is being transferred.

Section 24 amends s. 394.469, F.S., to provide that an individual currently charged with a crime may be discharged to law enforcement under certain conditions.

Section 25 amends s. 394.473, F.S., to change the term “patient” to “individual”.

Section 26 amends s. 394.475, F.S., to change the term “patient” to “individual”.

Section 27 amends s. 394.4785, F.S., to correct cross-references.

Section 28 repeals s. 394.4786, F.S., providing legislative intent.

Section 29 repeals s. 394.47865, F.S., relating to privatization of state hospitals.

Section 30 repeals s. 394.4787, F.S., providing definitions.

Section 31 repeals s. 394.4788, F.S., relating to the use of certain funds.

Section 32 repeals s. 394.4789, F.S., relating to referrals.

Section 33 amends s. 20.425, F.S., to correct cross-references.

Section 34 amends s. 39.407, F.S., to replace the term “involuntary placement” with “involuntary services”.

Section 35 amends s. 394.492, F.S., to correct cross-references.

Section 36 amends s. 394.495, F.S., to correct cross-references.

Section 37 amends s. 394.496, F.S., to correct cross-references.

Section 38 amends s. 394.9085, F.S., to correct cross-references.

Section 39 amends s. 409.972, F.S., to correct cross-references.

Section 40 amends s. 744.2007, F.S., to correct cross-references

Section 41 amends s. 790.065, F.S., to correct cross-references.

Section 42 amends s. 945.46, F.S., to replace the term “involuntary placement” with “involuntary services.”

Section 43 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DCF's acute care database is designed to collect individual-level encounter data. However, the department would be required to modify the system to collect and maintain data received from the individual public receiving and treatment facilities that serve DCF clients and report the data in aggregate by "Payor class" as set forth in Section 15 of the bill. According to the department, the modifications will require an estimated 560 hours of contract computer programming hours at a cost of \$140,000.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.453, 394.455, 394.457, 394.4573, 394.4574, 394.458, 394.459, 394.4593, 394.4597, 394.4598, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.467, 394.46715, 394.4672, 394.4685, 394.469, 394.473, 394.475, 394.4785, 20.425, 39.407, 394.492, 394.495, 394.496, 394.9085, 409.972, 744.2007, 790.065, and 945.46.

This bill creates section 394.4596 of the Florida Statutes.

This bill repeals the following sections of the Florida Statutes: 394.4595, 394.460, 394.4786, 394.47865, 394.4787, 394.4788, and 394.4789.

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 Children, Families, and Elder Affairs Committee on April 3, 2017:

- Adds advanced registered nurse practitioners while removing school psychologists from the list of professionals eligible to initiate certificates for involuntary examinations.
- Reinstates the current data collection requirements for public receiving and treatment facilities due annually to the Agency for Health Care Administration.
- Removes the requirement that an individual's clinical records may be released to the state attorney if a petition for involuntary services is filed.
- Reinstates the provision disallowing exceptions to transportation plans after June 30, 2017.
- Requires an individual in a facility on voluntary status receive notice every 6 months of his or her right to discharge.
- Removes physical or mental harm from the criteria necessary to subject an individual to involuntary examination.
- Removes the repeal of and reinstates s. 394.4655, F.S.
- Removes the prohibition against the court entering an order of involuntary inpatient placement for individuals with Alzheimer's disease, dementia, or traumatic brain-injury without a co-occurring mental illness.
- Removes the requirement that the court cannot order involuntary services if the services are not available.
- Removes the clarification that a public defender appointed to represent an indigent individual may not receive compensation for such representation.

- B. **Amendments:**

None.



289774

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Between lines 3495 and 3496
insert:

Section 43. For the 2017-2018 fiscal year, the nonrecurring
sum of \$140,000 from the Operations and Maintenance Trust Fund
in the Contracted Services category is appropriated to the
Department of Children and Families for the purpose of
implementing this act.



289774

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

12 And the title is amended as follows:

13 Between lines 116 and 117

14 insert:

15 an appropriation; providing

By the Committee on Children, Families, and Elder Affairs; and
Senator Garcia

586-03332-17

20171756c1

1 A bill to be entitled
2 An act relating to examination and treatment of
3 individuals with mental illness; amending s. 394.453,
4 F.S.; revising legislative intent; amending s.
5 394.455, F.S.; providing, revising, and deleting
6 definitions; amending s. 394.457, F.S.; providing
7 responsibilities of the Department of Children and
8 Families for a comprehensive statewide mental health
9 and substance abuse program; amending s. 394.4573,
10 F.S.; conforming terminology; amending s. 394.4574,
11 F.S.; providing for additional professionals to assess
12 a resident with a mental illness who resides in an
13 assisted living facility; amending s. 394.458, F.S.;
14 prohibiting the introduction or removal of certain
15 articles at a facility providing mental health
16 services; requiring such facilities to post a notice
17 thereof; amending s. 394.459, F.S.; revising rights of
18 individuals receiving mental health treatment and
19 services to provide for the use of health care
20 surrogates or proxies to make decisions; revising
21 requirements relating to express and informed consent
22 and liability for violations; requiring service
23 providers to provide information concerning advance
24 directives; amending s. 394.4593, F.S.; expanding the
25 definition of the term "employee" to include staff,
26 volunteers, and interns employed by a service provider
27 for purposes of reporting sexual misconduct; repealing
28 s. 394.4595, F.S., relating to the Florida statewide
29 and local advocacy councils and access to patients and

Page 1 of 121

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

586-03332-17

20171756c1

30 records; creating s. 394.4596, F.S.; requiring
31 designated receiving facilities to permit access
32 authority to an agency designated by the Governor to
33 serve as the federally mandated protection and
34 advocacy system for individuals with disabilities;
35 amending s. 394.4597, F.S.; providing rights and
36 responsibilities of the representative of an
37 individual admitted to a facility for involuntary
38 examination or services; amending s. 394.4598, F.S.;
39 specifying certain persons who are prohibited from
40 being appointed as a guardian advocate; providing
41 duties of a guardian advocate; amending s. 394.4599,
42 F.S.; revising requirements for a certain notice
43 related to involuntary admission; repealing s.
44 394.460, F.S., relating to rights of professionals;
45 amending s. 394.461, F.S.; authorizing governmental
46 facilities to provide voluntary and involuntary mental
47 health and substance abuse examinations and treatment
48 under certain conditions; providing additional
49 facility reporting requirements; amending s. 394.4615,
50 F.S., relating to confidentiality of clinical records;
51 providing additional circumstances in which
52 information from a clinical record may be released;
53 amending s. 394.462, F.S.; revising requirements for
54 transportation to receiving facilities and treatment
55 facilities; providing for a law enforcement officer to
56 transport an individual to a United States Department
57 of Veterans Affairs facility under certain
58 circumstances; providing immunity from liability;

Page 2 of 121

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

586-03332-17

20171756c1

59 deleting obsolete provisions; amending s. 394.4625,
 60 F.S.; revising criteria for voluntary admission to,
 61 and release or discharge from, a facility for
 62 examination and treatment; revising criteria for a
 63 determination of neglect to include mental and
 64 physical harm; requiring certain individuals charged
 65 with a crime to be discharged to the custody of a law
 66 enforcement officer under certain circumstances;
 67 amending s. 394.463, F.S.; requiring certain persons
 68 initiating an involuntary examination to provide
 69 notice to the individual's guardian, representative,
 70 or health care surrogate or proxy; revising a holding
 71 period for involuntary examination; amending s.
 72 394.467, F.S.; revising provisions relating to
 73 admission to a facility for involuntary services;
 74 authorizing the state attorney to represent the state
 75 in certain proceedings relating to a petition for
 76 involuntary services; granting the state attorney
 77 access to certain clinical records and witnesses;
 78 providing conditions for a continuance of the hearing;
 79 requiring the Division of Administrative Hearings to
 80 advise certain parties representing the individual of
 81 the right to an independent examination in continued
 82 involuntary services proceedings; amending s.
 83 394.46715, F.S.; providing purpose of department
 84 rules; amending s. 394.4672, F.S.; authorizing
 85 facilities of the United States Department of Veterans
 86 Affairs to provide certain mental health services;
 87 amending s. 394.4685, F.S.; revising provisions

Page 3 of 121

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

586-03332-17

20171756c1

88 governing transfer of individuals between and among
 89 public and private facilities; amending s. 394.469,
 90 F.S.; authorizing the discharge of an individual from
 91 involuntary services into the custody of a law
 92 enforcement officer under certain conditions; amending
 93 s. 394.473, F.S.; revising provisions relating to
 94 compensation of attorneys and expert witnesses in
 95 cases involving indigent individuals; amending s.
 96 394.475, F.S.; conforming terminology; amending s.
 97 394.4785, F.S.; defining the term "minor" for purposes
 98 of admission into a mental health facility; repealing
 99 s. 394.4595, F.S., relating to access to patients and
 100 patients' records by members of the Florida statewide
 101 and local advocacy councils; repealing s. 394.460,
 102 F.S., relating to the rights of professionals;
 103 repealing s. 394.4655, F.S., relating to involuntary
 104 outpatient services; repealing s. 394.4786, F.S.,
 105 relating to legislative intent; repealing s.
 106 394.47865, F.S., relating to the privatization of
 107 South Florida State Hospital; repealing s. 394.4787,
 108 F.S., relating to definitions; repealing s. 394.4788,
 109 F.S., relating to use of certain PMATF funds for the
 110 purchase of acute care mental health services;
 111 repealing s. 394.4789, F.S., relating to the
 112 establishment of a referral process and eligibility
 113 determination; amending ss. 20.425, 39.407, 394.4599,
 114 394.492, 394.495, 394.496, 394.9082, 394.9085,
 115 409.972, 744.2007, 790.065, and 945.46, F.S.;
 116 conforming references and cross-references; providing

Page 4 of 121

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

586-03332-17

20171756c1

an effective date.

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

Section 1. Section 394.453, Florida Statutes, is amended to read:

394.453 Legislative intent.—

(1) It is the intent of the Legislature:

(a) To authorize and direct the Department of Children and Families to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders and substance abuse impairment.

(b) That treatment programs for such disorders include, ~~but not be limited to,~~ comprehensive health, social, educational, and rehabilitative services for individuals ~~to persons~~ requiring intensive short-term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that:

1. Such individuals ~~persons~~ be provided with emergency service and temporary detention for evaluation if ~~when~~ required;

2. Such individuals ~~persons~~ be admitted to treatment facilities if ~~on a voluntary basis when~~ extended or continuing care is needed and unavailable in the community;

3. Involuntary placement be provided only if ~~when~~ expert evaluation determines it is necessary;

4. Any involuntary treatment or examination be accomplished in a setting that is clinically appropriate and most likely to

586-03332-17

20171756c1

facilitate the individual's discharge ~~person's return to the community~~ as soon as possible; and

5. ~~Individual~~ Dignity and human rights be guaranteed to all individuals ~~persons~~ who are admitted to mental health facilities ~~or who are being held under s. 394.463.~~

(c) That services provided to individuals ~~persons~~ in this state use the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance, necessary for individuals ~~persons~~ with mental health disorders and co-occurring mental health and substance use disorders to live successfully in their communities.

(d) That licensed, qualified health professionals be authorized to practice to the fullest extent of their education and training in the performance of professional functions necessary to carry out the intent of this part.

(2) It is the policy of this state that the use of restraint and seclusion ~~on clients~~ is justified only as an emergency safety measure to be used in response to imminent danger to the individual ~~client~~ or others. It is, therefore, the intent of the Legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving individuals experiencing ~~persons with~~ mental illness.

(3) 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

586-03332-17

20171756c1

psychiatry and other evolving models of care for individuals
~~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.

Section 2. Section 394.455, Florida Statutes, is amended to
 read:

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

(1) "Access center" means a facility that has medical,
 mental health, and substance abuse professionals to provide
 emergency screening and evaluation for mental health or
 substance abuse disorders and may provide transportation to an
 appropriate facility if an individual is in need of more
 intensive services.

(2) "Addictions receiving facility" is a secure, acute care
 facility that, at a minimum, provides emergency screening,
 evaluation, detoxification, and stabilization services; is
 operated 24 hours per day, 7 days per week; and is designated by
 the department to serve individuals found to have substance
 abuse impairment who qualify for services under this part.

(3) "Administrator" means the chief administrative officer
 of a receiving or treatment facility or his or her designee.

(4) "Adult" means an individual who is 18 years of age or
 older or who has had the disability of nonage removed under
 chapter 743.

(5) "Advance directive" has the same meaning as in s.
765.101.

~~(5) "Clinical psychologist" means a psychologist as defined~~

586-03332-17

20171756c1

~~in s. 490.003(7) with 3 years of postdoctoral experience in the~~
~~practice of clinical psychology, inclusive of the experience~~
~~required for licensure, or a psychologist employed by a facility~~
~~operated by the United States Department of Veterans Affairs~~
~~that qualifies as a receiving or treatment facility under this~~
~~part.~~

(6) "Clinical record" means all parts of the record
 required to be maintained and includes all medical records,
 progress notes, charts, and admission and discharge data, and
 all other information recorded by facility staff which pertains
 to an individual's admission, retention ~~the patient's~~
 hospitalization, or treatment.

(7) "Clinical social worker" means a person licensed to
practice social work under s. 491.005 or s. 491.006 or a person
employed as a clinical social worker by the United States
Department of Veterans Affairs or the United States Department
of Defense ~~as a clinical social worker under s. 491.005 or s.~~
~~491.006.~~

(8) "Community facility" means a community service provider
 that contracts with the department to furnish substance abuse or
 mental health services under part IV of this chapter.

(9) "Community mental health center or clinic" means a
 publicly funded, not-for-profit center that contracts with the
 department for the provision of inpatient, outpatient, day
 treatment, or emergency services.

(10) "Court," unless otherwise specified, means the circuit
 court.

(11) "Department" means the Department of Children and
 Families.

586-03332-17

20171756c1

233 (12) "Designated receiving facility" means a facility
 234 approved by the department which may be a public or private
 235 hospital, crisis stabilization unit, or addictions receiving
 236 facility; which provides, at a minimum, emergency screening,
 237 evaluation, and short-term stabilization for mental health or
 238 substance abuse disorders; and which may have an agreement with
 239 a corresponding facility for transportation and services.

240 (13) "Detoxification facility" means a facility licensed to
 241 provide detoxification services under chapter 397.

242 (14) "Electronic means" means a form of telecommunication
 243 which requires all parties to maintain visual as well as audio
 244 communication when being used to conduct an examination by a
 245 qualified professional.

246 (15) "Express and informed consent" means consent
 247 voluntarily given ~~in writing, by a competent person,~~ after
 248 sufficient explanation and disclosure of the subject matter
 249 involved, as documented in the clinical record, to enable the
 250 individual or his or her guardian, guardian advocate, or health
 251 care surrogate or proxy ~~person~~ to make a knowing and willful
 252 decision without any element of force, fraud, deceit, duress, or
 253 other form of constraint or coercion. Such consent must be in
 254 writing when provided by the individual, but may be provided
 255 verbally and documented in the clinical record when the
 256 individual's substitute decisionmaker is unable to reasonably
 257 provide it in writing.

258 (16) "Facility" means any hospital, community facility,
 259 public or private facility, or receiving or treatment facility
 260 providing for the evaluation, diagnosis, care, treatment,
 261 training, or hospitalization of individuals ~~persons who appear~~

586-03332-17

20171756c1

262 ~~to have or~~ who have been diagnosed as having a mental illness or
 263 substance abuse impairment. The term does not include a program
 264 or an entity licensed under chapter 400 or chapter 429.

265 (17) "Government facility" means a facility owned,
 266 operated, or administered by the Department of Corrections or
 267 the United States Department of Veterans Affairs.

268 ~~(18)(17)~~ "Guardian" means the natural guardian of a minor,
 269 or a person appointed by a court to act on behalf of a ward's
 270 person if the ward is a minor or has been adjudicated
 271 incapacitated.

272 ~~(19)(18)~~ "Guardian advocate" means a person appointed by a
 273 court to make decisions regarding mental health treatment on
 274 behalf of an individual ~~a patient~~ who has been found incompetent
 275 to consent to treatment pursuant to this part.

276 ~~(20)(19)~~ "Hospital" means a hospital licensed under chapter
 277 395 and part II of chapter 408.

278 ~~(21)(20)~~ "Incapacitated" means that an individual ~~a person~~
 279 has been adjudicated incapacitated pursuant to part V of chapter
 280 744 and a guardian of the individual ~~person~~ has been appointed.

281 ~~(22)(21)~~ "Incompetent to consent to treatment" means that
 282 an individual's ~~a state in which a person's~~ judgment is so
 283 affected by a mental illness or a substance abuse impairment
 284 that he or she lacks the capacity to make a well-reasoned,
 285 willful, and knowing decision concerning his or her medical,
 286 mental health, or substance abuse treatment.

287 (23) "Individual" means any person who is held or accepted
 288 for a mental health examination or treatment.

289 ~~(24)(22)~~ "Involuntary examination" means an examination
 290 performed under s. 394.463, ~~s. 397.6772, s. 397.679, s.~~

586-03332-17 20171756c1

291 ~~397.6798, or s. 397.6811~~ to determine if an individual ~~whether a~~
 292 ~~person~~ qualifies for involuntary services.

293 ~~(25)-(23)~~ "Involuntary services" means court-ordered
 294 outpatient services or inpatient placement for mental health
 295 treatment pursuant to s. 394.4655 or s. 394.467.

296 ~~(26)-(24)~~ "Law enforcement officer" has the same meaning as
 297 provided in s. 943.10 or a federal or tribal law enforcement
 298 officer as defined by federal law.

299 ~~(27)-(25)~~ "Marriage and family therapist" means a person
 300 licensed to practice marriage and family therapy under s.
 301 491.005 or s. 491.006 or a person employed as a marriage and
 302 family therapist by the United States Department of Veterans
 303 Affairs or the United States Department of Defense.

304 ~~(28)-(26)~~ "Mental health counselor" means a person licensed
 305 to practice mental health counseling under s. 491.005 or s.
 306 491.006 or a person employed as a mental health counselor by the
 307 United States Department of Veterans Affairs or the United
 308 States Department of Defense.

309 ~~(29)-(27)~~ "Mental health overlay program" means a mobile
 310 service that provides an independent examination for voluntary
 311 admission and a range of supplemental onsite services to an
 312 individual who has ~~persons with~~ a mental illness in a
 313 residential setting such as a nursing home, an assisted living
 314 facility, or an adult family-care home or a nonresidential
 315 setting such as an adult day care center. Independent
 316 examinations provided through a mental health overlay program
 317 must ~~only~~ be provided only under contract with the department
 318 for this service or be attached to a public receiving facility
 319 that is also a community mental health center.

586-03332-17 20171756c1

320 ~~(30)-(28)~~ "Mental illness" means an impairment of the mental
 321 or emotional processes that exercise conscious control of one's
 322 actions or of the ability to perceive or understand reality,
 323 which impairment substantially interferes with the individual's
 324 person's ability to meet the ordinary demands of living. As used
 325 in ~~For the purposes of~~ this part, the term does not include a
 326 developmental disability as defined in chapter 393,
 327 intoxication, or conditions manifested only by antisocial
 328 behavior or substance abuse impairment.

329 ~~(31)-(29)~~ "Minor" means an individual who is 17 years of age
 330 or younger and who has not had the disability of nonage removed
 331 pursuant to s. 743.01 or s. 743.015.

332 ~~(32)-(30)~~ "Mobile crisis response service" means a
 333 nonresidential crisis service available 24 hours per day, 7 days
 334 per week which provides immediate intensive assessments and
 335 interventions, including screening for admission into a mental
 336 health receiving facility, an addictions receiving facility, or
 337 a detoxification facility, for the purpose of identifying
 338 appropriate treatment services.

339 ~~(31)~~ "Patient" means ~~any person, with or without a co-~~
 340 ~~occurring substance abuse disorder, who is held or accepted for~~
 341 ~~mental health treatment.~~

342 ~~(33)-(32)~~ "Physician" means a medical practitioner licensed
 343 under chapter 458 or chapter 459 ~~who has experience in the~~
 344 ~~diagnosis and treatment of mental illness~~ or a physician
 345 employed by ~~a facility operated by~~ the United States Department
 346 of Veterans Affairs or the United States Department of Defense.

347 ~~(34)-(33)~~ "Physician assistant" means a person fully
 348 licensed as a physician assistant under chapter 458 or chapter

586-03332-17

20171756c1

349 459 or a person employed as a physician assistant by the United
 350 States Department of Veterans Affairs or the United States
 351 Department of Defense who has experience in the diagnosis and
 352 treatment of mental disorders.

353 (35)-(34) "Private facility" means a hospital or facility
 354 operated by a for-profit or not-for-profit corporation or
 355 association which provides mental health or substance abuse
 356 services and is not a public facility.

357 (36)-(35) "Psychiatric nurse" means an advanced registered
 358 nurse practitioner certified under s. 464.012 who has a master's
 359 or doctoral degree in psychiatric nursing, holds a national
 360 advanced practice certification as a psychiatric mental health
 361 advanced practice nurse, and has 2 years of post-master's
 362 clinical experience under the supervision of a physician or a
 363 person employed as a psychiatric nurse by the United States
 364 Department of Veterans Affairs or the United States Department
 365 of Defense.

366 (37)-(36) "Psychiatrist" means a medical practitioner
 367 licensed under chapter 458 or chapter 459 for at least 3 years,
 368 inclusive of psychiatric residency or a person employed as a
 369 psychiatrist by the United States Department of Veterans Affairs
 370 or the United States Department of Defense.

371 (38) "Psychologist" means a person defined as a
 372 psychologist under s. 490.003 or a person employed as a
 373 psychologist by the United States Department of Veterans Affairs
 374 or the United States Department of Defense.

375 (39)-(37) "Public facility" means a facility that has
 376 contracted with the department to provide mental health services
 377 to all individuals ~~persons~~, regardless of ability to pay, and is

586-03332-17

20171756c1

378 receiving state funds for such purpose.

379 (40)-(38) "Qualified professional" means a physician or a
 380 physician assistant licensed under chapter 458 or chapter 459; a
 381 psychiatrist licensed under chapter 458 or chapter 459; a
 382 psychologist as defined in s. 490.003(7); an advanced registered
 383 nurse practitioner licensed under part I of chapter 464; or a
 384 psychiatric nurse as defined in this section.

385 (41)-(39) "Receiving facility" means a public or private
 386 facility or hospital designated by the department to receive and
 387 hold individuals on involuntary status or refer, as appropriate,
 388 involuntary patients under emergency conditions for mental
 389 health or substance abuse evaluation and to provide treatment or
 390 transportation to the appropriate service provider. The term
 391 does not include a county jail.

392 (42)-(40) "Representative" means a person selected pursuant
 393 to s. 394.4597(2) to receive notice of proceedings during the
 394 time a patient is held in or admitted to a receiving or
 395 treatment facility.

396 (43)-(41) "Restraint" means:

397 (a) A physical restraint, including any manual method or
 398 physical or mechanical device, material, or equipment attached
 399 or adjacent to an individual's body so that he or she cannot
 400 easily remove the restraint and which restricts freedom of
 401 movement or normal access to one's body. "Physical restraint"
 402 includes the physical holding of an individual ~~a person~~ during a
 403 procedure to forcibly administer psychotropic medication.
 404 "Physical restraint" does not include physical devices such as
 405 orthopedically prescribed appliances, surgical dressings and
 406 bandages, supportive body bands, or other physical holding when

586-03332-17

20171756c1

necessary for routine physical examinations and tests or for purposes of orthopedic, surgical, or other similar medical treatment ~~when used to provide support for the achievement of functional body position or proper balance for protecting an individual or when used to protect a person from falling out of bed.~~

(b) A drug or medication used to control an individual's ~~a person's~~ behavior or to restrict his or her freedom of movement which is not part of the standard treatment regimen for an individual having ~~of a person with~~ a diagnosed mental illness.

(44)~~(42)~~ "Seclusion" means the physical segregation or involuntary isolation of an individual ~~a person~~ in a room or area from which the individual ~~person~~ is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the individual ~~person~~ from leaving the room or area. As used in ~~For purposes of~~ this part, the term does not mean isolation due to the individual's ~~a person's~~ medical condition or symptoms.

(45)~~(43)~~ "Secretary" means the Secretary of Children and Families.

(46)~~(44)~~ "Service provider" means a public or private receiving facility, a facility licensed under chapter 397, a treatment facility, an entity under contract with the department to provide mental health or substance abuse services, a community mental health center or clinic, a psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatrist, an advanced registered nurse practitioner, a psychiatric nurse, or

586-03332-17

20171756c1

a substance abuse qualified professional ~~as defined in s. 39.01.~~

(47)~~(45)~~ "Substance abuse impaired ~~impairment~~" means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner that a person has lost the power of self-control and has inflicted or is likely to inflict physical harm on himself, herself, or another.

(48) "Substance abuse qualified professional" has the same meaning as in s. 397.311(33).

(49)~~(46)~~ "Transfer evaluation" means the process, as approved by the department, in which the individual ~~by which a person who is being considered for placement in a state treatment facility~~ is evaluated for appropriateness of admission to a treatment ~~such~~ facility. The transfer evaluation shall be conducted by the department, a public receiving facility, or a community mental health center or clinic.

(50)~~(47)~~ "Treatment facility" means a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for extended treatment and hospitalization of individuals who have a mental illness, beyond that provided ~~for~~ by a receiving facility or a, ~~of persons who have a mental illness, including facilities of the United States Government, and any~~ private facility designated by the department when rendering such services ~~to a person~~ pursuant to ~~the provisions of this part. Patients treated in facilities of the United States Government shall be solely those whose care is the responsibility of the United States Department of Veterans Affairs.~~

(51)~~(48)~~ "Triage center" means a facility that has medical,

586-03332-17

20171756c1

465 mental health, and substance abuse professionals present or on
 466 call to provide emergency screening and evaluation for mental
 467 health or substance abuse disorders for individuals transported
 468 to the center by a law enforcement officer.

469 Section 3. Section 394.457, Florida Statutes, is amended to
 470 read:

471 394.457 Operation and administration.—

472 (1) ADMINISTRATION.—The Department of Children and Families
 473 is designated the “Mental Health Authority” of Florida. The
 474 department and the Agency for Health Care Administration shall
 475 exercise executive and administrative supervision over all
 476 ~~mental health~~ facilities, programs, and services.

477 (2) RESPONSIBILITIES OF THE DEPARTMENT.—The department is
 478 responsible for:

479 (a) The planning, evaluation, and implementation of a
 480 complete and comprehensive statewide program of mental health
 481 and substance abuse, including community services, receiving and
 482 treatment facilities, child services, research, and training as
 483 authorized and approved by the Legislature, based on the annual
 484 program budget of the department. The department is also
 485 responsible for the coordination of efforts with other
 486 departments and divisions of the state government, county and
 487 municipal governments, and private agencies concerned with and
 488 providing mental health or substance abuse services. It is
 489 responsible for establishing standards, providing technical
 490 assistance, supervising and exercising supervision of mental
 491 health and substance abuse programs, and of, and the treatment
 492 of individuals ~~patients~~ at, community facilities, other
 493 facilities serving individuals ~~for persons~~ who have a mental

586-03332-17

20171756c1

494 illness or substance abuse impairment, and any agency or
 495 facility providing services under ~~to patients pursuant to~~ this
 496 part.

497 (b) The publication and distribution of an information
 498 handbook to facilitate the understanding of ~~this part~~, the
 499 policies and procedures involved in the implementation of this
 500 part, and the responsibilities of the various service providers
 501 ~~of services~~ under this part. Distribution of this handbook may
 502 be limited to online electronic distribution. The department may
 503 ~~It shall~~ stimulate research by public and private agencies,
 504 institutions of higher learning, and hospitals in the interest
 505 of the elimination and amelioration of mental illnesses or
 506 substance abuse impairments ~~illness~~.

507 (3) POWER TO CONTRACT.—The department may contract to
 508 provide, and be provided with, services and facilities in order
 509 to carry out its responsibilities under this part with respect
 510 ~~to the following agencies:~~ public and private hospitals;
 511 receiving and treatment facilities; clinics; laboratories;
 512 departments, divisions, and other units of state government; ~~the~~
 513 state colleges and universities; ~~the~~ community colleges; private
 514 colleges and universities; counties, municipalities, and ~~any~~
 515 other political subdivisions ~~governmental unit~~, including
 516 facilities of the United States Government; and any other public
 517 or private entity that ~~which~~ provides or needs facilities or
 518 services. Baker Act funds for community inpatient, crisis
 519 stabilization, short-term residential treatment, and screening
 520 services under this part must be allocated to each county
 521 pursuant to the department’s funding allocation methodology.
 522 Notwithstanding s. 287.057(3)(e), contracts for community-based

586-03332-17

20171756c1

Baker Act services for inpatient, crisis stabilization, short-term residential treatment, and screening ~~provided~~ under this part, other than those with other units of government, ~~to be provided for the department~~ must be awarded using competitive ~~solicitation sealed bids~~ if the county commission of the county receiving the services makes a request to the department ~~department's district office~~ by January 15 of the contracting year. The department ~~district~~ may not enter into a competitively bid contract ~~under this provision~~ if such action will result in increases of state or local expenditures for Baker Act services ~~within the district~~. Contracts for these Baker Act services using competitive solicitation sealed bids are effective for 3 years. The department shall adopt rules establishing minimum standards for such contracted services and facilities and shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

(4) APPLICATION FOR AND ACCEPTANCE OF GIFTS AND GRANTS.—The department may apply for and accept any funds, grants, gifts, or services made available to it by any agency or department of the Federal Government or any other public or private agency or person individual in aid of mental health and substance abuse programs. All such moneys ~~must shall~~ be deposited in the State Treasury and ~~shall be~~ disbursed as provided by law.

(5) RULES.—The department shall adopt rules:

(a) ~~The department shall adopt rules~~ Establishing forms and procedures relating to the rights and privileges of individuals receiving examination or patients seeking mental health treatment from facilities under this part.

586-03332-17

20171756c1

(b) Implementing and administering ~~The department shall adopt rules necessary for the implementation and administration of the provisions of this part.~~ and A program subject to the ~~provisions of this part~~ may shall not be permitted to operate unless rules designed to ensure the protection of the health, safety, and welfare of the individuals examined and patients treated under through such program have been adopted. Such ~~rules adopted under this subsection~~ must include provisions governing the use of restraint and seclusion which are consistent with recognized best practices and professional judgment; prohibit inherently dangerous restraint or seclusion procedures; establish limitations on the use and duration of restraint and seclusion; establish measures to ensure the safety of program participants and staff during an incident of restraint or seclusion; establish procedures for staff to follow before, during, and after incidents of restraint or seclusion; establish professional qualifications of and training for staff who may order or be engaged in the use of restraint or seclusion; and establish mandatory reporting, data collection, and data dissemination procedures and requirements. Such ~~rules adopted under this subsection~~ must require that each instance of the use of restraint or seclusion be documented in the clinical record of the individual who has been restrained or secluded patient.

(c) ~~The department shall adopt rules~~ Establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service.

(6) PERSONNEL.—

(a) The department shall, by rule, establish minimum standards of education and experience for professional and

586-03332-17

20171756c1

technical personnel employed in mental health programs, including members of a mobile crisis response service.

(b) The department ~~may shall~~ design and distribute appropriate materials for the orientation and training of persons actively engaged in administering ~~implementing~~ the provisions of this part relating to the involuntary examination and treatment placement of individuals ~~persons~~ who are believed to have a mental illness or substance abuse impairment.

(7) PAYMENT FOR CARE ~~OF PATIENTS~~.—Fees and fee collections for individuals ~~patients~~ in state-owned, state-operated, or state-supported treatment facilities must be in accordance with ~~shall be according to~~ s. 402.33.

Section 4. Subsection (1) and paragraph (b) of subsection (2) of section 394.4573, Florida Statutes, are amended to read:

394.4573 Coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.—On or before December 1 of each year, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an assessment of the behavioral health services in this state. The assessment shall consider, at a minimum, the extent to which designated receiving systems function as no-wrong-door models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices. The department's assessment shall consider, at a minimum, the needs assessments conducted by the managing entities pursuant to s. 394.9082(5). Beginning in 2017, the department shall compile and include in the report all plans

586-03332-17

20171756c1

submitted by managing entities pursuant to s. 394.9082(8) and the department's evaluation of each plan.

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

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

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

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

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

586-03332-17

20171756c1

health care system.

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

(b) A designated receiving system that consists of one or more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and involuntary, and treatment or triage of patients who have a mental health or substance use disorder, or co-occurring disorders.

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

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

a. A central receiving system that consists of a designated

586-03332-17

20171756c1

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

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

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

An accurate inventory of the participating service providers which specifies the capabilities and limitations of each provider and its ability to accept patients under the designated receiving system agreements and the transportation plan developed pursuant to this section shall be maintained and made

586-03332-17 20171756c1

697 available at all times to all first responders in the service
698 area.

699 Section 5. Section 394.4574, Florida Statutes, is amended
700 to read:

701 394.4574 Responsibilities for coordination of services for
702 a ~~mental health~~ resident with a mental illness who resides in an
703 assisted living facility that holds a limited mental health
704 license.—

705 (1) As used in this section, the term “mental health
706 resident” means an individual who receives social security
707 disability income due to a mental disorder as determined by the
708 Social Security Administration or receives supplemental security
709 income due to a mental disorder as determined by the Social
710 Security Administration and receives optional state
711 supplementation.

712 (2) Medicaid managed care plans are responsible for
713 Medicaid enrolled mental health residents, and managing entities
714 under contract with the department are responsible for mental
715 health residents who are not enrolled in a Medicaid health plan.
716 A Medicaid managed care plan or a managing entity shall ensure
717 that:

718 (a) A ~~mental health~~ resident has been assessed by a
719 psychiatrist, ~~clinical~~ psychologist, clinical social worker, ~~or~~
720 psychiatric nurse, mental health counselor, marriage and family
721 therapist, or a qualified professional as defined in s.
722 394.455(40) an individual who is supervised by one of these
723 professionals, and determined to be appropriate to reside in an
724 assisted living facility. The documentation must be provided to
725 the administrator of the facility within 30 days after the

586-03332-17 20171756c1

726 ~~mental health~~ resident has been admitted to the facility. An
727 evaluation completed upon discharge from a state mental health
728 treatment facility ~~hospital~~ meets the requirements of this
729 subsection related to appropriateness for services ~~placement~~ as
730 a ~~mental health~~ resident if it was completed within 90 days
731 before admission to the facility.

732 (b) A cooperative agreement, as required in s. 429.075, is
733 developed by the mental health or substance abuse ~~care~~ services
734 provider that serves a ~~mental health~~ resident and the
735 administrator of the assisted living facility with a limited
736 mental health license in which the ~~mental health~~ resident is
737 living.

738 (c) The community living support plan, as defined in s.
739 429.02, has been prepared by a ~~mental health~~ resident and his or
740 her mental health case manager in consultation with the
741 administrator of the facility or the administrator's designee.
742 The plan must be completed and provided to the administrator of
743 the assisted living facility with a limited mental health
744 license in which the ~~mental health~~ resident lives within 30 days
745 after the resident's admission. The support plan and the
746 agreement may be in one document.

747 (d) The assisted living facility with a limited mental
748 health license is provided with documentation that the
749 individual meets the definition of a mental health resident.

750 (e) The ~~mental health~~ services provider assigns a case
751 manager to each ~~mental health~~ resident for whom the entity is
752 responsible. The case manager shall coordinate the development
753 and implementation of the community living support plan defined
754 in s. 429.02. The plan must be updated at least annually, or

586-03332-17

20171756c1

when there is a significant change in the resident's behavioral health status. Each case manager shall keep a record of the date and time of any face-to-face interaction with the resident and make the record available to the responsible entity for inspection. The record must be retained for at least 2 years after the date of the most recent interaction.

(f) Consistent monitoring and implementation of community living support plans and cooperative agreements are conducted by the resident's case manager.

(g) Concerns are reported to the appropriate regulatory oversight organization if a regulated provider fails to deliver appropriate services or otherwise acts in a manner that has the potential to result in harm to the resident.

(3) The ~~secretary of Children and Families~~, in consultation with the Agency for Health Care Administration, shall require each regional district administrator to develop, with community input, a detailed annual plan that demonstrates how the regional office, in cooperation with service providers, district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of assisted living facilities that hold a limited mental health license. This plan ~~must be consistent with the substance abuse and mental health district plan developed pursuant to s. 394.75 and must address~~ case management services; access to consumer-operated drop-in centers; access to services during evenings, weekends, and holidays; supervision of the clinical needs of the residents; and access to emergency psychiatric care.

Section 6. Section 394.458, Florida Statutes, is amended to read:

586-03332-17

20171756c1

394.458 Introduction or removal of certain articles unlawful; penalty.—

(1) ~~(a) Except as authorized by the facility administrator for a lawful purpose law or as specifically authorized by the person in charge of each hospital providing mental health services under this part, it is unlawful to knowingly and intentionally bring into any facility providing services under this part, or to take or attempt to take or send therefrom, any of the following articles introduce into or upon the grounds of such hospital, or to take or attempt to take or send therefrom, any of the following articles, which are hereby declared to be contraband for the purposes of this section:~~

(a) 1- Any intoxicating beverage or beverage which causes or may cause an intoxicating effect;

(b) 2- Any controlled substance as defined in chapter 893;

(c) Any imitation controlled substance as defined in s. 817.564; or

(d) 3- Any firearms or deadly weapon, except for certified law enforcement officers acting in their official capacity.

~~(b) It is unlawful to transmit to, or attempt to transmit to, or cause or attempt to cause to be transmitted to, or received by, any patient of any hospital providing mental health services under this part any article or thing declared by this section to be contraband, at any place which is outside of the grounds of such hospital, except as authorized by law or as specifically authorized by the person in charge of such hospital.~~

(2) A person who violates any provision of this section commits a felony of the third degree, punishable as provided in

586-03332-17

20171756c1

s. 775.082, s. 775.083, or s. 775.084.

(3) A facility providing services under this part shall post at each entry point of the facility a conspicuous notice that includes the text of this section.

Section 7. Section 394.459, Florida Statutes, is amended to read:

394.459 Rights of individuals receiving mental health treatment and services ~~patients~~.—

(1) RIGHT TO ~~INDIVIDUAL~~ DIGNITY.—It is the policy of this state that the individual dignity of all individuals held for examination or admitted for mental health treatment ~~the patient~~ shall be respected at all times and upon all occasions, including ~~any occasion~~ when the individual ~~patient~~ is taken into custody, held, or transported. Procedures, facilities, vehicles, and restraining devices used ~~utilized~~ for criminals or those accused of a crime may ~~shall~~ not be used in connection with individuals ~~persons~~ who have a mental illness, except for the protection of the individual ~~patient~~ or others. Individuals ~~Persons~~ who have a mental illness but who are not charged with a criminal offense may ~~shall~~ not be detained or incarcerated in the jails of this state. An individual ~~A person~~ who is receiving treatment for mental illness may ~~shall~~ not be deprived of any constitutional rights. However, if such an individual ~~a person~~ is adjudicated incapacitated, his or her rights may be limited to the same extent the rights of any incapacitated individual ~~person~~ are limited by law.

(2) RIGHT TO TREATMENT.—An individual held for examination or admitted for mental health treatment:

(a) Shall ~~A person shall~~ not be denied treatment for mental

586-03332-17

20171756c1

illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services from individuals ~~to persons~~ able to pay for services, including insurance or third-party payers ~~payments~~, shall be made by facilities providing services under ~~pursuant to~~ this part.

(b) Shall be provided ~~It is further the policy of the state that~~ the least restrictive appropriate available treatment be utilized based on the individual's ~~individual~~ needs and best interests, ~~of the patient and~~ consistent with the optimum improvement of the individual's ~~patient's~~ condition.

(c) Each person who remains at a receiving or treatment facility for more than 12 hours ~~Shall be given a physical examination by a health practitioner authorized by law to give such examinations and a mental health evaluation by a psychiatrist, psychologist, or psychiatric nurse, in a mental health receiving facility, within 24 hours after arrival at the facility if the individual has not been released or discharged pursuant to s. 394.463(2)(h) or s. 394.469. The physical examination and mental health evaluation must be documented in the clinical record. The physical and mental health examinations shall include efforts to identify indicators and symptoms of substance abuse impairment, substance abuse intoxication, and substance abuse withdrawal, within 24 hours after arrival at such facility.~~

(d) ~~Every patient in a facility~~ Shall be afforded the opportunity to participate in activities designed to enhance self-image and the beneficial effects of other treatments, as

586-03332-17

20171756c1

871 determined by the facility.

872 (e) Not more than 5 days after admission to a facility,
873 each patient shall have and receive an individualized treatment
874 plan in writing which the individual patient has had an
875 opportunity to assist in preparing and to review ~~before~~ prior to
876 ~~its~~ implementation. The plan must ~~shall~~ include a space for the
877 individual's patient's comments and signature.

878 (3) RIGHT TO EXPRESS AND INFORMED ~~PATIENT~~ CONSENT.—

879 ~~(a)1-~~ Each individual patient entering treatment shall be
880 asked to give express and informed consent for admission or
881 treatment.

882 (a) If the individual patient has been adjudicated
883 incapacitated or found to be incompetent to consent to
884 treatment, express and informed consent must to treatment shall
885 be sought instead from his or her the patient's guardian or
886 guardian advocate or health care surrogate or proxy. If the
887 individual patient is a minor, express and informed consent for
888 admission or treatment must be obtained from the minor's shall
889 ~~also be requested from the patient's guardian. Express and~~
890 ~~informed consent for admission or treatment of a patient under~~
891 ~~18 years of age shall be required from the patient's guardian,~~
892 unless the minor is seeking outpatient crisis intervention
893 services under s. 394.4784. ~~Express and informed consent for~~
894 ~~admission or treatment given by a patient who is under 18 years~~
895 ~~of age shall not be a condition of admission when the patient's~~
896 ~~guardian gives express and informed consent for the patient's~~
897 ~~admission pursuant to s. 394.463 or s. 394.467.~~

898 (b)2- Before giving express and informed consent, the
899 following information shall be provided and explained in plain

586-03332-17

20171756c1

900 language to the individual and to his or her patient, or to the
901 patient's guardian if the individual is an adult patient is 18
902 ~~years of age or older~~ and has been adjudicated incapacitated, ~~or~~
903 ~~to his or her the patient's~~ guardian advocate if the individual
904 ~~patient~~ has been found to be incompetent to consent to
905 treatment, to the health care surrogate or proxy, or to both the
906 individual patient and the guardian if the individual patient is
907 a minor; ~~+~~ the reason for admission or treatment; the proposed
908 treatment; the purpose of the treatment to be provided; the
909 common risks, benefits, and side effects thereof; the specific
910 dosage range for the medication, if when applicable; alternative
911 treatment modalities; the approximate length of care; the
912 potential effects of stopping treatment; how treatment will be
913 monitored; and that any consent given for treatment may be
914 revoked orally or in writing before or during the treatment
915 period by the individual receiving treatment patient or by a
916 person who is legally authorized to make health care decisions
917 on the individual's behalf of the patient.

918 ~~(b) In the case of medical procedures requiring the use of~~
919 ~~a general anesthetic or electroconvulsive treatment, and prior~~
920 ~~to performing the procedure, express and informed consent shall~~
921 ~~be obtained from the patient if the patient is legally~~
922 ~~competent, from the guardian of a minor patient, from the~~
923 ~~guardian of a patient who has been adjudicated incapacitated, or~~
924 ~~from the guardian advocate of the patient if the guardian~~
925 ~~advocate has been given express court authority to consent to~~
926 ~~medical procedures or electroconvulsive treatment as provided~~
927 ~~under s. 394.4598.~~

928 ~~(c) When the department is the legal guardian of a patient,~~

586-03332-17

20171756c1

929 ~~or is the custodian of a patient whose physician is unwilling to~~
 930 ~~perform a medical procedure, including an electroconvulsive~~
 931 ~~treatment, based solely on the patient's consent and whose~~
 932 ~~guardian or guardian advocate is unknown or unlocatable, the~~
 933 ~~court shall hold a hearing to determine the medical necessity of~~
 934 ~~the medical procedure. The patient shall be physically present,~~
 935 ~~unless the patient's medical condition precludes such presence,~~
 936 ~~represented by counsel, and provided the right and opportunity~~
 937 ~~to be confronted with, and to cross-examine, all witnesses~~
 938 ~~alleging the medical necessity of such procedure. In such~~
 939 ~~proceedings, the burden of proof by clear and convincing~~
 940 ~~evidence shall be on the party alleging the medical necessity of~~
 941 ~~the procedure.~~

942 ~~(d) The administrator of a receiving or treatment facility~~
 943 ~~may, upon the recommendation of the patient's attending~~
 944 ~~physician, authorize emergency medical treatment, including a~~
 945 ~~surgical procedure, if such treatment is deemed lifesaving, or~~
 946 ~~if the situation threatens serious bodily harm to the patient,~~
 947 ~~and permission of the patient or the patient's guardian or~~
 948 ~~guardian advocate cannot be obtained.~~

949 (4) QUALITY OF TREATMENT.—

950 (a) Each individual held for examination, admitted for
 951 mental health treatment, or receiving involuntary treatment
 952 patient shall receive services ~~that are, including, for a~~
 953 ~~patient placed under s. 394.4655, those services included in the~~
 954 ~~court order which are suited to his or her needs, and which~~
 955 ~~shall be~~ administered skillfully, safely, and humanely with full
 956 respect for the individual's patient's dignity and personal
 957 integrity. Each individual patient shall receive such medical,

586-03332-17

20171756c1

958 vocational, social, educational, and rehabilitative services as
 959 his or her condition requires in order to live successfully in
 960 the community. In order to achieve this goal, the department
 961 ~~shall is directed to~~ coordinate its mental health programs with
 962 all other programs of the department and other state agencies.

963 (b) Facilities shall develop and maintain, in a form
 964 accessible to and readily understandable by individuals held for
 965 examination, admitted for mental health treatment, or receiving
 966 involuntary treatment patients and consistent with rules adopted
 967 by the department, ~~the following:~~

968 1. Criteria, procedures, and required staff training for
 969 the any use of close or elevated levels of supervision; ~~of~~
 970 restraint, seclusion, or isolation; ~~or of~~ emergency treatment
 971 orders; ~~and for the use of~~ bodily control and physical
 972 management techniques.

973 2. Procedures for documenting, monitoring, and requiring
 974 clinical review of all uses of the procedures described in
 975 subparagraph 1. and for documenting and requiring review of any
 976 incidents resulting in injury to individuals receiving services
 977 patients.

978 3. A system for investigating, tracking, managing, and
 979 responding to complaints by individuals persons receiving
 980 services or persons individuals acting on their behalf.

981 (c) Receiving and treatment facilities shall have written
 982 procedures for reporting events that place individuals receiving
 983 services at risk of harm. Such events must be reported to the
 984 department as soon as reasonably possible after discovery and
 985 include, but are not limited to:

986 1. The death, regardless of cause or manner, of an

586-03332-17 20171756c1

individual examined or treated at a facility that occurs while
the individual is at the facility or that occurs within 72 hours
after release, if the death is known to the facility
administrator.

2. An injury sustained, or allegedly sustained, at a
facility, by an individual examined or treated at the facility
and caused by an accident, self-injury, assault, act of abuse,
neglect, or suicide attempt, if the injury requires medical
treatment by a licensed health care practitioner in an acute
care medical facility.

3. The unauthorized departure or absence of an individual
from a facility in which he or she has been held for involuntary
examination or involuntary treatment.

4. A disaster or crisis situation such as a tornado,
hurricane, kidnapping, riot, or hostage situation that
jeopardizes the health, safety, or welfare of individuals
examined or treated in a facility.

5. An allegation of sexual battery upon an individual
examined or treated in a facility.

(d)(e) A facility may not use seclusion or restraint for
punishment, in compensation to compensate for inadequate
staffing, or for the convenience of staff. Facilities shall
ensure that all staff, contractors, and volunteers are made
aware of these restrictions ~~on the use of seclusion and~~
~~restraint and shall make~~ and maintain records which demonstrate
that this information has been conveyed to each staff member,
contractor, and volunteer individual staff members.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.-

(a) Each individual held for examination or admitted for

586-03332-17 20171756c1

mental health treatment ~~person receiving services~~ in a facility
providing ~~mental health~~ services under this part has the right
to communicate freely and privately with persons outside the
facility unless it is determined that such communication is
likely to be harmful to the individual person or others. Each
facility shall make ~~available as soon as reasonably possible to~~
~~persons receiving services~~ a telephone that allows for free
local calls and access to a long-distance service available to
the individual as soon as reasonably possible. A facility is not
required to pay the costs of an individual's ~~a patient's~~ long-
distance calls. The telephone ~~must~~ shall be readily accessible
~~to the patient and shall be placed so that the individual~~
~~patient~~ may use it to communicate privately and confidentially.
The facility may establish reasonable rules for the use of this
telephone ~~which, provided that the rules do not interfere with~~
an individual's ~~a patient's~~ access to a telephone to report
abuse pursuant to paragraph (e).

(b) Each individual patient admitted to a facility under
~~the provisions of this part is shall be~~ allowed to receive,
send, and mail sealed, unopened correspondence; and the
individual's ~~no patient's~~ incoming or outgoing correspondence
~~may not shall~~ be opened, delayed, held, or censored by the
facility unless there is reason to believe that it contains
items or substances that which may be harmful to the individual
patient or others, in which case the administrator may direct
reasonable examination of such mail and may regulate the
disposition of such items or substances.

(c) Each facility shall allow ~~must permit~~ immediate access
to an individual held for examination or admitted for mental

586-03332-17

20171756c1

1045 health treatment ~~any patient~~, subject to the ~~patient's~~ right to
 1046 deny or withdraw consent at any time, by the individual, or by
 1047 ~~the individual's~~ patient's family members, guardian, guardian
 1048 advocate, health care surrogate or proxy, representative,
 1049 ~~Florida statewide or local advocacy council~~, or attorney, unless
 1050 such access would be detrimental to the individual patient. If
 1051 ~~the a patient's~~ right to communicate or to receive visitors is
 1052 restricted by the facility, written notice of such restriction
 1053 and the reasons for the restriction shall be served on the
 1054 individual and the individual's attorney, patient, the patient's
 1055 attorney, and the patient's guardian, guardian advocate, health
 1056 care surrogate or proxy, or representative; and such restriction
 1057 and the reason for the restriction, shall be recorded in ~~on~~ the
 1058 patient's clinical record ~~with the reasons therefor~~. The
 1059 restriction must ~~of a patient's right to communicate or to~~
 1060 ~~receive visitors shall~~ be reviewed at least every 7 days. The
 1061 right to communicate or receive visitors may ~~shall~~ not be
 1062 restricted as a means of punishment. ~~Nothing in~~ This paragraph
 1063 does not shall be construed to limit the establishment of rules
 1064 under provisions of paragraph (d).

1065 (d) Each facility shall establish reasonable rules
 1066 governing visitors, visiting hours, and the use of telephones by
 1067 individuals held for examination or admitted for mental health
 1068 treatment patients in the least restrictive possible manner. An
 1069 individual has ~~Patients shall have~~ the right to contact and to
 1070 receive communication from his or her ~~their~~ attorneys at any
 1071 reasonable time.

1072 (e) Each individual held for examination or admitted for
 1073 mental health treatment patient ~~receiving mental health~~

586-03332-17

20171756c1

1074 ~~treatment in any facility~~ shall have ready access to a telephone
 1075 in order to report an alleged abuse. The facility staff shall
 1076 orally and in writing inform each individual patient of the
 1077 procedure for reporting abuse and shall make every reasonable
 1078 effort to present the information in a language that the
 1079 individual patient understands. A written copy of that
 1080 procedure, including the telephone number of the central abuse
 1081 hotline and reporting forms, shall be posted in plain view.

1082 (f) The department must ~~shall~~ adopt rules providing a
 1083 procedure for reporting alleged abuse. Facility staff ~~shall be~~
 1084 ~~required~~, as a condition of employment, must ~~to~~ become familiar
 1085 with the requirements and procedures for ~~the~~ reporting ~~of~~ abuse.

1086 (6) CARE AND CUSTODY OF PERSONAL EFFECTS OF ~~PATIENTS~~. ~~The~~
 1087 rights of an individual held for examination or admitted for
 1088 mental health treatment ~~A patient's right~~ to the possession of
 1089 his or her clothing and personal effects shall be respected. The
 1090 facility may take temporary custody of such effects if ~~when~~
 1091 required for medical and safety reasons. The ~~A patient's~~
 1092 clothing and personal effects shall be inventoried upon their
 1093 removal into temporary custody. Copies of this inventory shall
 1094 be given to the individual and his or her patient ~~and to the~~
 1095 ~~patient's~~ guardian, guardian advocate, health care surrogate or
 1096 proxy, or representative and shall be recorded in the ~~patient's~~
 1097 clinical record. This inventory may be amended upon the request
 1098 of the individual and his or her patient ~~or the patient's~~
 1099 guardian, guardian advocate, health care surrogate or proxy, or
 1100 representative. The inventory and any amendments to it must be
 1101 witnessed by two members of the facility staff and by the
 1102 individual patient, if able. All of ~~the a patient's~~ clothing and

586-03332-17

20171756c1

personal effects held by the facility ~~must shall~~ be returned to the individual patient immediately upon his or her ~~the~~ discharge or transfer ~~of the patient~~ from the facility, unless such return would be detrimental to the individual patient. If personal effects are not returned ~~to the patient~~, the reason must be documented in the clinical record along with the disposition of the clothing and personal effects, which may be given instead to the individual's patient's guardian, guardian advocate, health care surrogate or proxy, or representative. As soon as practicable after an emergency transfer ~~of a patient~~, the individual's patient's clothing and personal effects shall be transferred to the individual's patient's new location, together with a copy of the inventory and any amendments, unless an alternate plan is approved by the individual patient, if he or she is able, and by his or her ~~the patient's~~ guardian, guardian advocate, health care surrogate or proxy, or representative.

(7) VOTING IN PUBLIC ELECTIONS.—An individual held for examination or admitted for mental health treatment ~~A patient~~ who is eligible to vote according to the laws of the state has the right to vote in ~~the~~ primary, and general, and special elections. The department shall establish rules to enable such individuals patients to obtain voter registration forms, applications for vote-by-mail ballots, and vote-by-mail ballots.

(8) HABEAS CORPUS.—

(a) At any time, and without notice, an individual held for mental health examination or admitted for inpatient treatment in ~~a person held in a receiving or treatment~~ facility, or a relative, friend, guardian, guardian advocate, health care surrogate or proxy, representative, or attorney, or the

586-03332-17

20171756c1

department, on behalf of such individual person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the court order a return to the writ in accordance with chapter 79. Each individual patient held in a facility shall receive a written notice of the right to petition for a writ of habeas corpus.

(b) At any time, and without notice, an individual held for mental health examination or admitted for inpatient treatment ~~a person who is a patient in a receiving or treatment~~ facility, or a relative, friend, guardian, guardian advocate, health care surrogate or proxy, representative, or attorney, or the department, on behalf of such individual person, may file a petition in the circuit court in the county where the individual patient is being held alleging that he or she the patient is being unjustly denied a right or privilege granted under this part herein or that a procedure authorized under this part herein is being abused. Upon the filing of such a petition, the court may ~~shall have the authority~~ to conduct a judicial inquiry and ~~to~~ issue any order ~~needed~~ to correct an abuse of the provisions of this part.

(c) The administrator of any ~~receiving or treatment~~ facility receiving a petition under this subsection shall file the petition with the clerk of the court no later than on the next court working day.

(d) A ~~No~~ fee may not ~~shall~~ be charged for ~~the~~ filing ~~of~~ a petition under this subsection.

(9) VIOLATIONS.—The department shall report to the Agency for Health Care Administration any violation of the rights or privileges of individuals patients, or of any procedures

586-03332-17

20171756c1

provided under this part, by any facility or professional licensed or regulated under state law by the agency. ~~The agency is authorized to impose~~ Any sanction authorized for violation of this part may be imposed, based solely on the investigation and findings of the department.

(10) LIABILITY FOR VIOLATIONS.—~~A~~ Any person who violates or abuses the any rights or privileges of individuals held or admitted for mental health treatment patients provided under by this part is liable for damages as determined by law. A ~~Any~~ person who acts reasonably, in good faith, and without negligence in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the preparation or execution of petitions, applications, certificates, reports, or other documents initiating admission to a facility or the apprehension, detention, transportation, examination, admission, diagnosis, treatment, or discharge of an individual a patient to or from a facility. ~~However, this section does not relieve any person from liability if such person commits negligence.~~

(11) RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE PLANNING.—~~An individual held for examination or admitted for mental health treatment~~ The patient shall have the opportunity to participate in treatment and discharge planning and shall be notified in writing of his or her right, upon discharge from the facility, to seek treatment from the professional or agency of the individual's patient's choice.

(12) POSTING OF NOTICE OF RIGHTS ~~OF PATIENTS~~.—Each facility shall post a notice that lists and describes listing and describing, in the language and terminology that the individual

586-03332-17

20171756c1

~~persons to whom the notice is addressed~~ can understand, the rights provided under ~~in~~ this section. This notice must ~~shall~~ include a statement that ~~provisions of~~ the federal Americans with Disabilities Act apply and the name and telephone number of a person to contact for further information. ~~The~~ This notice must ~~shall~~ be posted in a place readily accessible to individuals patients and in a format easily seen by the individuals served patients. ~~The~~ This notice must ~~shall~~ include the telephone numbers of Disability Rights Florida, Inc ~~the Florida local advocacy council and Advocacy Center for Persons with Disabilities, Inc.~~

Section 8. Section 394.4593, Florida Statutes, is amended to read:

394.4593 Sexual misconduct prohibited; reporting required; penalties.—

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

(a) "Employee" means ~~includes any~~ paid staff member, volunteer, or intern of the department or a service provider providing services pursuant to this part; any person under contract with the department or a service provider providing services pursuant to this part; and any person providing care or support to an individual a client on behalf of the department or its service providers.

(b) "Sexual activity" means:

1. Fondling the genital area, groin, inner thighs, buttocks, or breasts of an individual a person.

2. The oral, anal, or vaginal penetration by or union with the sexual organ of another or the anal or vaginal penetration of another by any other object.

586-03332-17

20171756c1

1219 3. Intentionally touching in a lewd or lascivious manner
 1220 the breasts, genitals, the genital area, or buttocks, or the
 1221 clothing covering them, of an individual ~~a person~~, or forcing or
 1222 enticing an individual ~~a person~~ to touch the perpetrator.

1223 4. Intentionally masturbating in the presence of another
 1224 individual person.

1225 5. Intentionally exposing the genitals in a lewd or
 1226 lascivious manner in the presence of another individual ~~person~~.

1227 6. Intentionally committing any other sexual act that does
 1228 not involve actual physical or sexual contact with another
 1229 individual ~~the victim~~, including, but not limited to,
 1230 sadomasochistic abuse, sexual bestiality, or the simulation of
 1231 any act involving sexual activity in the presence of the
 1232 individual ~~a victim~~.

1233 (c) "Sexual misconduct" means any sexual activity between
 1234 an employee and an individual held or admitted for examination
 1235 or treatment pursuant to this part ~~a patient~~, regardless of the
 1236 consent of that individual ~~the patient~~. The term does not
 1237 include an act done for a bona fide medical purpose or an
 1238 internal search conducted in the lawful performance of duty by
 1239 an employee.

1240 (2) An employee who engages in sexual misconduct with an
 1241 individual ~~a patient who~~.

1242 ~~(a) Is in the custody of the department; or~~

1243 ~~(b) Resides in a receiving facility or a treatment~~
 1244 ~~facility, as those terms are defined in s. 394.455,~~

1245
 1246 commits a felony of the second degree, punishable as provided in
 1247 s. 775.082, s. 775.083, or s. 775.084. An employee may be found

586-03332-17

20171756c1

1248 guilty of violating this subsection without having committed the
 1249 crime of sexual battery.

1250 (3) The consent of an individual held or admitted for
 1251 examination or treatment ~~the patient~~ to sexual activity is not a
 1252 defense to prosecution under this section.

1253 (4) This section does not apply to an employee who, at the
 1254 time of the sexual activity:

1255 (a) Is legally married to the individual involved in the
 1256 sexual activity ~~patient~~; or

1257 (b) Has no reason to believe that the individual involved
 1258 in the sexual activity is held or admitted for examination or
 1259 treatment pursuant to this part ~~person with whom the employee~~
 1260 ~~engaged in sexual misconduct is a patient receiving services as~~
 1261 ~~described in subsection (2).~~

1262 (5) An employee who witnesses sexual misconduct, or who
 1263 otherwise knows or has reasonable cause to suspect that a person
 1264 has engaged in sexual misconduct, shall immediately report the
 1265 incident to the department's central abuse hotline and to the
 1266 appropriate local law enforcement agency. Such employee shall
 1267 also prepare, date, and sign an independent report that
 1268 specifically describes the nature of the sexual misconduct, the
 1269 location and time of the incident, and the persons involved. The
 1270 employee shall deliver the report to the supervisor or program
 1271 director, who is responsible for providing copies to the
 1272 department's inspector general. The inspector general shall
 1273 immediately conduct an appropriate administrative investigation,
 1274 and, if there is probable cause to believe that sexual
 1275 misconduct has occurred, the inspector general shall notify the
 1276 state attorney in the circuit in which the incident occurred.

586-03332-17

20171756c1

1277 (6) (a) Any person who is required to make a report under
 1278 this section and who knowingly or willfully fails to do so, or
 1279 who knowingly or willfully prevents another person from doing
 1280 so, commits a misdemeanor of the first degree, punishable as
 1281 provided in s. 775.082 or s. 775.083.

1282 (b) Any person who knowingly or willfully submits
 1283 inaccurate, incomplete, or untruthful information with respect
 1284 to a report required under this section commits a misdemeanor of
 1285 the first degree, punishable as provided in s. 775.082 or s.
 1286 775.083.

1287 (c) Any person who knowingly or willfully coerces or
 1288 threatens any other person with the intent to alter testimony or
 1289 a written report regarding an incident of sexual misconduct
 1290 commits a felony of the third degree, punishable as provided in
 1291 s. 775.082, s. 775.083, or s. 775.084.

1292 (7) The provisions and penalties set forth in this section
 1293 are in addition to any other civil, administrative, or criminal
 1294 action provided by law which may be applied against an employee.

1295 Section 9. Section 394.4595, Florida Statutes, is repealed.

1296 Section 10. Section 394.4596, Florida Statutes, is created
 1297 to read:

1298 394.4596 Federally mandated protection and advocacy system
 1299 for individuals with disabilities.—The agency designated by the
 1300 governor as the federally mandated protection and advocacy
 1301 system for individuals with disabilities has specific access
 1302 authority under federal law to facilities, individuals,
 1303 information, and records. Any facility defined in s. 394.455(12)
 1304 shall allow this agency to exercise access authority provided to
 1305 it by state and federal law.

586-03332-17

20171756c1

1306 Section 11. Section 394.4597, Florida Statutes, is amended
 1307 to read:

1308 394.4597 Persons to be notified; individual's ~~patient's~~
 1309 representative.—

1310 (1) VOLUNTARY ~~ADMISSION PATIENTS.~~—At the time an individual
 1311 ~~a patient~~ is voluntarily admitted to a receiving or treatment
 1312 facility, the individual shall be asked to identify a person to
 1313 be notified in case of an emergency, and the identity and
 1314 contact information of that a person to be notified in case of
 1315 an emergency shall be entered in the patient's clinical record.

1316 (2) INVOLUNTARY ~~ADMISSION PATIENTS.~~—

1317 (a) At the time an individual ~~a patient~~ is admitted to a
 1318 facility for involuntary examination or services placement, or
 1319 when a petition for involuntary services placement is filed, the
 1320 name, address, and telephone number ~~names, addresses, and~~
 1321 telephone numbers of the individual's ~~patient's~~ guardian or
 1322 guardian advocate, health care surrogate or proxy, or
 1323 representative if he or she ~~the patient~~ has no guardian, and the
 1324 individual's ~~patient's~~ attorney shall be entered in the
 1325 ~~patient's~~ clinical record.

1326 (b) If the individual ~~patient~~ has no guardian, guardian
 1327 advocate, health care surrogate, or proxy, he or she ~~the patient~~
 1328 shall be asked to designate a representative. If the individual
 1329 ~~patient~~ is unable or unwilling to designate a representative,
 1330 the facility shall select a representative.

1331 (c) The individual ~~patient~~ shall be consulted with regard
 1332 to the selection of a representative by the receiving or
 1333 treatment facility and may ~~shall have authority to~~ request that
 1334 the any such representative be replaced.

586-03332-17

20171756c1

- 1335 (d) ~~If When~~ the receiving or treatment facility selects a
 1336 representative, first preference shall be given to a health care
 1337 surrogate, if one has been previously selected ~~by the patient~~.
 1338 If the individual patient has not previously selected a health
 1339 care surrogate, the selection, except for good cause documented
 1340 in the ~~patient's~~ clinical record, shall be made from the
 1341 following list in the order of listing:
- 1342 1. The individual's patient's spouse.
 - 1343 2. An adult child of the individual patient.
 - 1344 3. A parent of the individual patient.
 - 1345 4. The adult next of kin of the individual patient.
 - 1346 5. An adult friend of the individual patient.
- 1347 (e) The following persons are prohibited from selection as
 1348 an individual's ~~a patient's~~ representative:
- 1349 1. A professional providing clinical services to the
 1350 individual patient under this part.
 - 1351 2. The licensed professional who initiated the involuntary
 1352 examination of the individual patient, if the examination was
 1353 initiated by professional certificate.
 - 1354 3. An employee, a volunteer, a contractor, an
 1355 administrator, or a board member of the facility providing the
 1356 examination of the individual patient.
 - 1357 4. An employee, a volunteer, a contractor, an
 1358 administrator, or a board member of a treatment facility
 1359 providing treatment for the individual patient.
 - 1360 5. A person providing any substantial professional services
 1361 to the individual patient, including clinical services.
 - 1362 6. A creditor of the individual patient.
 - 1363 7. A person who is a party subject to an injunction for

Page 47 of 121

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

586-03332-17

20171756c1

- 1364 protection against domestic violence under s. 741.30, whether
 1365 the order of injunction is temporary or final, and for which the
 1366 individual patient was the petitioner.
- 1367 8. A person who is a party subject to an injunction for
 1368 protection against repeat violence, stalking, sexual violence,
 1369 or dating violence under s. 784.046, whether the order of
 1370 injunction is temporary or final, and for which the individual
 1371 patient was the petitioner.
- 1372 (f) The representative selected by the individual or
 1373 designated by the facility has the right, authority, and
 1374 responsibility to:
- 1375 1. Receive notice of the individual's admission;
 - 1376 2. Receive notice of proceedings affecting the individual;
 - 1377 3. Have immediate access to the individual unless such
 1378 access is documented to be detrimental to the individual;
 - 1379 4. Receive notice of any restriction of the individual's
 1380 right to communicate or receive visitors;
 - 1381 5. Receive a copy of the inventory of clothing and personal
 1382 effects upon the individual's admission and to request an
 1383 amendment to the inventory at any time;
 - 1384 6. Receive disposition of the individual's clothing and
 1385 personal effects if not returned to the individual, or to
 1386 approve an alternate plan;
 - 1387 7. Petition on behalf of the individual for a writ of
 1388 habeas corpus to question the cause and legality of the
 1389 individual's detention or to allege that the individual is being
 1390 unjustly denied a right or privilege granted under this part, or
 1391 that a procedure authorized under this part is being abused;
 - 1392 8. Apply for a change of venue for the individual's

Page 48 of 121

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

586-03332-17

20171756c1

1393 involuntary services placement hearing for the convenience of
 1394 the parties or witnesses or because of the individual's
 1395 condition;

1396 9. Receive written notice of any restriction of the
 1397 individual's right to inspect his or her clinical record;

1398 10. Receive notice of the release of the individual from a
 1399 receiving facility where an involuntary examination was
 1400 performed;

1401 11. Receive a copy of any petition for the individual's
 1402 involuntary services filed with the court; and

1403 12. Be informed by the court of the individual's right to
 1404 an independent expert evaluation pursuant to involuntary
 1405 services procedures.

1406 Section 12. Section 394.4598, Florida Statutes, is amended
 1407 to read:

1408 394.4598 Guardian advocate.—

1409 (1) The administrator may petition the court for the
 1410 appointment of a guardian advocate based upon the opinion of a
 1411 psychiatrist that an individual held for examination or admitted
 1412 for mental health treatment ~~the patient~~ is incompetent to
 1413 consent to treatment. If the court finds that the individual a
 1414 ~~patient~~ is incompetent to consent to treatment and has not been
 1415 adjudicated incapacitated and a guardian having with the
 1416 authority to consent to mental health or substance abuse
 1417 treatment has not been appointed, it shall appoint a guardian
 1418 advocate. The individual patient has the right to have an
 1419 attorney represent him or her at the hearing. If the individual
 1420 is not otherwise represented by counsel and person—is indigent,
 1421 the court shall appoint the office of the public defender to

586-03332-17

20171756c1

1422 represent him or her at the hearing. The individual patient has
 1423 the right to testify, cross-examine witnesses, and present
 1424 witnesses. The proceeding must ~~shall~~ be recorded ~~either~~
 1425 electronically or stenographically, and testimony shall be
 1426 ~~provided~~ under oath. One of the professionals authorized to give
 1427 an opinion in support of a petition for involuntary services
 1428 placement, as described in ~~s. 394.4655~~ or s. 394.467, shall must
 1429 testify. ~~The~~ A guardian advocate shall must meet the
 1430 qualifications of a guardian pursuant to ~~contained in~~ part IV of
 1431 chapter 744. A person may not be appointed as a guardian
 1432 advocate unless he or she agrees, ~~except that a professional~~
 1433 ~~referred to in this part, an employee of the facility providing~~
 1434 ~~direct services to the patient under this part, a departmental~~
 1435 ~~employee, a facility administrator, or member of the Florida~~
 1436 ~~local advocacy council shall not be appointed. A person who is~~
 1437 ~~appointed as a guardian advocate must agree to the appointment.~~

1438 (2) The following persons are prohibited from being
 1439 appointed as an individual's appointment as a patient's guardian
 1440 advocate:

1441 (a) A professional providing clinical services to the
 1442 individual patient under this part.

1443 (b) The licensed professional who initiated the involuntary
 1444 examination of the individual patient, if the examination was
 1445 initiated by professional certificate.

1446 (c) An employee, a contractor, a volunteer, an
 1447 administrator, or a board member of the facility providing the
 1448 examination of the individual patient.

1449 (d) An employee, a contractor, a volunteer, an
 1450 administrator, or a board member of a treatment facility

586-03332-17

20171756c1

providing treatment of the individual patient.

(e) A person providing any substantial professional services, excluding public and professional guardians, to the individual patient, including clinical services.

(f) A creditor of the individual patient.

(g) A party person ~~subject~~ to an injunction for protection against domestic violence under s. 741.30, whether the order of injunction is temporary or final, and for which the individual patient was the petitioner.

(h) A party person ~~subject~~ to an injunction for protection against repeat violence, stalking, sexual violence, or dating violence under s. 784.046, whether the order of injunction is temporary or final, and for which the individual patient was the petitioner.

(3) A facility requesting appointment of a guardian advocate shall, before must, prior to the appointment, provide the prospective guardian advocate with information concerning ~~about~~ the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for an individual held for examination or admitted for mental health treatment a patient, the facility shall provide all disclosures required under s. 394.459(3)(a)2 ~~to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects.~~ Before giving consent

586-03332-17

20171756c1

to treatment, the guardian advocate shall ~~must~~ meet and talk with the individual patient and the individual's patient's physician face-to-face in person, if ~~at all~~ possible, and by telephone, if not. The guardian advocate shall make every effort to make decisions regarding treatment that he or she believes the individual would have made under the circumstances if the individual were capable of making such decision. The decision of the guardian advocate may be reviewed by the court, upon petition of the individual's patient's attorney, the individual's patient's family, or the facility administrator.

(4) In lieu of the training required of guardians appointed under pursuant to chapter 744, a guardian advocate must, at a minimum, complete participate in a 4-hour training course approved by the court before exercising his or her authority. At a minimum, this training course must include information concerning rights of the individual about patient rights, psychotropic medications, the diagnosis of mental illness, the ethics of medical decisionmaking, and duties of guardian advocates.

(5) The required training course and the information provided to be supplied to prospective guardian advocates before their appointment must be developed by the department and, approved by the chief judge of the circuit court, and taught by a court-approved organization, which may include, but is not limited to, a community college, a guardianship organization, a local bar association, or The Florida Bar. The training course may be web-based, provided in video format, or other electronic means but must be capable of ensuring the identity and participation of the prospective guardian advocate. The court

586-03332-17

20171756c1

may waive some or all of the training requirements for guardian advocates or impose additional requirements. The court shall make its decision on a case-by-case basis and, in making its decision, shall consider the experience and education of the guardian advocate, the duties assigned to the guardian advocate, and the needs of the individual subject to involuntary services patient.

(6) In selecting a guardian advocate, the court shall give preference to a health care surrogate, if one has already been designated by the individual held for examination or admitted for mental health treatment patient. If the individual patient has not previously selected a health care surrogate, except for good cause documented in the court record, the selection shall be made from the following list in the order of listing:

(a) The individual's patient's spouse.

(b) An adult child of the individual patient.

(c) A parent of the individual patient.

(d) The adult next of kin of the individual patient.

(e) An adult friend of the individual patient.

(f) An adult trained and willing to serve as guardian advocate for the individual patient.

(7) If a guardian ~~having with~~ the authority to consent to medical treatment has not already been appointed or if the individual held for examination or admitted for mental health treatment patient has not already designated a health care surrogate, the court may authorize the guardian advocate to consent to medical treatment, as well as mental health and substance abuse treatment. Unless otherwise limited by the court, a guardian advocate ~~who has with~~ authority to consent to

586-03332-17

20171756c1

medical treatment ~~has shall have~~ the same authority to make health care decisions and ~~is be~~ subject to the same restrictions as a proxy appointed under part IV of chapter 765.

(a) Unless the guardian advocate has sought and received express court approval in proceeding separate from the proceeding to determine the competence of the individual patient to consent to medical treatment, the guardian advocate may not consent to:

1. ~~(a)~~ Abortion.

2. ~~(b)~~ Sterilization.

3. ~~(c)~~ Electroconvulsive treatment.

4. ~~(d)~~ Psychosurgery.

5. ~~(e)~~ Experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56.

(b) The court must base its decision on evidence that the treatment or procedure is essential to the care of the patient and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. The court shall follow the procedures set forth in subsection (1) of this section.

(8) The guardian advocate shall be discharged when the individual for whom he or she is appointed patient is discharged from an order for involuntary services ~~outpatient placement or involuntary inpatient placement~~ or when the individual patient is transferred from involuntary to voluntary status. The court ~~or a hearing officer~~ shall consider the competence of the individual patient pursuant to subsection (1) and may consider the competence to consent to treatment of an individual on

586-03332-17

20171756c1

1567 ~~involuntary status an involuntarily placed patient's competence~~
 1568 ~~to consent to treatment~~ at any hearing. Upon sufficient
 1569 evidence, the court may restore the individual's, ~~or the hearing~~
 1570 ~~officer may recommend that the court restore, the patient's~~
 1571 competence. A copy of the order restoring competence or the
 1572 certificate of discharge containing the restoration of
 1573 competence shall be provided to the individual patient and the
 1574 guardian advocate.

1575 Section 13. Paragraphs (c) and (d) of subsection (2) of
 1576 section 394.4599, Florida Statutes, are amended to read:

1577 394.4599 Notice.—

1578 (2) INVOLUNTARY ADMISSION.—

1579 (c)1. A receiving facility shall give notice of the
 1580 whereabouts of a minor who is being involuntarily held for
 1581 examination pursuant to s. 394.463 to the minor's parent,
 1582 guardian, caregiver, or guardian advocate, in person or by
 1583 telephone or other form of electronic communication, immediately
 1584 after the minor's arrival at the facility. The facility may
 1585 delay notification for no more than 24 hours after the minor's
 1586 arrival if the facility has submitted a report to the central
 1587 abuse hotline, pursuant to s. 39.201, based upon knowledge or
 1588 suspicion of abuse, abandonment, or neglect and if the facility
 1589 deems a delay in notification to be in the minor's best
 1590 interest.

1591 2. The receiving facility shall attempt to notify the
 1592 minor's parent, guardian, caregiver, or guardian advocate until
 1593 the receiving facility receives confirmation from the parent,
 1594 guardian, caregiver, or guardian advocate, verbally, by
 1595 telephone or other form of electronic communication, or by

Page 55 of 121

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

586-03332-17

20171756c1

1596 recorded message, that notification has been received. Attempts
 1597 to notify the parent, guardian, caregiver, or guardian advocate
 1598 must be repeated at least once every hour during the first 12
 1599 hours after the minor's arrival and once every 24 hours
 1600 thereafter and must continue until such confirmation is
 1601 received, unless the minor is released at the end of the 72-hour
 1602 examination period, or until a petition for involuntary services
 1603 is filed with the court pursuant to s. 394.463(2)(f)
 1604 ~~394.463(2)(g)~~. The receiving facility may seek assistance from a
 1605 law enforcement agency to notify the minor's parent, guardian,
 1606 caregiver, or guardian advocate if the facility has not received
 1607 within the first 24 hours after the minor's arrival a
 1608 confirmation by the parent, guardian, caregiver, or guardian
 1609 advocate that notification has been received. The receiving
 1610 facility must document notification attempts in the minor's
 1611 clinical record.

1612 (d) The written notice of the filing of the petition for
 1613 involuntary services for an individual being held must contain
 1614 the following:

1615 1. Notice that the petition for+

1616 ~~a. involuntary services inpatient treatment~~ pursuant to s.
 1617 394.467 has been filed with the circuit court in the county in
 1618 which the individual is hospitalized and the address of such
 1619 court; or

1620 b. Involuntary outpatient services pursuant to s. 394.4655
 1621 has been filed with the criminal county court, as defined in s.
 1622 394.4655(1), or the circuit court, as applicable, in the county
 1623 in which the individual is hospitalized and the address of such
 1624 court.

Page 56 of 121

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

586-03332-17

20171756c1

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

Section 14. Section 394.460, Florida Statutes, is repealed.

Section 15. Section 394.461, Florida Statutes, is amended to read:

394.461 Designation of receiving and treatment facilities and receiving systems.—The department may ~~is authorized to~~ designate and monitor receiving facilities, treatment facilities, and receiving systems and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. Only governmental facilities and facilities ~~Unless~~ designated by the department may, ~~facilities are not permitted to~~ hold or treat individuals on an involuntary basis ~~patients under this part.~~

(1) RECEIVING FACILITY.—The department may designate any ~~community facility as a receiving facility. Any other facility~~ within the state, including a private facility, as a receiving

586-03332-17

20171756c1

~~facility if or a federal facility, may be so designated by the department, provided that~~ such designation is agreed to by the governing body or authority of the facility.

(2) TREATMENT FACILITY.—The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. An individual may ~~A civil patient shall~~ not be admitted to a civil state treatment facility without previously undergoing a transfer evaluation. Before a court hearing for involuntary services placement ~~placement~~ in a state treatment facility, the court shall receive and consider the information documented in the transfer evaluation. Any other facility, including a private facility or a governmental ~~federal~~ facility, may be designated as a treatment facility by the department, if the ~~provided that such~~ designation is agreed to by the appropriate governing body or authority of the facility.

(3) GOVERNMENTAL FACILITIES.—Governmental facilities may provide voluntary and involuntary mental health or substance abuse examination and treatment for individuals in their care and custody using the procedures provided in this part and shall protect the rights of these individuals.

~~(4)-(3)~~ PRIVATE FACILITIES.—Private facilities designated as receiving and treatment facilities by the department may provide examination and treatment of individuals on an involuntary or voluntary basis ~~are subject to involuntary patients, as well as voluntary patients, and are subject to all the provisions of~~ this part.

~~(5)-(4)~~ REPORTING REQUIREMENTS.—

(a) A facility designated as a public receiving or treatment facility under this section shall report to the

586-03332-17

20171756c1

department on an annual basis the following data, unless these data are currently being submitted to the Agency for Health Care Administration:

1. Number of licensed beds.
2. Number of contract days.
3. Number of admissions by payor class and diagnoses.
4. Number of bed days by payor class.
5. Average length of stay by payor class.
6. Total revenues by payor class.

(b) For the purposes of this subsection, "payor class" means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay health insurance, private-pay health maintenance organization, private preferred provider organization, the Department of Children and Families, other government programs, self-pay individuals ~~patients~~, and charity care.

(c) The data required under this subsection shall be submitted to the department within no later than 90 days after ~~following~~ the end of the facility's fiscal year. A facility designated as a public receiving or treatment facility shall submit its initial report for the 6-month period ending June 30, 2008.

(d) The department shall issue an annual report based on the data collected ~~required~~ pursuant to this subsection, which must include data by facility. ~~The report shall include individual facilities' data,~~ as well as statewide totals. The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(6) ~~(5)~~ RECEIVING SYSTEM.—The department shall designate as a receiving system one or more facilities serving a defined

586-03332-17

20171756c1

geographic area developed pursuant to s. 394.4573 which is responsible for assessment and evaluation, both voluntary and involuntary, and treatment, stabilization, or triage for patients who have a mental illness, a substance use disorder, or co-occurring disorders. Any transportation plans developed pursuant to s. 394.462 must support the operation of the receiving system.

(7) ~~(6)~~ RULES.—The department may adopt rules relating to:

(a) Procedures and criteria for receiving and evaluating facility applications for designation as a receiving or treatment facility, which may include an onsite facility inspection and evaluation of an applicant's licensing status and performance history, as well as consideration of local service needs.

(b) Minimum standards consistent with this part which ~~that~~ a facility must meet and maintain in order to be designated as a receiving or treatment facility and procedures for monitoring continued adherence to such standards.

(c) Procedures and criteria for designating receiving systems which may include consideration of the adequacy of services provided by facilities within the receiving system to meet the needs of the geographic area using available resources.

(d) Procedures for receiving complaints against a designated facility or designated receiving system and for initiating inspections and investigations of facilities or receiving systems alleged to have violated the provisions of this part or rules adopted under this part.

(e) Procedures and criteria for the suspension or withdrawal of designation as a receiving or treatment facility

586-03332-17

20171756c1

or receiving system.

Section 16. Section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.-

(1) A clinical record shall be maintained for each individual held for examination or admitted for treatment under this part ~~patient~~. The record ~~must~~ shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from ~~the provisions of~~ s. 119.07(1). Unless waived by the express and informed consent of the individual, his or her, ~~by the patient or the patient's~~ guardian or guardian advocate, his or her health care surrogate or proxy, or, if ~~the patient is~~ deceased, by his or her ~~the patient's~~ personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record is ~~shall~~ not be lost by ~~either~~ authorized or unauthorized disclosure to any person, organization, or agency.

(2) The clinical record of an individual held for examination or admitted for treatment under this part shall be released if when:

(a) The individual patient or the individual's patient's guardian, guardian advocate, or health care surrogate or proxy authorizes the release. The guardian, ~~or~~ guardian advocate, or health care surrogate or proxy, shall be provided access to the appropriate clinical records ~~of the patient~~. The individual patient or the individual's patient's guardian, ~~or~~ guardian advocate, health care surrogate or proxy may authorize the release of information and clinical records to appropriate

586-03332-17

20171756c1

persons to ensure the continuity of the individual's patient's health ~~care~~ or mental health care.

(b) The individual patient is represented by counsel and the records are needed by such ~~the patient's~~ counsel for adequate representation.

(c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the individual person to whom such information pertains.

(d) The individual patient is committed to, ~~or is to be~~ returned to, the Department of Corrections ~~from the Department of Children and Families,~~ and the Department of Corrections requests the such records. The ~~These~~ records shall be furnished without charge to the Department of Corrections.

(3) Information from the clinical record may be released if ~~in the following circumstances:~~

(a) The individual ~~When a patient~~ has declared an intention to harm self or others ~~other persons~~. If the ~~When such~~ declaration has been made, the administrator may authorize the release of sufficient information to prevent harm ~~provide adequate warning to the person threatened with harm by the patient~~.

(b) ~~When~~ The administrator of the facility or secretary of the department deems that release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the individual patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or

586-03332-17

20171756c1

evaluation of programs.

(c) ~~The information is necessary for the purpose of determining whether an individual a person meets the criteria for involuntary services. In such circumstances outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record may be released to the state attorney, the public defender or the individual's patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(7)(b)2., in accordance with state and federal law.~~

(4) Information from clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals served and meets the requirements of department rules.

(5) Information from clinical records may be used by the Agency for Health Care Administration and, the department, ~~and the Florida advocacy councils~~ for the purpose of monitoring facility activity and investigating complaints concerning facilities.

(6) Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

(7) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from ~~the provisions of~~ s. 119.07(1).

(8) Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this

586-03332-17

20171756c1

section is not subject to civil or criminal liability for such release.

(9) ~~Nothing in This section does not is intended to prohibit the parent or next of kin of an individual who is held for examination or admitted for treatment under this part a person who is held in or treated under a mental health facility or program~~ from requesting and receiving information limited to a summary of that individual's person's treatment plan and current physical and mental condition. Release of such information must ~~shall~~ be in accordance with the code of ethics of the profession involved.

(10) An individual held for examination or admitted for treatment ~~Patients~~ shall have reasonable access to his or her ~~their~~ clinical records, unless such access is determined by the individual's patient's physician to be harmful to the individual patient. If the individual's patient's right to inspect his or her clinical record is restricted by the facility, written notice of the such restriction must shall be given to the individual and his or her patient and the patient's guardian, guardian advocate, attorney, health care surrogate or proxy, or ~~and~~ representative. In addition, the restriction must shall be recorded in the clinical record, together with the reasons for it. The restriction expires of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

(11) Any person who fraudulently alters, defaces, or falsifies the clinical record of an individual any person receiving ~~mental health~~ services in a facility subject to this part, or causes or procures any of these offenses to be

586-03332-17 20171756c1

committed, commits a misdemeanor of the second degree,
punishable as provided in s. 775.082 or s. 775.083.

Section 17. Section 394.462, Florida Statutes, is amended
to read:

394.462 Transportation.—A transportation plan shall be
developed and implemented by each county by July 1, 2017, in
collaboration with the managing entity in accordance with this
section. A county may enter into a memorandum of understanding
with the governing boards of nearby counties to establish a
shared transportation plan. When multiple counties enter into a
memorandum of understanding for this purpose, the counties shall
notify the managing entity and provide it with a copy of the
agreement. The transportation plan shall describe methods of
transport to a facility within the designated receiving system
for individuals subject to involuntary examination under s.
394.463 or involuntary admission under s. 397.6772, s. 397.679,
s. 397.6798, or s. 397.6811, and may identify responsibility for
other transportation to a participating facility when necessary
and agreed to by the facility. The plan may rely on emergency
medical transport services or private transport companies, as
appropriate. The plan shall comply with the transportation
provisions of this section and ss. 397.6772, 397.6795, 397.6822,
and 397.697.

(1) TRANSPORTATION TO A RECEIVING FACILITY.—

(a) Each county shall designate a single law enforcement
agency within the county, or portions thereof, to take an
individual ~~a person~~ into custody upon the entry of an ex parte
order or the execution of a certificate for involuntary
examination by an authorized qualified professional and to

586-03332-17 20171756c1

transport that person to the appropriate facility, excluding a
governmental facility, within the designated receiving system
pursuant to a transportation plan or an exception under
subsection (4), or to the nearest receiving facility if neither
apply. However, if the law enforcement officer providing
transportation believes that the individual is eligible for
services provided by the United States Department of Veterans
Affairs, the officer may transport the individual to a facility
operated by the United States Department of Veterans Affairs.

(b) A law enforcement officer acting in good faith pursuant
to this part may not be held criminally or civilly liable for
false imprisonment.

(c) ~~(b)~~ 1. The designated law enforcement agency may decline
to transport the individual ~~person~~ to a receiving facility only
if:

1. ~~a.~~ The county or jurisdiction designated by the county
has contracted ~~on an annual basis~~ with an emergency medical
transport service or private transport company for
transportation of individuals ~~persons~~ to receiving facilities.
~~pursuant to this section at the sole cost of the county, and~~

2. ~~b.~~ The law enforcement agency and the emergency medical
transport service or private transport company agree that the
continued presence of law enforcement personnel is not necessary
for the safety of the individual being transported ~~person~~ or
others.

3. ~~2.~~ The entity providing transportation may seek
reimbursement for transportation expenses. The party responsible
for payment for such transportation is the person receiving the
transportation. The county shall seek reimbursement from the

586-03332-17

20171756c1

following sources in the following order:

a. From a private or public third-party payor, if the individual being transported ~~person receiving the transportation~~ has applicable coverage.

b. From the individual being transported ~~person receiving the transportation~~.

c. From a financial settlement for medical care, treatment, hospitalization, or transportation payable or accruing to the injured party.

(d) ~~(e)~~ A company that transports an individual ~~a patient~~ pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transport of the individual patient. ~~The Such~~ company must be insured and maintain at least ~~provide no less than~~ \$100,000 in liability insurance with respect to such ~~the~~ transport ~~of~~ ~~patients~~.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(e) ~~If When~~ a law enforcement officer takes custody of an individual ~~a person~~ pursuant to this part, the officer may request assistance from emergency medical personnel if the ~~such~~ assistance is needed for the safety of the officer or the individual ~~person~~ in custody.

(f) ~~If When~~ a member of a mental health overlay program or a mobile crisis response service who is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 or s. 397.675 ~~and that professional evaluates an~~

586-03332-17

20171756c1

individual ~~a person~~ and determines that transportation to a receiving facility is needed, the service, ~~at its discretion~~, may transport the individual ~~person~~ to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the individual being transported ~~patient~~.

(g) ~~If a When any~~ law enforcement officer has custody of an individual ~~a person~~ based on a misdemeanor or a felony, ~~other than a forcible felony as defined in s. 776.08, who either noncriminal or minor criminal behavior that~~ meets the statutory guidelines for involuntary examination pursuant to s. 394.463, the law enforcement officer shall transport the individual person to the appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or to the nearest receiving facility if neither apply. Individuals ~~Persons~~ who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or to the nearest facility if neither apply.

(h) ~~If a When any~~ law enforcement officer has arrested an individual ~~a person~~ for a forcible felony, ~~as defined in s. 776.08, and it appears that the individual person meets the criteria~~ ~~statutory guidelines~~ for involuntary examination ~~or placement~~ under this part, the individual ~~such person~~ must first be processed in the same manner as any other criminal suspect.

586-03332-17

20171756c1

The law enforcement agency shall thereafter immediately notify the appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or to the nearest receiving facility if neither apply. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the individual ~~person~~. A receiving facility is not required to admit an individual ~~a person~~ charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the individual ~~person~~ where he or she is held.

(i) If the appropriate law enforcement officer believes that an individual ~~a person~~ has an emergency medical condition as defined in s. 395.002, the individual ~~person~~ may be ~~first~~ transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

(j) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by an individual who was ~~persons who have been~~ arrested for a violation ~~violations~~ of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.

(k) The appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or the nearest receiving facility if neither apply, must accept an individual ~~persons~~ brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

586-03332-17

20171756c1

The original of the form initiating the involuntary examination is not required for a receiving facility to accept such an individual or for transfers from one facility to another.

(l) The appropriate facility within the designated receiving system pursuant to a transportation plan or an exception under subsection (4), or the nearest receiving facility if neither apply, must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic screening or triage sufficient to refer the person to the appropriate services.

(m) Each law enforcement agency designated pursuant to paragraph (a) shall establish a policy that reflects a single set of protocols for the safe and secure transportation and transfer of custody of the individual ~~person~~. Each law enforcement agency shall provide a copy of the protocols to the managing entity.

(n) ~~If~~ When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of individuals ~~persons~~ to facilities within the designated receiving system, such service or company shall be given preference for transportation of individuals ~~persons~~ from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the individual ~~person~~ being transported is such that transportation by a law enforcement officer is necessary.

(o) This section ~~does not~~ may not be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with s. 401.445.

586-03332-17

20171756c1

(p) A law enforcement officer may transport an individual who appears to meet the criteria for voluntary admission under s. 394.4625(1)(a) to a receiving facility at the individual's request.

(2) TRANSPORTATION TO A TREATMENT FACILITY.—

(a) If the individual held for examination or admitted for treatment under this part or ~~neither the patient nor~~ any person legally obligated or responsible for the individual patient is not able to pay for the expense of transporting an individual a voluntary or involuntary patient to a treatment facility, the transportation plan established by the governing board of the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities in a safe and dignified manner.

(b) A company that transports an individual a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the individual patient. The ~~Such~~ company must be insured and provide at least ~~no less than~~ \$100,000 in liability insurance for such with respect to the transport of patients.

(c) A company that contracts with one or more counties to transport patients in accordance with this section shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(d) County or municipal law enforcement and correctional personnel and equipment may not be used to transport an individual patients adjudicated incapacitated or found by the court to meet the criteria for involuntary services under

586-03332-17

20171756c1

~~placement pursuant to~~ s. 394.467, except in small rural counties where there are no cost-efficient alternatives.

(3) TRANSFER OF CUSTODY.—Custody of an individual ~~a person~~ who is transported pursuant to this part ~~and, along with~~ related documentation, shall be relinquished to a responsible person individual at the appropriate receiving or treatment facility.

(4) EXCEPTIONS.—An exception to the requirements of this section may be granted by the secretary ~~of the department~~ for the purposes of improving service coordination or better meeting the special needs of individuals. A proposal for an exception shall ~~must~~ be submitted to the department after being approved by the governing boards of any affected counties.

(a) A proposal for an exception must identify the specific provision from which an exception is requested; describe how the proposal will be implemented by participating law enforcement agencies and transportation authorities; and provide a plan for the coordination of services.

(b) ~~An~~ The exception may be granted only for:

1. An arrangement centralizing and improving the provision of services within a county, circuit, or local area ~~district~~, which may include an exception to the requirement for transportation to the nearest receiving facility;

2. An arrangement ~~whereby by which~~ a facility may provide, in addition to required psychiatric or substance use disorder services, an environment and services ~~that which~~ are uniquely tailored to the needs of an identified group of individuals who have persons with special needs, such as persons who have with hearing impairments or visual impairments, or elderly persons who have with physical frailties; or

586-03332-17

20171756c1

2089 3. A specialized transportation system that provides an
 2090 efficient and humane method of transporting individuals ~~patients~~
 2091 to and among receiving facilities, ~~among receiving facilities,~~
 2092 and to treatment facilities.

2093
 2094 The exceptions provided in this subsection shall expire on June
 2095 30, 2017, and no new exceptions shall be granted after that
 2096 date. After June 30, 2017, the transport of a patient to a
 2097 facility that is not the nearest facility must be made pursuant
 2098 to a plan as provided in this section.

2099 Section 18. Section 394.4625, Florida Statutes, is amended
 2100 to read:

2101 394.4625 Voluntary admissions.—

2102 (1) EXAMINATION AND TREATMENT AUTHORITY TO RECEIVE
 2103 PATIENTS.—

2104 (a) In order to be admitted to a facility on a voluntary
 2105 basis:

2106 1. An individual must show evidence of mental illness.

2107 2. An individual must be suitable for treatment by the
 2108 facility.

2109 3. An adult must provide express and informed consent, and
 2110 must be competent to do so.

2111 4. A minor may only be admitted on the basis of the express
 2112 and informed consent of the minor's guardian in conjunction with
 2113 the assent of the minor.

2114 a. The assent of the minor is an affirmative agreement by
 2115 the minor to remain at the facility for examination or
 2116 treatment. Mere failure to object is not assent.

2117 b. The minor's assent must be verified through a clinical

586-03332-17

20171756c1

2118 assessment that is documented in the clinical record and
 2119 conducted within 12 hours after arrival at the facility by a
 2120 licensed professional authorized to initiate an involuntary
 2121 examination pursuant to s. 394.463.

2122 c. In verifying the minor's assent, the examining
 2123 professional must first provide the minor with an explanation as
 2124 to why the minor will be examined and treated, what the minor
 2125 can expect while in the facility, and when the minor may expect
 2126 to be released, using language that is appropriate to the
 2127 minor's age, experience, maturity, and condition. The examining
 2128 professional must determine and document that the minor is able
 2129 to understand this information.

2130 d. Unless the minor's assent is verified pursuant to this
 2131 section, a petition for involuntary services must be filed with
 2132 the court or the minor must be released to his or her guardian
 2133 within 24 hours after arrival. A facility may receive for
 2134 observation, diagnosis, or treatment any person 18 years of age
 2135 or older making application by express and informed consent for
 2136 admission or any person age 17 or under for whom such
 2137 application is made by his or her guardian. If found to show
 2138 evidence of mental illness, to be competent to provide express
 2139 and informed consent, and to be suitable for treatment, such
 2140 person 18 years of age or older may be admitted to the facility.
 2141 A person age 17 or under may be admitted only after a hearing to
 2142 verify the voluntariness of the consent.

2143 (b) A mental health overlay program or a mobile crisis
 2144 response service or a licensed professional who is authorized to
 2145 initiate an involuntary examination pursuant to s. 394.463 and
 2146 is employed by a community mental health center or clinic shall

586-03332-17

20171756c1

2147 ~~must, pursuant to district procedure approved by the respective~~
 2148 ~~district administrator,~~ conduct an initial assessment of the
 2149 ability of the following individuals ~~persons~~ to give express and
 2150 informed consent to treatment before such individuals ~~persons~~
 2151 may be admitted voluntarily:

2152 1. An individual ~~A person~~ 60 years of age or older for whom
 2153 transfer is being sought from a nursing home, assisted living
 2154 facility, adult day care center, or adult family-care home, if
 2155 the individual ~~when such person~~ has been diagnosed with ~~as~~
 2156 ~~suffering from~~ dementia.

2157 2. An individual ~~A person~~ 60 years of age or older for whom
 2158 transfer is being sought from a nursing home pursuant to s.
 2159 400.0255(11) ~~400.0255(12)~~.

2160 3. An individual who resides in a facility licensed under
 2161 chapter 400 or chapter 429 ~~A person~~ for whom all decisions
 2162 concerning medical treatment are currently being lawfully made
 2163 by a ~~the~~ health care surrogate or proxy designated under chapter
 2164 765.

2165 (c) If ~~When~~ an initial assessment of the ability of an
 2166 individual ~~a person~~ to give express and informed consent to
 2167 treatment is required under this part ~~section~~, and a mobile
 2168 crisis response service does not respond to the request for an
 2169 assessment within 2 hours after the request is made or informs
 2170 the requesting facility that it will not be able to respond
 2171 within 2 hours after the request is made, the requesting
 2172 facility may arrange for assessment by a ~~any~~ licensed
 2173 professional authorized to initiate an involuntary examination
 2174 under ~~pursuant to~~ s. 394.463. The professional may not be who is
 2175 ~~not~~ employed by, ~~or~~ under contract with, or ~~and does not~~ have a

586-03332-17

20171756c1

2176 financial interest in, ~~either~~ the facility initiating the
 2177 transfer or the ~~receiving~~ facility to which the transfer may be
 2178 made and may not have a financial interest in the outcome of the
 2179 assessment.

2180 (d) A facility may not admit an individual on voluntary
 2181 status or transfer an individual to voluntary status ~~as a~~
 2182 ~~voluntary patient a person~~ who has been adjudicated
 2183 incapacitated, unless the condition of incapacity has been
 2184 judicially removed, except when a court authorized a legal
 2185 guardian in adherence to s. 744.3725. If a facility admits an
 2186 individual on voluntary status who is later determined to have
 2187 been adjudicated incapacitated, the facility shall discharge the
 2188 individual or transfer the individual to involuntary status
 2189 unless there is a court order pursuant to s. 744.3725 ~~as a~~
 2190 ~~voluntary patient a person who is later determined to have been~~
 2191 ~~adjudicated incapacitated, and the condition of incapacity had~~
 2192 ~~not been removed by the time of the admission, the facility must~~
 2193 ~~either discharge the patient or transfer the patient to~~
 2194 ~~involuntary status~~.

2195 (e) The health care surrogate or proxy of an individual on
 2196 voluntary status ~~a voluntary patient~~ may not consent to the
 2197 provision of mental health treatment for that individual ~~the~~
 2198 ~~patient~~. An individual on voluntary status ~~A voluntary patient~~
 2199 who is unwilling or unable to provide express and informed
 2200 consent to mental health treatment must ~~either~~ be discharged or
 2201 transferred to involuntary status.

2202 (f) Within 24 hours after an individual's voluntary
 2203 admission, a physician or psychologist ~~admission of a voluntary~~
 2204 ~~patient, the admitting physician~~ shall document in the patient's

586-03332-17

20171756c1

clinical record ~~whether the individual that the patient~~ is able to give express and informed consent for admission. If the ~~individual patient~~ is not able to give express and informed consent for admission, the facility ~~must shall either~~ discharge ~~the patient~~ or transfer the ~~individual patient~~ to involuntary status pursuant to subsection (5).

(2) ~~RELEASE OR DISCHARGE OF VOLUNTARY PATIENTS.-~~

(a) A facility shall discharge an individual on voluntary status who a voluntary patient:

1. ~~Who~~ Has sufficiently improved so that retention in the facility is no longer clinically appropriate desirable. The ~~individual A patient~~ may ~~also~~ be discharged to the care of a community facility.

2. Has revoked ~~Who revokes~~ consent to admission or requests discharge. The individual or his or her A voluntary patient or a relative, friend, or attorney of the patient may request discharge either orally or in writing at any time following admission to the facility. The patient must be discharged within 24 hours after ~~of~~ the request, unless the request is rescinded or the ~~individual patient~~ is transferred to involuntary status pursuant to this section. The 24-hour time period may be extended by a treatment facility if when necessary for adequate discharge planning, but may shall not exceed 3 days excluding ~~exclusive of~~ weekends and holidays. If the ~~individual patient~~, or another on the ~~individual's patient's~~ behalf, makes an oral request for discharge to a staff member, the such request must ~~shall~~ be immediately entered in the ~~patient's~~ clinical record. If the request for discharge is made by a person other than the ~~individual patient~~, the discharge may be conditioned upon the

586-03332-17

20171756c1

individual's express and informed consent ~~of the patient~~.

(b) An individual on voluntary status ~~A voluntary patient~~ who has been admitted to a facility and who refuses to consent to or revokes consent to treatment ~~must shall~~ be discharged within 24 hours after such refusal or revocation, unless he or she is transferred to involuntary status pursuant to this section or unless the refusal or revocation is freely and voluntarily rescinded by the ~~individual patient~~.

(c) An individual on voluntary status who is currently charged with a crime shall be discharged to the custody of a law enforcement officer upon release or discharge from a facility, unless the individual has been released from law enforcement custody by posting of a bond, by a pretrial conditional release, or by other judicial release.

(3) NOTICE OF RIGHT TO DISCHARGE.—At the time of admission and at least every 6 months thereafter, an individual on voluntary status ~~a voluntary patient~~ shall be notified in writing of his or her right to apply for a discharge.

(4) TRANSFER TO VOLUNTARY STATUS.—An involuntary patient who applies to be transferred to voluntary status shall be transferred to voluntary status immediately, unless the individual has been ordered to involuntary services ~~patient has been charged with a crime, or has been involuntarily placed for treatment~~ by a court pursuant to s. 394.467 and continues to meet the criteria for involuntary placement. When transfer to voluntary status occurs, notice shall be given as provided in s. 394.4599.

(5) TRANSFER TO INVOLUNTARY STATUS.—If an individual on voluntary status ~~When a voluntary patient~~, or an authorized

586-03332-17

20171756c1

2263 person on the individual's ~~patient's~~ behalf, makes a request for
 2264 discharge, the request for discharge, unless freely and
 2265 voluntarily rescinded, must be communicated to a physician,
 2266 ~~clinical~~ psychologist, or psychiatrist as quickly as possible,
 2267 but ~~within not later than~~ 12 hours after the request is made. If
 2268 the individual ~~patient~~ meets the criteria for involuntary
 2269 services, the individual must be transferred to a designated
 2270 receiving facility or governmental facility and the
 2271 administrator of the receiving or governmental facility where
 2272 the individual is held ~~placement, the administrator of the~~
 2273 ~~facility~~ must file with the court a petition for involuntary
 2274 services ~~placement~~, within 2 court working days after the
 2275 request ~~for discharge~~ is made. If the petition is not filed
 2276 within 2 court working days, the individual must ~~patient shall~~
 2277 be discharged. Pending the filing of the petition, the
 2278 individual ~~patient~~ may be held and emergency mental health
 2279 treatment rendered in the least restrictive manner, upon the
 2280 written order of a physician, if it is determined that such
 2281 treatment is necessary for the safety of the individual ~~patient~~
 2282 or others.

2283 Section 19. Section 394.463, Florida Statutes, is amended
 2284 to read:

2285 394.463 Involuntary examination.-

2286 (1) CRITERIA.-~~An individual may be subject to A person may~~
 2287 ~~be taken to a receiving facility for~~ involuntary examination if
 2288 there is reason to believe that he or she ~~the person~~ has a
 2289 mental illness and because of this ~~his or her~~ mental illness:

2290 (a)1. The individual ~~person~~ has refused voluntary
 2291 examination after conscientious explanation and disclosure of

586-03332-17

20171756c1

2292 the purpose of the examination; or

2293 2. The individual ~~person~~ is unable to determine for himself
 2294 or herself whether examination is necessary; and

2295 (b)1. ~~Without care or treatment;~~

2296 1. The individual ~~person~~ is likely to suffer from neglect
 2297 or refuse to care for himself or herself; such neglect or
 2298 refusal poses a real and present threat of substantial harm to
 2299 his or her well-being; and it is not apparent that the ~~such~~ harm
 2300 may be avoided through the help of willing family members or
 2301 friends or the provision of other services; or

2302 2. There is a substantial likelihood that individual
 2303 without care or treatment the person will cause serious bodily
 2304 harm to self ~~himself or herself~~ or others in the near future, as
 2305 evidenced by recent behavior.

2306 (2) INVOLUNTARY EXAMINATION.-

2307 (a) An involuntary examination may be initiated by any one
 2308 of the following means:

2309 1. A circuit or county court may enter an ex parte order
 2310 stating that an individual ~~a person~~ appears to meet the criteria
 2311 for involuntary examination and specifying the findings on which
 2312 that conclusion is based. The ex parte order for involuntary
 2313 examination must be based on written or oral sworn testimony
 2314 that includes specific facts that support the findings. If other
 2315 less restrictive means are not available, such as voluntary
 2316 appearance for outpatient evaluation, a law enforcement officer,
 2317 or other designated agent of the court, shall take the
 2318 individual ~~person~~ into custody and deliver him or her to an
 2319 appropriate, or the nearest, facility within the designated
 2320 receiving system pursuant to s. 394.462 for involuntary

586-03332-17

20171756c1

2321 examination. The ~~order of the court~~ order must ~~shall~~ be made a
 2322 part of the ~~patient's~~ clinical record. A fee may not be charged
 2323 for the filing of a ~~petition an order~~ under this subsection. A
 2324 facility accepting the individual patient based on ~~the this~~
 2325 order must send a copy of the order to the department the next
 2326 working day. The order may be submitted electronically through
 2327 existing data systems, if available. The order ~~is shall be~~ valid
 2328 only until the individual person is delivered to the facility or
 2329 for the period specified in the order itself, whichever comes
 2330 first. If ~~a~~ no time limit is not specified in the order, the
 2331 order ~~is shall be~~ valid for 7 days after the date ~~it that the~~
 2332 ~~order~~ was signed.

2333 2. A law enforcement officer shall take an individual a
 2334 person who appears to meet the criteria for involuntary
 2335 examination into custody and deliver or arrange for the delivery
 2336 of the individual the person or have him or her delivered to an
 2337 appropriate, or the nearest, facility within the designated
 2338 receiving system pursuant to s. 394.462 for examination. The
 2339 officer shall complete ~~execute~~ a written report detailing the
 2340 circumstances under which the individual person was taken into
 2341 custody, which must be made a part of the ~~patient's~~ clinical
 2342 record. ~~A Any~~ facility accepting the individual patient based on
 2343 this report must send a copy of the report to the department the
 2344 next working day.

2345 3. A physician, ~~clinical~~ psychologist, psychiatric nurse,
 2346 mental health counselor, marriage and family therapist, ~~or~~
 2347 clinical social worker, advanced registered nurse practitioner,
 2348 or physician assistant may execute a certificate stating that he
 2349 or she has examined the individual a person within the preceding

586-03332-17

20171756c1

2350 48 hours and finds that the individual person appears to meet
 2351 the criteria for involuntary examination and stating his or her
 2352 ~~the~~ observations upon which that conclusion is based. If other
 2353 less restrictive means, such as voluntary appearance for
 2354 outpatient evaluation, are not available, a law enforcement
 2355 officer shall take into custody the individual person named in
 2356 the certificate and deliver him or her to the appropriate, or
 2357 nearest, facility within the designated receiving system
 2358 pursuant to s. 394.462 for involuntary examination. A law
 2359 enforcement officer may only take an individual into custody on
 2360 the basis of a certificate within 7 calendar days after the
 2361 certificate is signed. The law enforcement officer shall execute
 2362 a written report detailing the circumstances under which the
 2363 individual person was taken into custody. The report and
 2364 certificate shall be made a part of the ~~patient's~~ clinical
 2365 record. ~~A Any~~ facility accepting the individual patient based on
 2366 ~~the this~~ certificate must send a copy of the certificate to the
 2367 department the next working day. The document may be submitted
 2368 electronically through existing data systems, if applicable.

2369 (b) A law enforcement officer who initiates an involuntary
 2370 examination of an individual pursuant to subparagraph (a)2., or
 2371 a professional who initiates an involuntary examination of an
 2372 individual pursuant to subparagraph (a)3., may notify the
 2373 individual's guardian, representative, or health care surrogate
 2374 or proxy of such examination. A receiving facility accepting an
 2375 individual for involuntary examination shall make and document
 2376 immediate attempts to notify the individual's guardian,
 2377 representative, or health care surrogate or proxy upon the
 2378 individual's arrival.

586-03332-17

20171756c1

2379 ~~(c)(b)~~ An individual ~~A person~~ may not be removed from any
 2380 program or residential services placement licensed under chapter
 2381 400 or chapter 429 and transported to a receiving facility for
 2382 involuntary examination unless an ex parte order, a professional
 2383 certificate, or a law enforcement officer's report is first
 2384 prepared. If the condition of the individual ~~person~~ is such that
 2385 preparation of a law enforcement officer's report is not
 2386 practicable before removal, the report must ~~shall~~ be completed
 2387 as soon as possible after removal, but ~~in any case~~ before the
 2388 individual ~~person~~ is transported to a receiving facility. A
 2389 facility admitting an individual ~~a person~~ for involuntary
 2390 examination who is not accompanied by the required ex parte
 2391 order, professional certificate, or law enforcement officer's
 2392 report must ~~shall~~ notify the department of the ~~such~~ admission by
 2393 certified mail or by e-mail, if available, by the next working
 2394 day. The provisions of this paragraph do not apply when
 2395 transportation is provided by the patient's family or guardian.
 2396 ~~(e) A law enforcement officer acting in accordance with an~~
 2397 ~~ex parte order issued pursuant to this subsection may serve and~~
 2398 ~~execute such order on any day of the week, at any time of the~~
 2399 ~~day or night.~~
 2400 ~~(d) A law enforcement officer acting in accordance with an~~
 2401 ~~ex parte order issued pursuant to this subsection may use such~~
 2402 ~~reasonable physical force as is necessary to gain entry to the~~
 2403 ~~premises, and any dwellings, buildings, or other structures~~
 2404 ~~located on the premises, and to take custody of the person who~~
 2405 ~~is the subject of the ex parte order.~~
 2406 ~~(d)(e)~~ The department shall receive and maintain the
 2407 copies of ex parte petitions and orders for involuntary

Page 83 of 121

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

586-03332-17

20171756c1

2408 examinations pursuant to this section, involuntary services
 2409 petitions and orders, involuntary outpatient services orders
 2410 ~~issued pursuant to s. 394.4655, involuntary inpatient placement~~
 2411 orders issued pursuant to s. 394.467, professional certificates,
 2412 and law enforcement officers' reports. These documents are ~~shall~~
 2413 ~~be considered~~ part of the clinical record, governed by ~~the~~
 2414 ~~provisions of~~ s. 394.4615. These documents shall be used to
 2415 prepare annual reports analyzing the data obtained from these
 2416 documents, without information identifying individuals held for
 2417 examination or admitted for treatment patients, and shall
 2418 provide copies of reports to the department, the President of
 2419 the Senate, the Speaker of the House of Representatives, and the
 2420 minority leaders of the Senate and the House of Representatives.
 2421 ~~(e)(f)~~ An individual held for examination ~~A patient~~ shall
 2422 be examined by a physician, ~~or a clinical psychologist, or by a~~
 2423 psychiatric nurse performing within the framework of an
 2424 established protocol with a psychiatrist at a facility without
 2425 unnecessary delay to determine if the criteria for involuntary
 2426 services are met. Emergency treatment may be provided upon the
 2427 order of a physician if the physician determines that such
 2428 treatment is necessary for the safety of the individual patient
 2429 or others. The individual patient may not be released by the
 2430 receiving facility or its contractor without the documented
 2431 approval of a psychiatrist or a clinical psychologist or, if the
 2432 receiving facility is owned or operated by a hospital or health
 2433 system, the release may also be approved by a psychiatric nurse
 2434 performing within the framework of an established protocol with
 2435 a psychiatrist, or an attending emergency department physician
 2436 with experience in the diagnosis and treatment of mental illness

Page 84 of 121

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

586-03332-17

20171756c1

after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.

~~(f)-(g)~~ Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court if inpatient treatment is deemed necessary or with the criminal county court, as defined in s. 394.4655(1), as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(4)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

~~(g)-(h)~~ If an individual ~~A person~~ for whom an involuntary

586-03332-17

20171756c1

examination has been initiated ~~who is also~~ being evaluated or treated at a hospital for an emergency medical condition as defined specified in s. 395.002, the involuntary examination ~~must be examined by a facility within 72 hours. The 72-hour~~ period begins when the individual patient arrives at the hospital and ceases when a the attending physician documents that the individual patient has an emergency medical condition. The 72-hour period resumes when the physician documents that the emergency medical condition has stabilized or does not exist. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient services pursuant to s. 394.4655(2) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary services or placement, if appropriate, or released directly from the hospital providing emergency medical services. ~~The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient services or involuntary outpatient placement must be entered into the patient's clinical record. This paragraph is not intended to prevent~~ A hospital providing emergency medical services may transfer an individual from appropriately ~~transferring a patient~~ to another hospital before stabilization if the requirements of s. 395.1041(3)(c) are have been met.

~~(i)~~ One of the following must occur within 12 hours after a the patient's attending physician documents that the individual's patient's medical condition has stabilized or that an emergency medical condition has been stabilized or does not

586-03332-17

20171756c1

2495 exist:

2496 1. The individual shall be examined by a physician,
 2497 psychiatric nurse, or psychologist and, if found not to meet the
 2498 criteria for involuntary examination pursuant to this section,
 2499 shall be released directly from the hospital providing the
 2500 emergency medical services. The results of the examination,
 2501 including the final disposition, shall be entered into the
 2502 clinical record ~~patient must be examined by a facility and~~
 2503 ~~released; or~~

2504 2. The individual shall be transferred to a receiving
 2505 facility for examination if ~~patient must be transferred to a~~
 2506 ~~designated facility in which~~ appropriate medical and mental
 2507 health treatment is available. However, the receiving facility
 2508 must be notified of the transfer within 2 hours after the
 2509 individual's ~~patient's~~ condition has been stabilized or after
 2510 determination that an emergency medical condition does not
 2511 exist.

2512 (3) NOTICE OF RELEASE.—Notice of the release shall be given
 2513 to the individual's ~~patient's~~ guardian, health care surrogate or
 2514 proxy, or representative, ~~to any person who executed a~~
 2515 ~~certificate admitting the patient to the receiving facility,~~ and
 2516 to any court that ordered the individual's examination ~~which~~
 2517 ~~ordered the patient's evaluation.~~

2518 Section 20. Section 394.467, Florida Statutes, is amended
 2519 to read:

2520 394.467 Involuntary inpatient placement.—

2521 (1) CRITERIA.—An individual ~~A person~~ may be ordered for
 2522 involuntary inpatient placement for treatment upon a finding of
 2523 the court by clear and convincing evidence that:

586-03332-17

20171756c1

2524 (a) He or she has a mental illness and because of his or
 2525 her mental illness:

2526 1.a. He or she has refused voluntary inpatient placement
 2527 for treatment after sufficient and conscientious explanation and
 2528 disclosure of the purpose of inpatient placement for treatment;
 2529 or

2530 b. He or she is unable to determine for himself or herself
 2531 whether inpatient placement is necessary; and

2532 2.a. He or she is incapable of surviving alone or with the
 2533 help of willing and responsible family or friends, including
 2534 available alternative services, and, without treatment, is
 2535 likely to suffer from neglect or refuse to care for himself or
 2536 herself, and such neglect or refusal poses a real and present
 2537 threat of substantial harm to his or her well-being; or

2538 b. There is substantial likelihood that in the near future
 2539 he or she will inflict serious bodily harm on self or others, as
 2540 evidenced by recent behavior causing, attempting, or threatening
 2541 such harm; and

2542 (b) All available less restrictive treatment alternatives
 2543 that would offer an opportunity for improvement of his or her
 2544 condition have been judged to be inappropriate.

2545 (2) ADMISSION TO A TREATMENT FACILITY.—~~An individual~~ A
 2546 ~~patient~~ may be retained by a facility or involuntarily ordered
 2547 placed in a treatment facility upon the recommendation of the
 2548 administrator of the facility where the individual ~~patient~~ has
 2549 been examined and after adherence to the notice and hearing
 2550 procedures provided in s. 394.4599. The recommendation must be
 2551 supported by the opinion of a psychiatrist and the second
 2552 opinion of a ~~clinical~~ psychologist or another psychiatrist, both

586-03332-17

20171756c1

of whom have personally examined the individual ~~patient~~ within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, if the administrator certifies that a psychiatrist or ~~clinical~~ psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse. Any opinion authorized in this subsection may be conducted through a face-to-face examination, in person, or by electronic means. Such recommendation shall be entered on a petition for involuntary inpatient placement certificate that authorizes the facility to retain the individual being held ~~patient~~ pending transfer to a treatment facility or completion of a hearing.

(3) PETITION FOR INVOLUNTARY INPATIENT PLACEMENT.—

(a) The administrator of the receiving facility shall file a petition for involuntary inpatient placement in the court in the county where the individual ~~patient~~ is located. Upon filing, the clerk of the court shall provide copies to the department, the individual, his or her ~~patient, the patient's~~ guardian, guardian advocate, health care surrogate or proxy, or representative, and the state attorney and public defender of the judicial circuit in which the individual ~~patient~~ is located. A fee may not be charged for the filing of a petition under this subsection.

(b) A receiving or treatment facility filing a petition for involuntary inpatient placement shall send a copy of the petition to the Department of Children and Families by the next working day.

586-03332-17

20171756c1

(4) APPOINTMENT OF COUNSEL.—

Within 1 court working day after the filing of a petition for involuntary inpatient placement, the court shall appoint the public defender to represent the individual ~~person~~ who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall ~~immediately~~ notify the public defender of the ~~such~~ appointment. Any attorney representing the individual ~~patient~~ shall have access to the individual ~~patient~~, witnesses, and records relevant to the presentation of the individual's ~~patient's~~ case and shall represent the interests of the individual ~~patient~~, regardless of the source of payment to the attorney.

(5) CONTINUANCE OF HEARING.—The individual ~~patient~~ is entitled, with the concurrence of the individual's ~~patient's~~ counsel, to at least one continuance of the hearing for up to 4 weeks.

(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

(a)1. The court shall hold the hearing on involuntary services ~~inpatient placement~~ within 5 court working days after the petition is filed, unless a continuance is granted.

2. Except for good cause documented in the court file, which may be demonstrated by administrative order of the court, the hearing must be held in the receiving or treatment facility where the individual is located. If the hearing cannot be held in the receiving or treatment facility, it must be held in a location convenient to the individual as is consistent with orderly procedure, and which is not likely to be injurious to the individual's county or the facility, as appropriate, ~~where the patient is located, must be as convenient to the patient as~~

586-03332-17

20171756c1

2611 ~~is consistent with orderly procedure, and shall be conducted in~~
 2612 ~~physical settings not likely to be injurious to the patient's~~
 2613 ~~condition. If the court finds that the individual's patient's~~
 2614 ~~attendance at the hearing is not consistent with the best~~
 2615 ~~interests of the individual patient, and the individual's~~
 2616 ~~patient's counsel does not object, the court may waive the~~
 2617 ~~presence of the individual patient from all or any portion of~~
 2618 ~~the hearing. Alternatively, if the individual wishes to~~
 2619 ~~voluntarily waive his or her attendance at the hearing, the~~
 2620 ~~court must determine that the individual's waiver is knowing,~~
 2621 ~~intelligent, and voluntary before waiving the presence of the~~
 2622 ~~individual from all or any portion of the hearing. The state~~
 2623 ~~attorney for the circuit in which the patient is located shall~~
 2624 ~~represent the state, rather than the petitioning facility~~
 2625 ~~administrator, as the real party in interest in the proceeding.~~
 2626 3. The court may appoint a magistrate to preside at the
 2627 hearing. One of the professionals who executed the petition for
 2628 involuntary inpatient placement certificate shall be a witness.
 2629 The court shall ensure that the individual and his or her
 2630 guardian, guardian advocate, health care surrogate or proxy, or
 2631 representative are informed patient and the patient's guardian
 2632 or representative shall be informed by the court of the right to
 2633 an independent expert examination. If the individual patient
 2634 cannot afford such an examination, the court shall ensure that
 2635 one is provided, as otherwise provided for by law. The
 2636 independent expert's report is confidential and not
 2637 discoverable, unless the expert is ~~to be~~ called as a witness for
 2638 the individual patient at the hearing. The testimony in the
 2639 hearing must be ~~given~~ under oath, and the proceedings must be

586-03332-17

20171756c1

2640 recorded. The individual patient may refuse to testify at the
 2641 hearing.
 2642 (b) If the court concludes that the individual patient
 2643 meets the criteria for involuntary ~~services inpatient placement,~~
 2644 it may order that the individual patient be transferred to a
 2645 treatment facility or, if the individual patient is at a
 2646 treatment facility, that the individual patient be retained
 2647 there or be treated at any other appropriate facility, or that
 2648 the individual patient receive services, on an involuntary
 2649 basis, for up to 90 days. However, any order for involuntary
 2650 mental health services in a treatment facility may be for up to
 2651 6 months. The order must ~~shall~~ specify the nature and extent of
 2652 the individual's patient's mental illness. The court may not
 2653 order an individual with traumatic brain injury or dementia who
 2654 lacks a co-occurring mental illness to be involuntarily placed
 2655 in a state treatment facility. The facility shall discharge the
 2656 individual a patient any time the individual patient no longer
 2657 meets the criteria for involuntary inpatient placement, unless
 2658 the individual patient has transferred to voluntary status.
 2659 (c) If at any time before the conclusion of the hearing on
 2660 involuntary inpatient placement it appears to the court that the
 2661 individual person does not meet the criteria for involuntary
 2662 inpatient placement under this section, but instead meets the
 2663 criteria for involuntary outpatient services, the court may
 2664 order the person evaluated for involuntary outpatient services
 2665 pursuant to s. 394.4655. The petition and hearing procedures set
 2666 forth in s. 394.4655 shall apply. If the person instead meets
 2667 the criteria for involuntary assessment, protective custody, or
 2668 involuntary admission pursuant to s. 397.675, then the court may

586-03332-17

20171756c1

order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings are governed by chapter 397.

~~(f)(d)~~ At the hearing on involuntary inpatient placement, the court shall consider testimony and evidence regarding the individual's ~~patient's~~ competence to consent to treatment. If the court finds that the individual ~~patient~~ is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598.

~~(g)(e)~~ The administrator of the petitioning facility shall provide a copy of the court order and adequate documentation of an individual's ~~a patient's~~ mental illness to the administrator of a treatment facility if the individual ~~patient~~ is ordered for involuntary inpatient placement, whether by civil or criminal court. The documentation must include any advance directives made by the individual ~~patient~~, a psychiatric evaluation of the individual ~~patient~~, and any evaluations of the individual ~~patient~~ performed by a psychiatric nurse, a ~~clinical~~ psychologist, a marriage and family therapist, a mental health counselor, or a clinical social worker. The administrator of a treatment facility may refuse admission to an individual ~~any patient~~ directed to its facilities on an involuntary basis, whether by civil or criminal court order, who is not accompanied by adequate orders and documentation.

(7) PROCEDURE FOR CONTINUED INVOLUNTARY INPATIENT PLACEMENT.—

(a) Hearings on petitions for continued involuntary inpatient placement of an individual placed at any treatment facility are administrative hearings and must be conducted in

586-03332-17

20171756c1

accordance with s. 120.57(1), except that any order entered by the administrative law judge is final and subject to judicial review in accordance with s. 120.68. Orders concerning individuals ~~patients~~ committed after successfully pleading not guilty by reason of insanity are governed by s. 916.15.

~~1.(b)~~ If the individual ~~patient~~ continues to meet the criteria for involuntary inpatient placement and is being treated at a treatment facility, the administrator shall, before the expiration of the period the treatment facility is authorized to retain the individual ~~patient~~, file a petition requesting authorization for continued involuntary inpatient placement. The request must be accompanied by a statement from the individual's ~~patient's~~ physician, psychiatrist, psychiatric nurse, or ~~clinical~~ psychologist justifying the request, a brief description of the individual's ~~patient's~~ treatment during the time he or she was involuntarily placed, and an individualized plan of continued treatment. Notice of the hearing must be provided ~~as provided~~ in accordance with s. 394.4599. If an individual's attendance at the hearing is voluntarily waived, the administrative law judge must determine that the waiver is knowing, intelligent, and voluntary before waiving the presence of the individual from all or a portion of the hearing. Alternatively, if an individual's ~~a patient's~~ attendance at the hearing is voluntarily waived, the administrative law judge must determine that the waiver is knowing and voluntary before waiving the presence of the individual ~~patient~~ from all or a portion of the hearing. Alternatively, if at the hearing the administrative law judge finds that attendance at the hearing is not consistent with the individual's best interests ~~of the~~

586-03332-17

20171756c1

2727 ~~patient~~, the administrative law judge may waive the presence of
 2728 the individual patient from all or any portion of the hearing,
 2729 unless the individual patient, through counsel, objects to the
 2730 waiver of presence. The testimony in the hearing must be under
 2731 oath, and the proceedings must be recorded.

2732 ~~2.(e)~~ Unless the individual patient is otherwise
 2733 represented or is ineligible, he or she shall be represented at
 2734 the hearing on the petition for continued involuntary inpatient
 2735 placement by the public defender of the circuit in which the
 2736 facility is located.

2737 3. The Division of Administrative Hearings shall ensure
 2738 that the individual who is the subject of the petition and his
 2739 or her guardian, guardian advocate, health care surrogate or
 2740 proxy, or representative are informed of the individual's right
 2741 to an independent expert examination. If the individual cannot
 2742 afford such an examination, the court shall ensure that one is
 2743 provided as otherwise provided for by law.

2744 ~~4.(d)~~ If at a hearing it is shown that the individual
 2745 ~~patient~~ continues to meet the criteria for involuntary inpatient
 2746 placement, the administrative law judge shall sign the order for
 2747 continued involuntary inpatient placement for up to 90 days.
 2748 However, any order for involuntary mental health services in a
 2749 treatment facility may be for up to 6 months. The same procedure
 2750 must ~~shall~~ be repeated before the expiration of each additional
 2751 period the individual patient is retained.

2752 ~~5.(e)~~ If continued involuntary inpatient placement is
 2753 necessary for an individual a patient admitted while serving a
 2754 criminal sentence, but his or her sentence is about to expire,
 2755 or for a minor involuntarily placed, but who is about to reach

586-03332-17

20171756c1

2756 the age of 18, the administrator shall petition the
 2757 administrative law judge for an order authorizing continued
 2758 involuntary inpatient placement.

2759 ~~6.(f)~~ If the individual patient has been previously found
 2760 incompetent to consent to treatment, the administrative law
 2761 judge shall consider testimony and evidence regarding the
 2762 individual's patient's competence. If the administrative law
 2763 judge finds evidence that the individual patient is now
 2764 competent to consent to treatment, the ~~administrative law~~ judge
 2765 may issue a recommended order to the court that found the
 2766 individual patient incompetent to consent to treatment that the
 2767 individual's patient's competence be restored and that any
 2768 guardian advocate previously appointed be discharged.

2769 ~~7.(g)~~ If the individual patient has been ordered to undergo
 2770 involuntary inpatient placement and has previously been found
 2771 incompetent to consent to treatment, the court shall consider
 2772 testimony and evidence regarding the individual's patient's
 2773 incompetence. If the individual's patient's competency to
 2774 consent to treatment is restored, the discharge of the guardian
 2775 advocate shall be governed by s. 394.4598.

2776
 2777 The procedure required in this paragraph subsection must be
 2778 followed before the expiration of each additional period the
 2779 individual is patient is involuntarily receiving involuntary
 2780 services.

2781 (8) RETURN TO FACILITY.-If an individual a patient
 2782 involuntarily held at a treatment facility under this part
 2783 leaves the facility without the administrator's authorization,
 2784 the administrator may authorize a search for the individual

586-03332-17

20171756c1

2785 ~~patient~~ and his or her return to the facility. The administrator
 2786 may request the assistance of a law enforcement agency in this
 2787 regard.

2788 Section 21. Section 394.46715, Florida Statutes, is amended
 2789 to read:

2790 394.46715 Rulemaking authority.—The department may adopt
 2791 rules to administer this part.

2792 Section 22. Section 394.4672, Florida Statutes, is amended
 2793 to read:

2794 394.4672 Procedure for placement of veteran with federal
 2795 agency.—

2796 (1) A facility owned, operated, or administered by the
 2797 United States Department of Veterans Affairs that provides
 2798 mental health services shall have authority as granted by the
 2799 Department of Veterans' Affairs to:

2800 (a) Initiate and conduct involuntary examination pursuant
 2801 to s. 394.463.

2802 (b) Provide voluntary admission and treatment pursuant to
 2803 s. 394.4625.

2804 (c) Petition for involuntary placement pursuant to s.
 2805 394.467.

2806 (2)(1) If the court determines that an individual meets the
 2807 criteria for involuntary placement and he or she ~~Whenever it is~~
 2808 ~~determined by the court that a person meets the criteria for~~
 2809 ~~involuntary placement and it appears that such person is~~
 2810 eligible for care or treatment by the United States Department
 2811 of Veterans Affairs or other agency of the United States
 2812 Government, the court, upon receipt of documentation a
 2813 ~~certificate~~ from the United States Department of Veterans

586-03332-17

20171756c1

2814 Affairs or another ~~such other~~ agency showing that facilities are
 2815 available and that the individual person is eligible for care or
 2816 treatment therein, may place that individual person with the
 2817 United States Department of Veterans Affairs or other federal
 2818 agency. The individual person whose placement is sought shall be
 2819 personally served with notice of the pending placement
 2820 proceeding in the manner as provided in this part, ~~and nothing~~
 2821 ~~in~~ This section does not ~~shall~~ affect the individual's ~~his or~~
 2822 ~~her~~ right to appear and be heard in the proceeding. Upon being
 2823 placed, the individual is ~~placement, the person shall be~~ subject
 2824 to the ~~rules and~~ regulations of the United States Department of
 2825 Veterans Affairs or other federal agency.

2826 (3)(2) The judgment or order of placement by a court of
 2827 competent jurisdiction of another state or of the District of
 2828 Columbia, which places an individual ~~placing a person~~ with the
 2829 United States Department of Veterans Affairs or other federal
 2830 agency for care or treatment, ~~has, shall have~~ the same force and
 2831 effect in this state as in the jurisdiction of the court
 2832 entering the judgment or making the order, ~~and~~ The courts of
 2833 the placing state or of the District of Columbia shall retain be
 2834 ~~deemed to have retained~~ jurisdiction over the individual of the
 2835 ~~person~~ so placed. Consent is ~~hereby~~ given to the application of
 2836 the law of the placing state or district with respect to the
 2837 authority of the chief officer of any facility of the United
 2838 States Department of Veterans Affairs or other federal agency
 2839 operated in this state to retain custody or to transfer, parole,
 2840 or discharge the individual person.

2841 (4)(3) Upon receipt of documentation from a certificate of
 2842 the United States Department of Veterans Affairs or another such

586-03332-17

20171756c1

2843 ~~other~~ federal agency that facilities are available for the care
 2844 or treatment of individuals who have mental illness and that the
 2845 individual mentally ill persons and that the person is eligible
 2846 for ~~that~~ care or treatment, the administrator of the receiving
 2847 or treatment facility may ~~cause the~~ transfer ~~of~~ that individual
 2848 person to the United States Department of Veterans Affairs or
 2849 other federal agency. Upon ~~effecting~~ such transfer, the
 2850 committing court shall be notified by the transferring agency.
 2851 An individual may not be transferred ~~No person shall be~~
 2852 ~~transferred to the United States Department of Veterans Affairs~~
 2853 ~~or other federal agency~~ if he or she is confined pursuant to the
 2854 conviction of any felony or misdemeanor or if he or she has been
 2855 acquitted of the charge solely on the ground of insanity, unless
 2856 before ~~prior to~~ transfer the court placing the individual ~~such~~
 2857 ~~person~~ enters an order for the transfer after appropriate motion
 2858 and hearing and without objection by the United States
 2859 Department of Veterans Affairs.

2860 (5)(4) An individual ~~Any person~~ transferred as provided in
 2861 this section shall be deemed to be placed with the United States
 2862 Department of Veterans Affairs or other federal agency pursuant
 2863 to the original order ~~placement~~.

2864 Section 23. Section 394.4685, Florida Statutes, is amended
 2865 to read:

2866 394.4685 Transfer of patients among facilities.—

2867 (1) TRANSFER BETWEEN PUBLIC FACILITIES.—

2868 (a) An individual ~~A patient~~ who has been admitted to a
 2869 public receiving facility, or his or her ~~the~~ family member,
 2870 guardian, ~~or~~ guardian advocate, or health care surrogate or
 2871 proxy ~~of such patient~~, may request the transfer of the

586-03332-17

20171756c1

2872 individual patient to another public receiving facility. An
 2873 individual ~~A patient~~ who has been admitted to a public treatment
 2874 facility, or his or her ~~the~~ family member, guardian, ~~or~~ guardian
 2875 advocate, or health care surrogate or proxy of such patient, may
 2876 request the transfer of the individual patient to another public
 2877 treatment facility. Depending on the medical treatment or mental
 2878 health treatment needs of the individual patient and the
 2879 availability of appropriate facility resources, the individual
 2880 ~~patient~~ may be transferred at the discretion of the department.
 2881 If the department approves the transfer of an individual on
 2882 involuntary status, notice in accordance with involuntary
 2883 patient, notice according to the provisions of s. 394.4599 must
 2884 be given before ~~shall be given prior to~~ the transfer by the
 2885 transferring facility. The department shall respond to the
 2886 request for transfer within 2 working days after receipt of the
 2887 request by the facility administrator.

2888 (b) If ~~When~~ required by the medical treatment or mental
 2889 health treatment needs of the individual patient or the
 2890 efficient use ~~utilization~~ of a public receiving or public
 2891 treatment facility, an individual ~~a patient~~ may be transferred
 2892 from one receiving facility to another, ~~or from one treatment~~
 2893 ~~facility to another, at the department's discretion~~, or, with
 2894 the express and informed consent of the individual or the
 2895 individual's guardian, guardian advocate, or health care
 2896 surrogate or proxy patient or the patient's guardian or guardian
 2897 advocate, to a facility in another state. Notice in accordance
 2898 with ~~according to the provisions of s. 394.4599 must~~ ~~shall be~~
 2899 given before ~~prior to~~ the transfer by the transferring facility.
 2900 If prior notice is not possible, notice of the transfer shall be

586-03332-17

20171756c1

provided as soon as practicable after the transfer.

(2) TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.—

(a) An individual ~~A patient~~ who has been admitted to a public receiving or public treatment facility and has requested, ~~either~~ personally or through his or her guardian, ~~or~~ guardian advocate, or health care surrogate or proxy, and is able to pay for treatment in a private facility shall be transferred at the individual's ~~patient's~~ expense to a private facility upon acceptance of the individual ~~patient~~ by the private facility.

(b) A public receiving facility initiating the ~~a~~ patient transfer of an individual to a licensed hospital for acute care mental health services not accessible through the public receiving facility shall notify the hospital of such transfer and send the hospital all records relating to the emergency psychiatric or medical condition.

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.—

(a) An individual or the individual's ~~A patient or the patient's~~ guardian, ~~or~~ guardian advocate, or health care surrogate or proxy may request the transfer of the individual ~~patient~~ from a private to a public facility, and the individual ~~patient~~ may be so transferred upon acceptance of the individual ~~patient~~ by the public facility.

(b) A private facility may request the transfer of an individual ~~a patient~~ from the facility to a public facility, and the individual ~~patient~~ may be so transferred upon acceptance of the individual ~~patient~~ by the public facility. The cost of such transfer is ~~shall be~~ the responsibility of the transferring facility.

(c) A public facility must respond to a request for the

586-03332-17

20171756c1

transfer of an individual ~~a patient~~ within 24 hours ~~2 working days~~ after receipt of the request.

(4) TRANSFER BETWEEN PRIVATE FACILITIES.—

(a) An individual being held ~~A patient~~ in a private facility or his or her ~~the patient's~~ guardian, ~~or~~ guardian advocate, or health care surrogate or proxy may request the transfer of the individual ~~patient~~ to another private facility at any time, and the individual ~~patient~~ shall be transferred upon acceptance of the individual ~~patient~~ by the facility to which transfer is sought.

(b) A private facility may request the transfer of an individual from the facility to another private facility, and the individual may be transferred upon acceptance of the individual by the facility to which the individual is being transferred.

Section 24. Section 394.469, Florida Statutes, is amended to read:

394.469 Discharge from ~~of~~ involuntary placement patients.—

(1) POWER TO DISCHARGE.—At any time an individual ~~a patient~~ is found to no longer meet the criteria for involuntary placement, the administrator shall:

(a) Discharge the individual ~~patient~~, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;

(b) Transfer the individual ~~patient~~ to voluntary status on the administrator's ~~his or her~~ own authority or at the individual's ~~patient's~~ request, unless the individual is ~~patient~~ is under criminal charge or adjudicated incapacitated;

586-03332-17

20171756c1

(c) Discharge the individual to the custody of a law enforcement officer, if the individual is currently charged with any crime and has not been released from law enforcement custody by posting of a bond, or by a pretrial conditional release or by other judicial release; or

~~(d)(e)~~ Place an improved individual patient, except individuals described in paragraph (c) a patient under a criminal charge, on convalescent status in the care of a community facility.

(2) NOTICE.—Notice of discharge or transfer of an individual must be provided in accordance with a patient shall be given as provided in s. 394.4599.

Section 25. Section 394.473, Florida Statutes, is amended to read:

394.473 Attorney ~~Attorney's~~ fee; expert witness fee.—

(1) ~~In the case of an indigent person for whom~~ An attorney ~~is appointed to represent an individual pursuant to the provisions of this part, the attorney~~ shall be compensated by the state pursuant to s. 27.5304. A public defender appointed to represent an indigent individual may not ~~In the case of an indigent person, the court may appoint a public defender. The public defender shall receive no additional compensation other than that usually paid his or her office.~~

(2) ~~If an indigent individual's case requires In the case of an indigent person for whom~~ expert testimony ~~is required~~ in a court hearing pursuant to ~~the provisions of this part act~~, the expert shall be compensated by the state pursuant to s. 27.5303 or s. 27.5304, as applicable, unless the expert, except one who is classified as a full-time employee of the state or ~~who~~ is

Page 103 of 121

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

586-03332-17

20171756c1

receiving remuneration from the state for his or her time in attendance at the hearing, ~~shall be compensated by the state pursuant to s. 27.5304.~~

Section 26. Section 394.475, Florida Statutes, is amended to read:

394.475 Acceptance, examination, and involuntary services placement of Florida residents from out-of-state mental health authorities.—

(1) Upon the request of the state mental health authority of another state, the department may ~~is authorized to~~ accept an individual as a patient, for up to a period of not more than 15 days, ~~a person~~ who is and has been a bona fide resident of this state for at least a period of not less than 1 year.

(2) An individual ~~Any person~~ received pursuant to subsection (1) shall be examined by the staff of the state facility where the individual such patient has been admitted accepted, ~~which examination shall be completed~~ during the 15-day period.

(3) If, upon examination, the individual such a person requires continued involuntary services placement, a petition for a hearing regarding involuntary services placement shall be filed with the court of the county ~~where~~ wherein the treatment facility receiving the individual patient is located or the county where the individual patient is a resident.

(4) During the pendency of the examination period and the pendency of the involuntary services placement proceedings, an individual such person may continue to be held in the treatment facility unless the court having jurisdiction enters an order to the contrary.

Page 104 of 121

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

586-03332-17

20171756c1

3017 Section 27. Section 394.4785, Florida Statutes, is amended
 3018 to read:
 3019 394.4785 Children and adolescents; admission and placement
 3020 in mental health facilities.—
 3021 (1) A child or adolescent ~~as~~ defined as a minor in s.
 3022 394.455(31) in s. 394.492 may not be admitted to a state-owned
 3023 or state-operated mental health treatment facility. A minor
 3024 child may be admitted pursuant to s. 394.4625, s. 394.463, or s.
 3025 394.467 to a crisis stabilization unit or a residential
 3026 treatment center licensed under this chapter or a hospital
 3027 licensed under chapter 395. The treatment center, unit, or
 3028 hospital must provide the least restrictive available treatment
 3029 that is appropriate to the ~~individual~~ needs of the minor child
 3030 ~~or adolescent~~ and must adhere to the guiding principles, system
 3031 of care, and service planning provisions of ~~contained in~~ part
 3032 III of this chapter.
 3033 (2) A minor who is younger than 14 years of age ~~person~~
 3034 ~~under the age of 14~~ who is admitted to a ~~any~~ hospital ~~licensed~~
 3035 ~~pursuant to chapter 395~~ may not be admitted to a bed in a room
 3036 or ward with an adult ~~patient~~ in a mental health unit or share
 3037 common areas with an adult ~~patient~~ in a mental health unit.
 3038 However, a minor ~~person~~ 14 years of age or older may be admitted
 3039 to a bed in a room or ward in the mental health unit with an
 3040 adult if a the admitting physician documents in the clinical
 3041 case record that the services are ~~such placement is~~ medically
 3042 indicated or for reasons of safety. The ~~Such~~ placement shall be
 3043 reviewed by a the attending physician or a designee or on-call
 3044 physician each day and documented in the clinical case record.
 3045 Section 28. Section 394.4786, Florida Statutes, is

Page 105 of 121

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

586-03332-17

20171756c1

3046 repealed.
 3047 Section 29. Section 394.47865, Florida Statutes, is
 3048 repealed.
 3049 Section 30. Section 394.4787, Florida Statutes, is
 3050 repealed.
 3051 Section 31. Section 394.4788, Florida Statutes, is
 3052 repealed.
 3053 Section 32. Section 394.4789, Florida Statutes, is
 3054 repealed.
 3055 Section 33. Paragraph (a) of subsection (5) of section
 3056 20.425, Florida Statutes, is amended to read:
 3057 20.425 Agency for Health Care Administration; trust funds.—
 3058 The following trust funds shall be administered by the Agency
 3059 for Health Care Administration:
 3060 (5) Public Medical Assistance Trust Fund.
 3061 (a) Funds to be credited to and uses of the trust fund
 3062 shall be administered in accordance with s. the provisions of
 3063 ~~ss. 394.4786 and~~ 409.918.
 3064 Section 34. Paragraph (a) of subsection (3) and subsection
 3065 (6) of section 39.407, Florida Statutes, are amended to read:
 3066 39.407 Medical, psychiatric, and psychological examination
 3067 and treatment of child; physical, mental, or substance abuse
 3068 examination of person with or requesting child custody.—
 3069 (3) (a) 1. Except as otherwise provided in subparagraph (b) 1.
 3070 or paragraph (e), before the department provides psychotropic
 3071 medications to a child in its custody, the prescribing physician
 3072 shall attempt to obtain express and informed consent, as defined
 3073 in s. 394.455(15) and as described in s. 394.459(3) ~~(a)~~, from the
 3074 child's parent or legal guardian. The department must take steps

Page 106 of 121

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

586-03332-17 20171756c1

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

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

(6) Children who are in the legal custody of the department may be placed by the department, without prior approval of the court, in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395 for residential mental health treatment only pursuant to this section or may be placed by the court in accordance with an order of involuntary examination or involuntary services ~~placement~~ entered pursuant

586-03332-17 20171756c1

to s. 394.463 or s. 394.467. All children placed in a residential treatment program under this subsection must have a guardian ad litem appointed.

(a) As used in this subsection, the term:

1. "Residential treatment" means placement for observation, diagnosis, or treatment of an emotional disturbance in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395.

2. "Least restrictive alternative" means the treatment and conditions of treatment that, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the child or adolescent or others from physical injury.

3. "Suitable for residential treatment" or "suitability" means a determination concerning a child or adolescent with an emotional disturbance as defined in s. 394.492(5) or a serious emotional disturbance as defined in s. 394.492(6) that each of the following criteria is met:

a. The child requires residential treatment.

b. The child is in need of a residential treatment program and is expected to benefit from mental health treatment.

c. An appropriate, less restrictive alternative to residential treatment is unavailable.

(b) Whenever the department believes that a child in its legal custody is emotionally disturbed and may need residential treatment, an examination and suitability assessment must be conducted by a qualified evaluator who is appointed by the Agency for Health Care Administration. This suitability assessment must be completed before the placement of the child

586-03332-17

20171756c1

in a residential treatment center for emotionally disturbed children and adolescents or a hospital. The qualified evaluator must be a psychiatrist or a psychologist licensed in Florida who has at least 3 years of experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents and who has no actual or perceived conflict of interest with any inpatient facility or residential treatment center or program.

(c) Before a child is admitted under this subsection, the child shall be assessed for suitability for residential treatment by a qualified evaluator who has conducted a personal examination and assessment of the child and has made written findings that:

1. The child appears to have an emotional disturbance serious enough to require residential treatment and is reasonably likely to benefit from the treatment.

2. The child has been provided with a clinically appropriate explanation of the nature and purpose of the treatment.

3. All available modalities of treatment less restrictive than residential treatment have been considered, and a less restrictive alternative that would offer comparable benefits to the child is unavailable.

A copy of the written findings of the evaluation and suitability assessment must be provided to the department, to the guardian ad litem, and, if the child is a member of a Medicaid managed care plan, to the plan that is financially responsible for the child's care in residential treatment, all of whom must be

586-03332-17

20171756c1

provided with the opportunity to discuss the findings with the evaluator.

(d) Immediately upon placing a child in a residential treatment program under this section, the department must notify the guardian ad litem and the court having jurisdiction over the child and must provide the guardian ad litem and the court with a copy of the assessment by the qualified evaluator.

(e) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director's designee must ensure that an individualized plan of treatment has been prepared by the program and has been explained to the child, to the department, and to the guardian ad litem, and submitted to the department. The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child's foster parents must be involved to the maximum extent consistent with the child's treatment needs. The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured. A copy of the plan must be provided to the child, to the guardian ad litem, and to the department.

(f) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child's placement in the program. The residential treatment program must determine whether the child is receiving benefit toward the treatment goals and whether the

586-03332-17

20171756c1

child could be treated in a less restrictive treatment program. The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem and to the department. The department must submit the report to the court. The report must include a discharge plan for the child. The residential treatment program must continue to evaluate the child's treatment progress every 30 days thereafter and must include its findings in a written report submitted to the department. The department may not reimburse a facility until the facility has submitted every written report that is due.

(g)1. The department must submit, at the beginning of each month, to the court having jurisdiction over the child, a written report regarding the child's progress toward achieving the goals specified in the individualized plan of treatment.

2. The court must conduct a hearing to review the status of the child's residential treatment plan no later than 3 months after the child's admission to the residential treatment program. An independent review of the child's progress toward achieving the goals and objectives of the treatment plan must be completed by a qualified evaluator and submitted to the court before its 3-month review.

3. For any child in residential treatment at the time a judicial review is held pursuant to s. 39.701, the child's continued placement in residential treatment must be a subject of the judicial review.

4. If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the department to place the child in the least

586-03332-17

20171756c1

restrictive setting that is best suited to meet his or her needs.

(h) After the initial 3-month review, the court must conduct a review of the child's residential treatment plan every 90 days.

(i) The department must adopt rules for implementing timeframes for the completion of suitability assessments by qualified evaluators and a procedure that includes timeframes for completing the 3-month independent review by the qualified evaluators of the child's progress toward achieving the goals and objectives of the treatment plan which review must be submitted to the court. The Agency for Health Care Administration must adopt rules for the registration of qualified evaluators, the procedure for selecting the evaluators to conduct the reviews required under this section, and a reasonable, cost-efficient fee schedule for qualified evaluators.

Section 35. Subsections (5) and (6) of section 394.492, Florida Statutes, are amended to read:

394.492 Definitions.—As used in ss. 394.490-394.497, the term:

(5) "Child or adolescent who has an emotional disturbance" means a person under 18 years of age who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community.

586-03332-17

20171756c1

3249 The emotional disturbance must not be considered to be a
 3250 temporary response to a stressful situation. The term does not
 3251 include a child or adolescent who meets the criteria for
 3252 involuntary placement under s. 394.467(1).

3253 (6) "Child or adolescent who has a serious emotional
 3254 disturbance or mental illness" means a person under 18 years of
 3255 age who:

3256 (a) Is diagnosed as having a mental, emotional, or
 3257 behavioral disorder that meets one of the diagnostic categories
 3258 specified in the most recent edition of the Diagnostic and
 3259 Statistical Manual of Mental Disorders of the American
 3260 Psychiatric Association; and

3261 (b) Exhibits behaviors that substantially interfere with or
 3262 limit his or her role or ability to function in the family,
 3263 school, or community, which behaviors are not considered to be a
 3264 temporary response to a stressful situation.

3265 The term includes a child or adolescent who meets the criteria
 3266 for involuntary placement under s. 394.467(1).

3268 Section 36. Paragraphs (a) and (c) of subsection (3) of
 3269 section 394.495, Florida Statutes, are amended to read:

3270 394.495 Child and adolescent mental health system of care;
 3271 programs and services.—

3272 (3) Assessments must be performed by:

3273 (a) A professional as defined in s. 394.455(7), (33), (36),
 3274 or (37) 394.455(5), (7), (32), (35), or (36);

3275 (c) A person who is under the direct supervision of a
 3276 qualified professional as defined in s. 394.455(7), (33), (36),
 3277 or (37) 394.455(5), (7), (32), (35), or (36) or a professional

Page 113 of 121

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

586-03332-17

20171756c1

3278 licensed under chapter 491.

3279 Section 37. Subsection (5) of section 394.496, Florida
 3280 Statutes, is amended to read:

3281 394.496 Service planning.—

3282 (5) A professional as defined in s. 394.455(7), (33), (36),
 3283 or (37) 394.455(5), (7), (32), (35), or (36) or a professional
 3284 licensed under chapter 491 must be included among those persons
 3285 developing the services plan.

3286 Section 38. Subsection (6) of section 394.9085, Florida
 3287 Statutes, is amended to read:

3288 394.9085 Behavioral provider liability.—

3289 (6) For purposes of this section, the terms "detoxification
 3290 services," "addictions receiving facility," and "receiving
 3291 facility" have the same meanings as those provided in ss.
 3292 397.311(25)(a)4., 397.311(25)(a)1., and 394.455(41) 394.455(39),
 3293 respectively.

3294 Section 39. Paragraph (b) of subsection (1) of section
 3295 409.972, Florida Statutes, is amended to read:

3296 409.972 Mandatory and voluntary enrollment.—

3297 (1) The following Medicaid-eligible persons are exempt from
 3298 mandatory managed care enrollment required by s. 409.965, and
 3299 may voluntarily choose to participate in the managed medical
 3300 assistance program:

3301 (b) Medicaid recipients residing in residential commitment
 3302 facilities operated through the Department of Juvenile Justice
 3303 or a treatment facility as defined in s. 394.455(51)
 3304 394.455(47).

3305 Section 40. Subsection (7) of section 744.2007, Florida
 3306 Statutes, is amended to read:

Page 114 of 121

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

586-03332-17

20171756c1

3307 744.2007 Powers and duties.—

3308 (7) A public guardian may not commit a ward to a treatment
3309 facility, as defined in s. ~~394.455(51)~~ 394.455(47), without an
3310 involuntary placement proceeding as provided by law.

3311 Section 41. Paragraph (a) of subsection (2) of section
3312 790.065, Florida Statutes, is amended to read:

3313 790.065 Sale and delivery of firearms.—

3314 (2) Upon receipt of a request for a criminal history record
3315 check, the Department of Law Enforcement shall, during the
3316 licensee's call or by return call, forthwith:

3317 (a) Review any records available to determine if the
3318 potential buyer or transferee:

3319 1. Has been convicted of a felony and is prohibited from
3320 receipt or possession of a firearm pursuant to s. 790.23;

3321 2. Has been convicted of a misdemeanor crime of domestic
3322 violence, and therefore is prohibited from purchasing a firearm;

3323 3. Has had adjudication of guilt withheld or imposition of
3324 sentence suspended on any felony or misdemeanor crime of
3325 domestic violence unless 3 years have elapsed since probation or
3326 any other conditions set by the court have been fulfilled or
3327 expunction has occurred; or

3328 4. Has been adjudicated mentally defective or has been
3329 committed to a mental institution by a court or as provided in
3330 sub-sub-subparagraph b.(II), and as a result is prohibited by
3331 state or federal law from purchasing a firearm.

3332 a. As used in this subparagraph, "adjudicated mentally
3333 defective" means a determination by a court that a person, as a
3334 result of marked subnormal intelligence, or mental illness,
3335 incompetency, condition, or disease, is a danger to himself or

Page 115 of 121

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

586-03332-17

20171756c1

3336 herself or to others or lacks the mental capacity to contract or
3337 manage his or her own affairs. The phrase includes a judicial
3338 finding of incapacity under s. 744.331(6)(a), an acquittal by
3339 reason of insanity of a person charged with a criminal offense,
3340 and a judicial finding that a criminal defendant is not
3341 competent to stand trial.

3342 b. As used in this subparagraph, "committed to a mental
3343 institution" means:

3344 (I) Involuntary commitment, commitment for mental
3345 defectiveness or mental illness, and commitment for substance
3346 abuse. The phrase includes involuntary services ~~inpatient~~
3347 ~~placement~~ as defined in s. 394.467, ~~involuntary outpatient~~
3348 ~~placement as defined in s. 394.4655~~, involuntary assessment and
3349 stabilization under s. 397.6818, and involuntary substance abuse
3350 treatment under s. 397.6957, but does not include a person in a
3351 mental institution for observation or discharged from a mental
3352 institution based upon the initial review by the physician or a
3353 voluntary admission to a mental institution; or

3354 (II) Notwithstanding sub-sub-subparagraph (I), voluntary
3355 admission to a mental institution for outpatient or inpatient
3356 treatment of a person who had an involuntary examination under
3357 s. 394.463, where each of the following conditions have been
3358 met:

3359 (A) An examining physician found that the person is an
3360 imminent danger to himself or herself or others.

3361 (B) The examining physician certified that if the person
3362 did not agree to voluntary treatment, a petition for involuntary
3363 outpatient or inpatient treatment would have been filed under s.
3364 394.463(2)(f)3. ~~394.463(2)(i)4.~~, or the examining physician

Page 116 of 121

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

586-03332-17

20171756c1

certified that a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.

(C) Before agreeing to voluntary treatment, the person received written notice of that finding and certification, and written notice that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license under s. 790.06 and the person acknowledged such notice in writing, in substantially the following form:

"I understand that the doctor who examined me believes I am a danger to myself or to others. I understand that if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand that if that petition is filed, I have the right to contest it. In the event a petition has been filed, I understand that I can subsequently agree to voluntary treatment prior to a court hearing. I understand that by agreeing to voluntary treatment in either of these situations, I may be prohibited from buying firearms and from applying for or retaining a concealed weapons or firearms license until I apply for and receive relief from that restriction under Florida law."

(D) A judge or a magistrate has, pursuant to sub-sub-paragraph c.(II), reviewed the record of the finding, certification, notice, and written acknowledgment classifying the person as an imminent danger to himself or herself or others, and ordered that such record be submitted to the department.

c. In order to check for these conditions, the department

Page 117 of 121

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

586-03332-17

20171756c1

shall compile and maintain an automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions.

(I) Except as provided in sub-sub-subparagraph (II), clerks of court shall submit these records to the department within 1 month after the rendition of the adjudication or commitment. Reports shall be submitted in an automated format. The reports must, at a minimum, include the name, along with any known alias or former name, the sex, and the date of birth of the subject.

(II) For persons committed to a mental institution pursuant to sub-sub-subparagraph b.(II), within 24 hours after the person's agreement to voluntary admission, a record of the finding, certification, notice, and written acknowledgment must be filed by the administrator of the receiving or treatment facility, as defined in s. 394.455, with the clerk of the court for the county in which the involuntary examination under s. 394.463 occurred. No fee shall be charged for the filing under this sub-sub-subparagraph. The clerk must present the records to a judge or magistrate within 24 hours after receipt of the records. A judge or magistrate is required and has the lawful authority to review the records ex parte and, if the judge or magistrate determines that the record supports the classifying of the person as an imminent danger to himself or herself or others, to order that the record be submitted to the department. If a judge or magistrate orders the submittal of the record to the department, the record must be submitted to the department within 24 hours.

d. A person who has been adjudicated mentally defective or

Page 118 of 121

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

586-03332-17

20171756c1

3423 committed to a mental institution, as those terms are defined in
 3424 this paragraph, may petition the court that made the
 3425 adjudication or commitment, or the court that ordered that the
 3426 record be submitted to the department pursuant to sub-sub-
 3427 subparagraph c.(II), for relief from the firearm disabilities
 3428 imposed by such adjudication or commitment. A copy of the
 3429 petition shall be served on the state attorney for the county in
 3430 which the person was adjudicated or committed. The state
 3431 attorney may object to and present evidence relevant to the
 3432 relief sought by the petition. The hearing on the petition may
 3433 be open or closed as the petitioner may choose. The petitioner
 3434 may present evidence and subpoena witnesses to appear at the
 3435 hearing on the petition. The petitioner may confront and cross-
 3436 examine witnesses called by the state attorney. A record of the
 3437 hearing shall be made by a certified court reporter or by court-
 3438 approved electronic means. The court shall make written findings
 3439 of fact and conclusions of law on the issues before it and issue
 3440 a final order. The court shall grant the relief requested in the
 3441 petition if the court finds, based on the evidence presented
 3442 with respect to the petitioner's reputation, the petitioner's
 3443 mental health record and, if applicable, criminal history
 3444 record, the circumstances surrounding the firearm disability,
 3445 and any other evidence in the record, that the petitioner will
 3446 not be likely to act in a manner that is dangerous to public
 3447 safety and that granting the relief would not be contrary to the
 3448 public interest. If the final order denies relief, the
 3449 petitioner may not petition again for relief from firearm
 3450 disabilities until 1 year after the date of the final order. The
 3451 petitioner may seek judicial review of a final order denying

Page 119 of 121

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

586-03332-17

20171756c1

3452 relief in the district court of appeal having jurisdiction over
 3453 the court that issued the order. The review shall be conducted
 3454 de novo. Relief from a firearm disability granted under this
 3455 sub-subparagraph has no effect on the loss of civil rights,
 3456 including firearm rights, for any reason other than the
 3457 particular adjudication of mental defectiveness or commitment to
 3458 a mental institution from which relief is granted.

3459 e. Upon receipt of proper notice of relief from firearm
 3460 disabilities granted under sub-subparagraph d., the department
 3461 shall delete any mental health record of the person granted
 3462 relief from the automated database of persons who are prohibited
 3463 from purchasing a firearm based on court records of
 3464 adjudications of mental defectiveness or commitments to mental
 3465 institutions.

3466 f. The department is authorized to disclose data collected
 3467 pursuant to this subparagraph to agencies of the Federal
 3468 Government and other states for use exclusively in determining
 3469 the lawfulness of a firearm sale or transfer. The department is
 3470 also authorized to disclose this data to the Department of
 3471 Agriculture and Consumer Services for purposes of determining
 3472 eligibility for issuance of a concealed weapons or concealed
 3473 firearms license and for determining whether a basis exists for
 3474 revoking or suspending a previously issued license pursuant to
 3475 s. 790.06(10). When a potential buyer or transferee appeals a
 3476 nonapproval based on these records, the clerks of court and
 3477 mental institutions shall, upon request by the department,
 3478 provide information to help determine whether the potential
 3479 buyer or transferee is the same person as the subject of the
 3480 record. Photographs and any other data that could confirm or

Page 120 of 121

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

586-03332-17

20171756c1

negate identity must be made available to the department for such purposes, notwithstanding any other provision of state law to the contrary. Any such information that is made confidential or exempt from disclosure by law shall retain such confidential or exempt status when transferred to the department.

Section 42. Subsection (1) of section 945.46, Florida Statutes, is amended to read:

945.46 Initiation of involuntary placement proceedings with respect to a mentally ill inmate scheduled for release.—

(1) If an inmate who is receiving mental health treatment in the department is scheduled for release through expiration of sentence or any other means, but continues to be mentally ill and in need of care and treatment, as defined in s. 945.42, the warden is authorized to initiate procedures for involuntary placement pursuant to s. 394.467, 60 days prior to such release.

Section 43. This act shall take effect July 1, 2017.

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 1760

INTRODUCER: Senators Grimsley and Campbell

SUBJECT: Health Care Facility Regulation

DATE: April 17, 2017

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	Favorable
2.	Forbes	Williams	AHS	Pre-meeting
3.			AP	
4.			RC	

I. Summary:

SB 1760 includes regulatory reductions, revisions to minimize or eliminate conflicts with federal or state requirements, and new provisions to recognize changing needs, and deletes obsolete provisions in the regulation of health care facilities by the Agency for Health Care Administration (AHCA or agency). The bill:

- Abolishes the licensure of clinical laboratories and health care risk managers. The requirement for clinical laboratories to be certified under federal requirements remains in effect. Health care risk managers remain an integral part of a comprehensive risk management program, but will no longer require licensure.
- Removes mobile surgical facilities from health care facility regulation.
- Authorizes hospitals to use alternate-site testing for certain laboratory services.
- Requires the agency to adopt rules for minimum licensure requirements relating to pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care services, psychiatric services, and comprehensive medical rehabilitation.
- Requires each home health agency to identify the home health services it provides and indicate whether each service is considered skilled care. Additional regulatory requirements will apply to home health agencies providing skilled services.
- Establishes a voluntary process to apply for a certificate of exemption from licensure for a person providing home health services that are exempt from licensure.
- Enhances and clarifies the provisions affecting unlicensed activity for nurse registries and assisted living facilities.
- Clarifies responsibilities of nurse registries to reinforce the status of persons they refer to be independent contractors rather than employees.
- Removes prohibitions on a nurse registry providing remuneration to certain individuals who may provide referrals.

- Deletes certain provisions within specific facility licensing chapters to eliminate inconsistencies with the general facility licensing chapter, or to reduce regulatory burdens.
- Authorizes a licensee to request the alignment of the expiration date for multiple licenses held by the licensee.
- Repeals the subscriber assistance program and the statewide managed care ombudsman committee.

The AHCA estimates a total annual revenue reduction of \$1,448,266 due to repeal of licensure for clinical laboratories and health care risk managers.

The act is effective July 1, 2017, except as otherwise expressly provided in the act.

II. Present Situation:

The AHCA is created in s. 20.42, F.S. It is the chief health policy and planning entity for the state and is responsible for, among other things, health facility licensure, inspection, and regulatory enforcement. It licenses or certifies and regulates 40 different types of health care providers, including hospitals, nursing homes, assisted living facilities, and home health agencies. In total, the agency licenses, certifies, regulates or provides exemptions for more than 42,000 providers.¹

Generally applicable provisions of health care provider licensure are addressed in the Health Care Licensing Procedures Act in part II of ch. 408, F.S. Additional chapters or sections in the Florida Statutes provide specific licensure or regulatory requirements pertaining to health care providers in this state.²

Due to the many diverse issues within the bill, pertinent background is provided within the effect of proposed changes for the reader's convenience.

III. Effect of Proposed Changes:

Clinical Laboratories and Clinical Laboratory Personnel

Clinical Laboratories

The federal Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA).³ Facilities that provide clinical laboratory services are required to be certified by the CMS CLIA laboratory certification program which operates in conjunction with the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC). Certain laboratories may qualify as a waived testing laboratory and receive a CLIA Certificate of Waiver.⁴

¹ See the Agency for Health Care Administration, Division of Health Quality Assurance web page available at: <http://ahca.myflorida.com/MCHQ/index.shtml> (last visited March 22, 2017).

² See s. 408.802, F.S., for the health care provider types and applicable licensure statutes.

³ <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA> (last visited Mar. 17, 2017).

⁴ Waived testing laboratories: employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible, pose no reasonable risk of harm to the patient if the test is performed incorrectly, use tests that are cleared

Clinical laboratories in the state performing non-waived tests must also obtain a state license from the AHCA and comply with part I of ch. 483, F.S., relating to clinical laboratories, and the general licensing provisions in part II of ch. 408, F.S. This requirement also applies to a clinical laboratory operated by one or more practitioners such as physicians, chiropractors, podiatrists, optometrists, or dentists, exclusively in connection with the diagnosis and treatment of their own patients.⁵

As of July 1, 2016, the agency licenses 3,862 clinical laboratories and collects an average of \$1,129,000 per year in recurring licensure fees and an average of \$254,400 per year in recurring biennial assessments required by s. 408.033, F.S. The federal CLIA program certifies another 17,877 Florida-based laboratories that only perform waived testing which is exempt from state licensure requirements.⁶

Section 72 repeals part I of ch. 483, F.S., relating to the licensure and regulation of clinical laboratories by the agency. Part I includes ss. 483.011 - 483.26, F.S. Laboratories will continue to be certified by, or receive a certificate of waiver from the CMS under the CLIA. Included within the repeal is a requirement that lab results must be reported directly to the licensed practitioner or other authorized person who requested it, and the authorization for a laboratory to disclose the results without a patient's consent to other health care practitioners and providers involved in the care or treatment of the patient as specified in s. 456.057(7)(a), F.S.

Conforming amendments:

- Sections 5, 7, 10, and 16 amend ss. 381.0031, 381.004, 384.31, and 395.009, F.S., respectively, to remove references to a laboratory licensed under ch. 483, F.S., and to instead refer to a laboratory certified by the CMS under the CLIA.
- Section 6 amends s. 381.0034, F.S., to conform a cross-reference to the repeal of part I of ch. 483, F.S.
- Section 8 amends s. 383.313, F.S., to conform the performance of laboratory services by a birth center with the repeal of clinical laboratory licensure and the changes in the licensure of clinical laboratory personnel.
- Section 33 amends s. 395.7015, F.S., to remove licensed clinical laboratories from the annual assessment imposed on health care entities.
- Section 34 amends s. 400.0625, F.S., to require all clinical laboratory tests performed for a nursing home to be performed by a licensed clinical laboratory, with certain exceptions. (See comment under technical deficiencies.) The bill also deletes the requirement that clinical laboratory tests performed prior to admission in the nursing home by qualified labs shall be accepted in lieu of additional laboratory tests that might be required as a part of the routine examinations for admission.

by the FDA for home use, and conduct testing that is considered non-technical requiring little or no difficulty. See Agency for Health Care Administration, Waived Laboratories:

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/waived_apps.shtml (last visited Mar. 17, 2017).

⁵ Section 483.035(1), F.S.

⁶ Agency for Health Care Administration, *Senate Bill 1760 Analysis* (March 10, 2017), p. 5, (on file with the Senate Committee on Health Policy).

- Section 47 amends s. 400.9905, F.S., relating to health care clinics, to remove cross-reference to licensure under part I of ch. 483.
- Section 48 amends s. 408.033, F.S., relating to local and state health planning, to remove the assessment imposed on clinical laboratories as a funding source of local health councils.
- Section 51 amends s. 408.07, F.S., relating to the Florida Center for Health Information and Transparency and related reporting by licensed health care facilities to remove the definition of clinical laboratories.
- Section 54 amends s. 408.802, F.S., to delete clinical laboratories from regulation under part II of ch. 408, F.S.
- Section 59 amends s. 408.820, F.S., to delete specified exemptions applicable to the regulation of clinical laboratories.
- Section 60 amends s. 409.905, F.S., to delete reference to licensure under ch. 483 and adds the requirement for certification by the CMS under CLIA for laboratory services that are paid for by Medicaid.
- Sections 62 and 71 amend ss. 409.975 and 458.345, F.S., respectively, to conform a cross-reference to the renumbered definitions in s. 408.07, F.S., in section 51.
- Sections 68 and 69 amend ss. 456.001 and 456.057 F.S., respectively, to conform cross-references that have changed due to the repeal of part I of ch. 483, F.S.
- Section 75 amends s. 483.803, F.S., to conform definitions to the repeal of part I of ch. 483, F.S.
- Sections 76 and 77 amend ss. 483.813 and 491.003, F.S., to remove references to provisions in part I of ch. 483, F.S.
- Section 78 amends s. 627.351, F.S., relating to medical malpractice risk apportionment to remove clinical laboratories from the definition of health care provider.
- Section 94 amends s. 945.36, F.S., to affirmatively authorize certain law enforcement personnel to administer a urine screen drug test on inmates and releases, rather than exempting the law enforcement personnel from part I of ch. 483, F.S.

Clinical Laboratory Personnel

Individuals who perform testing in licensed clinical laboratories are required to be licensed by the Department of Health, Board of Clinical Laboratory Personnel (board). Licenses issued by the board are specific to the role of the individuals and the specialties in which they perform that role. Certain exemptions from licensure by the board apply, such as for physicians, chiropractors, podiatrists, or dentists, and certain researchers.⁷ The board is composed of seven members and has authority to adopt rules to implement the provisions of part III of ch. 483, F.S., relating to clinical laboratory personnel.

Section 1 amends s. 20.43, F.S., to repeal the Board of Clinical Laboratory Personnel under the Division of Medical Quality Assurance in the Department of Health.

Section 74 amends s. 483.801, F.S., to exempt from licensure persons engaged in testing performed by laboratories that are wholly owned and operated by one or more practitioners who are licensed under Florida law as allopathic or osteopathic physicians, chiropractors, podiatrists, optometrists, or dentists and who practice in the same group practice, and in which no clinical

⁷ Sections 483.801 and 483.813, F.S.

laboratory work is performed for patients referred by a health care provider who is not a member of the same group.

Hospital and Health Care Facility Licensure

The regulation of, and all references to, mobile surgical facilities are removed from health care facility regulation. Part I of ch. 395, F.S., was amended to include mobile surgical facility as a license type in 1998. A definition of a mobile surgical facility restricts its use to the Department of Corrections (DOC) or a private correctional facility to provide surgical procedures to inmates. No license has ever been issued for a mobile surgical facility and none are anticipated. The DOC operates one hospital which does not offer surgical services directly to its inmates; rather it contracts with a licensed ambulatory surgical center (ASC). A separate license type is not needed in order to meet the surgical needs of the inmate population.⁸

Conforming amendments:

- Sections 11, 12, 61, 62, and 80 amend ss. 385.211, 394.4787, 409.9116, 409.975, and 627.64194, F.S., respectively, to conform a cross-reference to the renumbered definitions in s. 395.002, F.S.
- Sections 13, 14, 15, 18, 19, 92, and 93 amend ss. 395.001, 395.002, 395.003, 395.0161, 395.0163, 766.118, and 766.202, F.S., respectively, to remove reference to a mobile surgical facility in the section.
- Section 33 amends s. 395.7015, F.S., to remove mobile surgical facilities from the annual assessment imposed on health care entities.
- Section 49 amends s. 408.036, F.S., to remove mobile surgical facilities as a project subject to an exemption for certificates of need (CON).
- Section 54 amends s. 408.802, F.S., to delete mobile surgical facilities from regulation under part II of ch. 408, F.S.
- Section 59 amends s. 408.820, F.S., to delete specified exemptions applicable to the regulation of mobile surgical facilities.

Section 17 creates s. 395.0091, F.S., relating to alternate-site testing, to enable hospitals to use a laboratory testing site in which the testing is done under the administrative control of a hospital but performed out of the physical or administrative confines of the central laboratory. This section directs the agency, in consultation with the Board of Clinical Laboratory Personnel, to adopt by rule the criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director. The rule must address, at a minimum, a hospital internal needs assessment, a protocol of implementation, criteria to be used in selecting the method of testing, minimum training and education requirements of professionals in the laboratory, an internal and external quality control protocol, tracking mechanisms between the alternate-site and the central laboratory, and recordkeeping. An alternate-site testing location must be registered when the hospital renews its license.

Section 26 repeals s. 395.10974, F.S., which establishes the licensure requirements for health care risk managers. Section 20 amends s. 395.0197, F.S., to require an internal risk manager of a health care facility to demonstrate to the hiring facility or its governing board, competence, by

⁸ *Supra* note 6, p. 3.

education or experience in the same areas⁹ as required to be demonstrated to the agency for licensure as a health care risk manager. This section also removes references to licensure under s. 395.10974, F.S., as a risk manager.

Conforming amendments:

- Section 23 repeals s. 395.10971, F.S., which provides legislative findings and intent with respect to the health care risk manager program.
- Section 24 repeals s. 395.10972, F.S., which establishes a health care risk manager advisory council within the agency. There are no current council members, and there have been no council meetings for at least 10 years. In addition, the statute contains no defined role or responsibilities for the council.¹⁰
- Section 25 amends s. 395.10973, F.S., to eliminate the agency's rulemaking authority for licensure standards, determination of qualification, and licensure of a health care risk manager.
- Section 27 repeals s. 395.10975, F.S., relating to grounds for denial, suspension, or revocation of a health care risk manager's license.
- Section 54 amends s. 408.802, F.S., to delete health care risk managers from regulation under part II of ch. 408, F.S.
- Section 59 amends s. 408.820, F.S., to delete specified exemptions applicable to the regulation of health care risk managers.
- Sections 70 and 88 amend ss. 458.307 and 641.55, F.S., respectively, to remove reference to the licensure requirement for a health care risk manager.

Section 21 repeals s. 395.1046, F.S., relating to the complaint investigation procedures for alleged violation of the emergency access to care provisions found in s. 395.1041, F.S. The state's emergency access to care provisions are similar to the federal Emergency Medical Treatment and Labor Act, commonly known as EMTALA.¹¹ The agency enforces the emergency access to care requirements through the uniform complaint investigation procedure used for all license types and these complaints are given top priority. Section 395.1046, F.S., duplicates the complaint investigation procedures found in the general licensing provisions in part II of ch. 408, F.S. Also, s. 395.1046, F.S., provides confidentiality protections and a public records exemption for the results in the investigation report, that the agency proposes is an unnecessary level of confidentiality.¹²

⁹ These areas include: applicable standards of health care risk management; applicable federal, state, and local health and safety laws and rules; general risk management administration; patient care; medical care; personal and social care; accident prevention; departmental organization and management; community interrelationships; and medical terminology. See s. 395.10974(1), F.S.

¹⁰ *Supra* n. 6, p. 4.

¹¹ EMTALA, also known as the patient antidumping statute, was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272. Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the emergency department of a hospital and request examination or treatment for an emergency medical condition, regardless of ability to pay. The statute further provides that, if a hospital finds that such an individual has an emergency medical condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility. See the CMS.gov website at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html> (last visited March 18, 2017).

¹² *Supra* n. 6, p. 3.

Section 22 amends s. 395.1055, F.S., to requires the agency to adopt rules to ensure that all hospitals providing pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care services, psychiatric services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by the agency. The licensure requirement shall include quality of care, nurse staffing, physician staffing, physical plant, equipment, emergency transportation, and data reporting standards. The agency indicates that adopted rules for all these procedures may take some time due to the interaction of various stakeholders.¹³ The CON process includes standards; however, these conditions are not required to be met for continued licensure.¹⁴

Section 28 amends s. 395.602, F.S., relating to rural hospitals, to remove the definitions of “emergency care hospital,” “essential access community hospital,” “inactive rural hospital bed,” and “rural primary care hospital.” These definitions relate to obsolete rural hospital programs that are no longer available or applicable to rural hospitals. Hospitals are authorized to make changes to their bed inventory at will so there is no longer a need to maintain an inventory of inactive rural hospital beds for CON purposes.¹⁵

Conforming amendments:

- Section 29 amends s. 395.603, F.S., to remove provisions relating to the deactivation of general hospital beds in order to seek licensure for programs that are now obsolete.
- Section 30 repeals s. 395.604, F.S., relating to licensing hospitals for these obsolete programs.
- Section 31 repeals s. 395.605, F.S., relating to licensing emergency care hospitals which is now an obsolete program.
- Section 95 amends s. 1009.65, F.S., to conform a cross-reference to the renumbered definitions in s. 395.602, F.S.

Section 32 amends s. 395.701, F.S., relating to hospital assessments on inpatient and outpatient services. Current law excludes hospitals operated by the agency or the DOC. This section amends the current exclusion to any hospital operated by a state agency, to specifically exclude hospitals operated by the Department of Children and Families.¹⁶

Home Health Agencies

Section 35 amends s. 400.464, F.S., to require any license issued after June 30, 2017, to specify the home health services that the organization is authorized to perform and indicate whether each service is considered skilled care. In addition, providing or advertising services that require licensure and which are not specified on the face of the license issued after June 30, 2017, constitutes prohibited unlicensed activity.

¹³ *Supra* note 6, p. 4.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

The bill authorizes a voluntary process for applying for a certificate of exemption from licensure for a person providing home health services who is exempt from licensure as a home health agency. The agency may charge a fee of \$100 or the actual cost of processing this certificate.

Conforming amendment:

Section 40 amends s. 400.497, F.S., relating to agency rulemaking to include applications for certificates of exemption from licensure.

Section 36 amends s. 400.471, F.S., to require application for a change of ownership or for the addition of skilled services. Applicants for license renewal no longer need to provide volume data. Under the bill, evidence of contingency funding refers to the general licensing provisions in part II of ch. 408, F.S., to eliminate an inconsistency between the two chapters. Under current law, a home health agency that is not Medicare or Medicaid certified and does not provide skilled care is exempt from providing proof of accreditation. This bill provides the exemption only if the home health agency does not provide skilled care. The bill further clarifies that the accrediting organization must be recognized by the agency, the survey must demonstrate compliance with Florida laws pertaining to home health agencies, and must be continuously maintained.

Section 36 and 37 amend ss. 400.471 and 400.474, F.S., respectively, to clarify that a licensed home health agency must provide the services specified in the written agreement with the patient except in emergency situations that are beyond the provider's control that make it impossible to provide the services.

Section 38 amends s. 400.476, F.S., to require a home health agency that provides skilled nursing care to have a director of nursing. Current law exempts a home health agency from this requirement if it is Medicare or Medicaid certified or provides only physical, occupational, or speech therapy. This exemption is repealed.

Section 39 amends s. 400.484, F.S., renaming deficiencies as violations with respect to providing care by home health agencies and tying these violations to the general licensing provisions for health care facilities in part II of ch. 408, F.S.

Nurse Registries

Section 41 amends s. 400.506, F.S., to remove a grace period of 10-working days after notification from the agency that licensure is required, for an unlicensed nurse registry to cease operating to avoid committing a misdemeanor of the second degree. Under the bill, the unlicensed nurse registry must cease operations immediately. The agency is authorized to impose a fine of \$1,000 per day in accordance with s. 408.812, F.S., in the general licensing provisions pertaining to unlicensed activity, rather than the \$500 fine specified in this statute specifically relating to nurse registries.

This section clarifies the status of persons referred by the nurse registry as independent contractors rather than employees. Current law provides that is in not the obligation of a nurse registry to monitor, supervise, manage, or train a referred caregiver. The bill strengthens this concept by providing that a nurse registry is not permitted to do any of those activities. Similarly,

although a nurse registry is required to act as a repository of records, the bill provides that the nurse registry is not permitted to review or act upon such records, except for providing patients with information and notifying applicable licensing boards if a referred caregiver has credentialing deficiencies.

In addition, this section of the bill removes the prohibitions on a nurse registry providing remuneration to a case manager, discharge planner, facility based staff member, third party vendor, physician, member of the physician's office staff, or an immediate family member of a physician for referrals. Current law already exempts nurse registries from this prohibition if they do not bill Medicare or Medicaid or share a controlling interest with any entity that bills Medicare or Medicaid.

Assisted Living Facilities (ALF)

Section 63 amends s. 429.02, F.S., to revise the definition of personal services to prohibit an ALF from providing personal services to individuals who are not residents of the facility unless the ALF is providing authorized adult day care services within the licensed ALF. Section 67 amends s. 429.41, F.S., to require rulemaking for reasonable and fair minimum standards on this prohibition.

Section 64 amends s. 429.04, F.S., relating to exemptions from licensure to clarify and expand the exemptions to include a licensed hospital, nursing home, inpatient hospice, home for special services,¹⁷ intermediate care facility, or transitional living facility. Additionally, this section assigns the burden of providing documentation substantiating an exemption to the person or entity asserting an exemption in response to an agency investigation of unlicensed activity.

A current exemption includes any person who provides housing, meals, or one or more personal services on a 24-hour basis in the person's own home to not more than two adults who do not receive optional state supplementation. The bill specifies that in addition to owning or renting the home, the person who provides these services must have established the home as the person's permanent residence. If the person holds a homestead exemption at a different address, a presumption exists that the person has not established permanent residence as required by this section. Furthermore, the bill provides that the exemption does not apply to a person or entity who previously held licensure issued by the agency and such license was revoked or licensure renewal was denied by final order, or when the license was voluntarily relinquished during agency enforcement proceedings.

Section 65 amends s. 429.08, F.S., relating to unlicensed facilities to clarify and create a felony of the third degree penalty for renting or otherwise maintaining a building or property that operates or maintains an unlicensed ALF. Similarly, this section now provides that any person who owns, operates, or maintains an unlicensed ALF after receiving notice from the agency that licensure is required and to cease such operation commits a felony of the third degree. Current law provides a six-month window after a statutory or rule change takes place if the change

¹⁷ Homes for special services is defined in s. 400.801, F.S., as a site licensed by the agency prior to January 1, 2006, where specialized health care services are provided, including personal and custodial care, but not continuous nursing services.

placed the person in the position of violating this provision before the violation occurs. This six-month timeframe is repealed in the bill.

Section 66 amends s. 429.176, F.S., to prohibit an ALF from operating for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Multiphasic Health Testing Centers

Section 73 amends s. 483.294, F.S., to remove the requirement that a multiphasic health testing center must be inspected at least annually. Inspections are to be done in accordance with s. 408.811, F.S., which provides that inspections for relicensure shall occur biennially; however, an inspection may be performed at any time as needed. The general licensing provisions in part II of ch. 408, F.S., allow for accreditation inspections to be accepted in lieu of a full licensure inspection.

Amendments referencing General Licensing Provisions and Technical Amendments

Hospices

Section 42 amends s. 400.606, F.S., to remove the required submission of certain financial information at licensure renewal. This requirement conflicts with submission requirements in the general licensure requirements in part II of ch. 408, F.S.

Home Medical Equipment Providers

Section 43 is a technical amendment to s. 400.925, F.S., to move wheelchairs and related seating and positioning devices to a separate paragraph within the definition of home medical equipment.

Section 44 amends s. 400.931, F.S., to require a licensed home medical equipment provider to notify the agency of a change in the general manager within the timeframes established in part II of ch. 408, F.S., which is 21 days, rather than the 45-day timeframe provided in this section of law.

Section 45 is a technical amendment to s. 400.933, F.S., correcting the name of the state agency that issues medical oxygen retail establishment permits. It is now the Department of Business and Professional Regulation.

Health Care Service Pools

Section 46 amends s. 400.980, F.S., to require changes of information contained on the original registration application to be submitted to the agency within the timeframes established in part II of ch. 408, F.S., rather than 14 days prior to the change as required in this section of law.

General Licensing Provisions

Section 55 amends s. 408.803, F.S., to add a definition of “relative.”

Section 56 amends s. 408.806, F.S., relating to the license application process, to require the licensee to ensure that no person has any ownership interest in a licensee, directly or indirectly, who is ineligible pursuant to s. 408.809(4), F.S., which lists additional disqualifying offenses, most of which are fraud-related activity. Additionally, the licensee is required to ensure that no person holds or has held any ownership interest in a provider that has had a license or change of ownership application denied, revoked, or excluded pursuant to s. 408.815, F.S., which includes false representation; intentional or negligent acts affecting a client; demonstrated pattern of deficient performance; or being excluded, suspended, or terminated from participation in any state's Medicaid program or Medicare.

This section also authorizes a licensee that holds a license for multiple providers licensed by the agency to request alignment of all license expiration dates. In order to accomplish this, the agency is authorized to issue a license for an abbreviated licensure period with a prorated licensure fee.

Section 57 amends s. 408.810, F.S., to exempt an applicant for a change of ownership from submitting proof of financial ability to operate if the provider has been licensed for at least five years and the change is the result of a corporate reorganization under which the controlling interest is unchanged or solely due to the death of a controlling interest, and the surviving controlling interest continue to hold at least 51 percent of the ownership.

The agency is authorized to adopt rules to address the circumstances under which a controlling interest, an administrator, an employee, a contractor, or a representative thereof who is not a relative of the patient or client may act as a legal representative, agent, health care surrogate, power of attorney, or guardian of a patient or client. According to the agency, licensure regulations are currently inconsistent in this area. Due to the vulnerability of persons receiving health or custodial care, allowing the paid caregiver to control finances or health care decisions of the patient can result in exploitation or abuse. In some cases, the facility has a surety bond, but this is not required for all provider types.¹⁸

Section 58 amends s. 408.812, F.S., relating to unlicensed activity, to provide that unlicensed activity constitutes abuse and neglect, as defined in s. 415.102, F.S.¹⁹ This section eliminates the requirement that a person or entity must apply for a license after receiving notification from the agency that the person or entity is engaging in unlicensed activity. If a controlling interest or licensee has more than one provider and fails to license all providers that require licensure, the agency may impose a fine, regardless of correction, as one of the authorized sanctions.

Subscriber Assistance Program

Section 53 of the bill repeals s. 408.7056, F.S., relating to the subscriber assistance program, effective January 1, 2018.

¹⁸ *Supra* note 6, pp. 6-7.

¹⁹ In summary, s. 415.102, F.S., defines "abuse" as any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health; and that abuse includes acts and omissions. "Neglect" is defined as the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult. Refer to s. 415.102(16), F.S., for additional acts that constitute neglect.

The subscriber assistance panel (SAP) was created in 1985 to assist members of managed care entities whose grievances or appeals were not satisfactorily resolved by the managed care entity upon exhaustion of the managed care entity's internal grievance and appeal process. Under the federal Patient Protection and Affordable Care Act (PPACA),²⁰ managed care entities were given an option to either comply with the state's external review requirement or opt-out and participate in the federal external review program. The majority of health plans in Florida elected to use the federal program and the SAP program experienced a significant decrease in the number of cases being reviewed by the panel.²¹

The SAP is currently available to members of managed care entities with coverage by: Statewide Medicaid Managed Care, Healthy Kids, Prepaid Health Clinics, or grandfathered policies²² that have not elected to have all of their health insurance policies subject to an external review process by independent review organization(s). Medicaid recipients in managed care can file for an external review through a Medicaid Fair Hearing and members with grandfathered commercial policies may appeal through independent review organizations.²³

Repeal of the SAP eliminates this program as an external appeal option for members in Healthy Kids and Prepaid Health Clinics, although according to the agency, no Prepaid Health Clinic members have used the SAP. At this time, these members do not have another avenue in which to file an external appeal.²⁴

Conforming amendments:

- Sections 2, 3, 4, 85, and 87 amend ss. 220.1845, 376.30781, 376.86, 641.51, and 641.515, F.S., respectively, to strike a cross-reference to s. 408.7056, F.S., to conform those provisions to repeal of the subscriber assistance program.
- Sections 79, 81, and 83 amend ss. 627.602, 627.6531, and 641.312, F.S., respectively, to delete an exemption for a health insurance policy, group health insurance policy, and health maintenance organization (HMO) contract that is subject to the subscriber assistance program.
- Section 82 amends s. 641.185, F.S., to remove a principle concerning regulatory oversight by various state entities relating to an HMO's expedited review of unresolved grievances pursuant to the subscriber assistance program.

²⁰ Pub. Law No. 111-148 (Mar. 23, 2010) amended by Pub. Law. No. 111-152 (Mar. 30, 2010).

²¹ According to the agency, between FY 2011-2012 and FY 2012-2013, when the majority of plans opted to use the federal external review program, the number of cases received by the SAP dropped from 415 to 213. The number of cases heard by the SAP dropped from 74 to 17. There has been an uptick in both number of cases received by the subscriber assistance program and the number of cases heard by the panel for FY 2014-2015 and FY 2015-2016, with the latest full year of data showing 350 cases received and 53 cases heard. The predominant outcome of the cases in FY 2015-2016 was a determination of non-jurisdiction (#221), followed by submission of an incomplete application (#31) and found in favor of the subscriber (#27). See the chart prepared by the agency for activity since FY 2009-2010 at *supra* note 4, p. 7.

²² A grandfathered health plan is a plan that existed on March 23, 2010, the date that the PPACA was enacted, and that at least one person had been continuously covered for 1 year. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. See Healthcare.gov, *Grandfathered Health Plans*, <https://www.healthcare.gov/glossary/grandfathered-health-plan/> (last visited Mar. 23, 2017).

²³ *Supra* note 6, p. 7.

²⁴ *Id.*

- Section 84 amends s. 641.3154, F.S., to remove reference to an action after a recommendation is made by the SAP.
- Section 86 amends s. 641.511, F.S., relating to HMOs, to remove notice requirements to subscribers regarding the subscriber assistance program and authorizations for a subscriber to submit a grievance to the subscriber assistance program. This section also repeals a requirement for the HMO to maintain records of all grievances and report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievance, and the final disposition of the grievances.

Managed Care Ombudsman Committees

The Statewide Managed Care Ombudsman Committee (statewide committee) and the district managed care ombudsman committees (district committees) were established in 1996.²⁵ The statewide committee is created within the agency as a consumer protection and advocacy organization on behalf of managed care subscribers. The statewide committee has administrative authority over the district committees and consists of the chairpersons of the district committees.

A district committee is created in s. 641.65, F.S., in each district of the agency that has staff assigned for the regulation of managed care programs. Each district committee must have no fewer than nine members or more than 16 members, including at least four physicians, one licensed under chs. 458, 459, 460, and 461; one psychologist; one registered nurse; one clinical social worker; one attorney; and one consumer.²⁶

According to the agency, due to the very stringent committee composition requirements, the majority of districts could not form district committees. The first committee was established in 1999 and only three other districts were able to meet committee requirements. The last activity on record was in 2010 and there are currently no active committees.²⁷

Section 89 repeals s. 641.60, F.S., which authorizes the Statewide Managed Care Ombudsman Council.

Conforming amendments:

- Section 90 amends s. 641.70, F.S., relating to district managed care ombudsman committees, to remove all references to the statewide Managed Care Ombudsman Council.
- Section 91 amends s. 641.75, F.S., to conform cross-references to the repeal of s. 641.60, F.S.

Obsolete and Miscellaneous Provisions

Section 9 repeals s. 383.335, F.S., to remove a birth center exemption to one aspect of licensure for providers in existence over 30 years ago. Currently, no providers meet this exemption.²⁸

Conforming Amendment:

²⁵ Chapter 96-391, L.O.F.

²⁶ Section 641.65(2), F.S.

²⁷ *Supra* note 6, p. 8.

²⁸ *Supra* note 6, p. 10.

- Section 47 amends s. 400.9905, F.S., relating to health care clinics to correct the cross-reference to statutes affecting birth centers.

Section 50 amends s. 408.061, F.S., relating to data collection by the agency from health care facilities, to conform cross-references and to exclude hospitals operated by state agencies from the requirement to submit certain financial reports.

The effective date of the bill is July 1, 2017, except as otherwise expressly provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Repealing the licensure requirement for health care risk managers will save each risk manager the cost of the licensure fee, which is \$104.54 for initial applicants and \$52.78 for renewal applicants.²⁹

Repealing clinical laboratory licensure will save each clinical laboratory that was required to be licensed and is accredited \$100 biennially. If not accredited, the fee is between \$400 - \$3,919 biennially, depending upon the annual volume of non-waived tests performed.³⁰

²⁹ See the Application checklist available at:

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/risk_manager.shtml (last visited Mar. 24, 2017).

³⁰ See AHCA Clinical laboratory fees, available at:

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/fees.shtml (last visited Mar. 24, 2017).

C. Government Sector Impact:

The AHCA expects a reduction in revenue related to risk manager application fees (approximately \$64,866 per year), and for laboratory licensure application fees (\$1,383,400 per year). The total revenue reduction is approximately \$1,448,266 annually.

VI. Technical Deficiencies:

The bill repeals the Board of Clinical Laboratory Personnel within the DOH, authorized by s. 20.43(3)(g)22, F.S. However, section 17 creates a new section of law, s. 395.0091, relating to alternate-site testing, that requires the agency, acting in consultation with the Board of Clinical Laboratory Personnel, to adopt rules pertaining to alternate-site testing.

Section 34 amends s. 400.0625, F.S., to require all clinical laboratory tests performed for a nursing home to be performed by a licensed clinical laboratory with certain exceptions. Given the repeal of clinical laboratory licensure in section 72, and the corresponding substitution of CMS-issued certificates under CLIA, an amendment might be needed for clarity.

Section 56 amends s. 408.806, F.S., relating to the license application process. The new language in the bill for subsection (1) refers to a licensee. For an initial application, a license has not yet been issued. It may be appropriate to assign the responsibilities to the applicant.

Section 89 of the bill repeals the Statewide Managed Care Ombudsman Committee but fails to conform references to the statewide committee in ss. 641.65 and 641.75(1) and (2), F.S.

VII. Related Issues:

Section 86 amends s. 641.511, F.S., relating to HMOs. Among other things, it eliminates a requirement for the HMO to maintain records of all grievances and report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievance, and the final disposition of the grievances. Eliminating this provision may be overly broad, if a similar recordkeeping/reporting provision does not exist, because it is not apparent how regulators could monitor subscriber grievances.

The bill repeals the Statewide Managed Care Ombudsman Committee but does not eliminate the district managed care ombudsman committees. District committees have not been established in most of the districts and no committees have been active since 2010. Other resources exist for protecting the rights of subscribers in managed care plans. For example, the Office of the Insurance Consumer Advocate is established in s. 627.0613, F.S., to represent subscribers as appropriate.³¹ Eliminating the district committees or revising their structure might also be considered.

³¹ See also The Office of the Insurance Consumer Advocate Overview website: <http://www.myfloridacfo.com/division/ICA/Overview.htm> (last visited March 23, 2017).

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 20.43, 220.1845, 376.30781, 376.86, 381.0031, 381.0034, 381.004, 383.313, 384.31, 385.211, 394.4787, 395.001, 395.002, 395.003, 395.009, 395.0161, 395.0163, 395.0197, 395.1055, 395.10973, 395.602, 395.603, 395.701, 395.7015, 400.0625, 400.464, 400.471, 400.474, 400.476, 400.484, 400.497, 400.506, 400.606, 400.925, 400.931, 400.933, 400.980, 400.9905, 408.033, 408.036, 408.061, 408.07, 408.20, 408.802, 408.803, 408.806, 408.810, 408.812, 408.820, 409.905, 409.9116, 409.975, 429.02, 429.04, 429.08, 429.176, 429.41, 456.001, 456.057, 458.307, 458.345, 483.294, 483.801, 483.803, 483.813, 491.003, 627.351, 627.602, 627.64194, 627.6513, 641.185, 641.312, 641.3154, 641.51, 641.511, 641.515, 641.55, 641.70, 641.75, 766.118, 766.202, 945.36, and 1009.65.

This bill creates section 395.0091 of the Florida Statutes.

This bill repeals the following sections of the Florida Statutes: 383.335, 395.1046, 395.10971, 395.10972, 395.10974, 395.10975, 395.604, 395.605, 408.7056, 483.011, 483.021, 483.031, 483.035, 483.041, 483.051, 483.061, 483.091, 483.101, 483.111, 483.172, 483.181, 483.191, 483.201, 483.221, 483.23, 483.245, 483.26, and 641.60.

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:

None.



286602

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

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

20.43 Department of Health.—There is created a Department
of Health.

(3) The following divisions of the Department of Health are
established:



286602

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.
2. The Board of Medicine, created under chapter 458.
3. The Board of Osteopathic Medicine, created under chapter 459.
4. The Board of Chiropractic Medicine, created under chapter 460.
5. The Board of Podiatric Medicine, created under chapter 461.
6. Naturopathy, as provided under chapter 462.
7. The Board of Optometry, created under chapter 463.
8. The Board of Nursing, created under part I of chapter 464.
9. Nursing assistants, as provided under part II of chapter 464.
10. The Board of Pharmacy, created under chapter 465.
11. The Board of Dentistry, created under chapter 466.
12. Midwifery, as provided under chapter 467.
13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
14. The Board of Nursing Home Administrators, created under part II of chapter 468.
15. The Board of Occupational Therapy, created under part III of chapter 468.
16. Respiratory therapy, as provided under part V of chapter 468.
17. Dietetics and nutrition practice, as provided under



286602

part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part II ~~III~~ of chapter 483.

23. Medical physicists, as provided under part IV of chapter 483.

24. The Board of Opticianry, created under part I of chapter 484.

25. The Board of Hearing Aid Specialists, created under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

30. Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 2. Section 154.13, Florida Statutes, is created to read:

154.13 Designated facilities; jurisdiction.—Any designated facility owned or operated by a public health trust and located



286602

within the boundaries of a municipality is under the exclusive jurisdiction of the county creating the public health trust and is not within the jurisdiction of the municipality.

Section 3. Paragraph (k) of subsection (2) of section 220.1845, Florida Statutes, is amended to read:

220.1845 Contaminated site rehabilitation tax credit.—

(2) AUTHORIZATION FOR TAX CREDIT; LIMITATIONS.—

(k) In order to encourage the construction and operation of a new health care facility as defined in s. 408.032 or s. 408.07, or a health care provider as defined in s. 408.07 ~~or s. 408.7056~~, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed \$500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 4. Paragraph (f) of subsection (3) of section 376.30781, Florida Statutes, is amended to read:

376.30781 Tax credits for rehabilitation of drycleaning-solvent-contaminated sites and brownfield sites in designated brownfield areas; application process; rulemaking authority; revocation authority.—

(3)

(f) In order to encourage the construction and operation of a new health care facility or a health care provider, as defined



286602

in s. 408.032 ~~or~~ s. 408.07, ~~or s. 408.7056~~, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed \$500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 5. Subsection (1) of section 376.86, Florida Statutes, is amended to read:

376.86 Brownfield Areas Loan Guarantee Program.—

(1) The Brownfield Areas Loan Guarantee Council is created to review and approve or deny, by a majority vote of its membership, the situations and circumstances for participation in partnerships by agreements with local governments, financial institutions, and others associated with the redevelopment of brownfield areas pursuant to the Brownfields Redevelopment Act for a limited state guaranty of up to 5 years of loan guarantees or loan loss reserves issued pursuant to law. The limited state loan guaranty applies only to 50 percent of the primary lenders loans for redevelopment projects in brownfield areas. If the redevelopment project is for affordable housing, as defined in s. 420.0004, in a brownfield area, the limited state loan guaranty applies to 75 percent of the primary lender's loan. If the redevelopment project includes the construction and operation of a new health care facility or a health care



286602

provider, as defined in s. 408.032 ~~or~~ s. 408.07, ~~or s.~~
~~408.7056~~, on a brownfield site and the applicant has obtained
documentation in accordance with s. 376.30781 indicating that
the construction of the health care facility or health care
provider by the applicant on the brownfield site has received a
certificate of occupancy or a license or certificate has been
issued for the operation of the health care facility or health
care provider, the limited state loan guaranty applies to 75
percent of the primary lender's loan. A limited state guaranty
of private loans or a loan loss reserve is authorized for
lenders licensed to operate in the state upon a determination by
the council that such an arrangement would be in the public
interest and the likelihood of the success of the loan is great.

Section 6. Subsection (2) of section 381.0031, Florida
Statutes, is amended to read:

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

(2) Any practitioner licensed in this state to practice
medicine, osteopathic medicine, chiropractic medicine,
naturopathy, or veterinary medicine; any hospital licensed under
part I of chapter 395; or any laboratory appropriately certified
by the Centers for Medicare and Medicaid Services under the
federal Clinical Laboratory Improvement Amendments and the
federal rules adopted thereunder which ~~licensed under chapter~~
~~483 that~~ diagnoses or suspects the existence of a disease of
public health significance shall immediately report the fact to
the Department of Health.

Section 7. Subsection (3) of section 381.0034, Florida
Statutes, is amended to read:



286602

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or part II ~~III~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 8. Paragraph (c) of subsection (4) of section 381.004, Florida Statutes, is amended to read:

381.004 HIV testing.—

(4) HUMAN IMMUNODEFICIENCY VIRUS TESTING REQUIREMENTS; REGISTRATION WITH THE DEPARTMENT OF HEALTH; EXEMPTIONS FROM REGISTRATION.—No county health department and no other person in this state shall conduct or hold themselves out to the public as conducting a testing program for acquired immune deficiency syndrome or human immunodeficiency virus status without first registering with the Department of Health, reregistering each year, complying with all other applicable provisions of state law, and meeting the following requirements:

(c) The program shall have all laboratory procedures performed in a laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder ~~licensed under the provisions of chapter 483.~~

Section 9. Paragraph (f) of subsection (4) of section 381.0405, Florida Statutes, is amended to read:

381.0405 Office of Rural Health.—



286602

(4) COORDINATION.—The office shall:

(f) Assume responsibility for state coordination of the Rural Hospital Transition Grant Program, ~~the Essential Access Community Hospital Program,~~ and other federal rural health care programs.

Section 10. Section 383.30, Florida Statutes, is amended to read:

383.30 Birth Center Licensure Act; short title.—Sections 383.30-383.332 ~~383.335~~ shall be known and may be cited as the "Birth Center Licensure Act."

Section 11. Section 383.301, Florida Statutes, is amended to read:

383.301 Licensure and regulation of birth centers; legislative intent.—It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, maintenance, and operation of birth centers by providing for licensure of birth centers and for the development, establishment, and enforcement of minimum standards with respect to birth centers. The requirements of part II of chapter 408 shall apply to the provision of services that require licensure pursuant to ss. 383.30-383.332 ~~383.335~~ and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 383.30-383.332 ~~383.335~~. A license issued by the agency is required in order to operate a birth center in this state.

Section 12. Section 383.302, Florida Statutes, is amended to read:

383.302 Definitions of terms used in ss. 383.30-383.332



286602

~~383.335.~~—As used in ss. 383.30–383.332 ~~383.335~~, the term:

(1) “Agency” means the Agency for Health Care Administration.

(2) “Birth center” means any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.

(3) “Clinical staff” means individuals employed full time or part time by a birth center who are licensed or certified to provide care at childbirth.

(4) “Consultant” means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center and who either:

(a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology, or

(b) Has hospital obstetrical privileges.

(5) “Governing body” means any individual, group, corporation, or institution which is responsible for the overall operation and maintenance of a birth center.

(6) “Governmental unit” means the state or any county, municipality, or other political subdivision or any department, division, board, or other agency of any of the foregoing.

(7) “Licensed facility” means a facility licensed in accordance with s. 383.305.

(8) “Low-risk pregnancy” means a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.



286602

(9) "Person" means any individual, firm, partnership, corporation, company, association, institution, or joint stock association and means any legal successor of any of the foregoing.

(10) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of maternity care located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion and control of the licensee.

Section 13. Subsection (1) of section 383.305, Florida Statutes, is amended to read:

383.305 Licensure; fees.—

(1) In accordance with s. 408.805, an applicant or a licensee shall pay a fee for each license application submitted under ss. 383.30-383.332 ~~383.335~~ and part II of chapter 408. The amount of the fee shall be established by rule.

Section 14. Subsection (1) of section 383.309, Florida Statutes, is amended to read:

383.309 Minimum standards for birth centers; rules and enforcement.—

(1) The agency shall adopt and enforce rules to administer ss. 383.30-383.332 ~~383.335~~ and part II of chapter 408, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions,



286602

disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.

(c) Licensed facilities are established, organized, and operated consistent with established programmatic standards.

Section 15. Subsection (1) of section 383.313, Florida Statutes, is amended to read:

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center must obtain and continuously maintain certification by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvements Amendments and rules adopted thereunder in order to ~~may perform simple laboratory tests specified, as defined by rule of the agency, and which are appropriate to meet the needs of the patient is exempt from the requirements of chapter 483, provided no more than five physicians are employed by the birth center and testing is conducted exclusively in connection with the diagnosis and treatment of clients of the birth center.~~

Section 16. Subsection (1) and paragraph (a) of subsection (2) of section 383.33, Florida Statutes, are amended to read:

383.33 Administrative penalties; moratorium on admissions.—

(1) In addition to the requirements of part II of chapter 408, the agency may impose an administrative fine not to exceed \$500 per violation per day for the violation of any provision of ss. 383.30-383.332 ~~383.335~~, part II of chapter 408, or applicable rules.



286602

(2) In determining the amount of the fine to be levied for a violation, as provided in this section, the following factors shall be considered:

(a) The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of ss. 383.30-383.332 ~~383.335~~, part II of chapter 408, or applicable rules were violated.

Section 17. Section 383.335, Florida Statutes, is repealed.

Section 18. Section 384.31, Florida Statutes, is amended to read:

384.31 Testing of pregnant women; duty of the attendant.— Every person, including every physician licensed under chapter 458 or chapter 459 or midwife licensed under part I of chapter 464 or chapter 467, attending a pregnant woman for conditions relating to pregnancy during the period of gestation and delivery shall cause the woman to be tested for sexually transmissible diseases, including HIV, as specified by department rule. Testing shall be performed by a laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder ~~approved~~ for such purposes ~~under part I of chapter 483~~. The woman shall be informed of the tests that will be conducted and of her right to refuse testing. If a woman objects to testing, a written statement of objection, signed by the woman, shall be placed in the woman's medical record and no testing shall occur.

Section 19. Subsection (2) of section 385.211, Florida



286602

Statutes, is amended to read:

385.211 Refractory and intractable epilepsy treatment and research at recognized medical centers.—

(2) Notwithstanding chapter 893, medical centers recognized pursuant to s. 381.925, or an academic medical research institution legally affiliated with a licensed children's specialty hospital as defined in s. 395.002(27) ~~s. 395.002(28)~~ that contracts with the Department of Health, may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC cannabis for the treatment for refractory or intractable epilepsy. The authority for recognized medical centers to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities described in this section.

Section 20. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(27) ~~s. 395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 21. Section 395.001, Florida Statutes, is amended to read:

395.001 Legislative intent.—It is the intent of the Legislature to provide for the protection of public health and



286602

safety in the establishment, construction, maintenance, and operation of hospitals and, ambulatory surgical centers, ~~and mobile surgical facilities~~ by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

Section 22. Present subsections (22) through (33) of section 395.002, Florida Statutes, are renumbered as subsections (21) through (32), respectively, and subsections (3) and (16) and present subsections (21) and (23) of that section are amended, to read:

395.002 Definitions.—As used in this chapter:

(3) “Ambulatory surgical center” ~~or “mobile surgical facility”~~ means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. ~~Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.~~



286602

(16) "Licensed facility" means a hospital or, ambulatory surgical center, ~~or mobile surgical facility~~ licensed in accordance with this chapter.

~~(21) "Mobile surgical facility" is a mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957 and in which inmate patients are admitted to and discharged from said facility within the same working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to chapter 957, and not to the general public.~~

(22) ~~(23)~~ "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital or, ambulatory surgical, ~~or mobile surgical~~ care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44) ~~s. 408.07(45)~~, reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.



286602

Section 23. Paragraphs (a) and (b) of subsection (1) and paragraph (b) of subsection (2) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital or, ambulatory surgical center, ~~or mobile surgical facility~~ in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital," or "ambulatory surgical center," ~~or "mobile surgical facility"~~ unless such facility has first secured a license under the provisions of this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital," or "ambulatory surgical center," ~~or "mobile surgical facility"~~ as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(44) ~~s. 408.07(45)~~, issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002(22) ~~s. 395.002(23)~~. Such



286602

license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 24. Subsection (1) of section 395.009, Florida Statutes, is amended to read:

395.009 Minimum standards for clinical laboratory test results and diagnostic X-ray results; prerequisite for issuance or renewal of license.—

(1) As a requirement for issuance or renewal of its license, each licensed facility shall require that all clinical laboratory tests performed by or for the licensed facility be performed by a clinical laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder ~~licensed under the provisions of chapter 483.~~

Section 25. Section 395.0091, Florida Statutes, is created to read:

395.0091 Alternate-site testing.—The agency, in consultation with the Board of Clinical Laboratory Personnel, shall adopt by rule the criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director. At a minimum, the criteria must address: hospital internal needs assessment; a protocol for implementation, including the identification of tests to be performed and who will perform them; selection of the method of testing to be used for alternate-site testing; minimum training and education requirements for those who will perform alternate-site testing,



286602

such as documented training, licensure, certification, or other medical professional background not limited to laboratory professionals; documented inservice training and initial and ongoing competency validation; an appropriate internal and external quality control protocol; an internal mechanism for the central laboratory to identify and track alternate-site testing; and recordkeeping requirements. Alternate-site testing locations must register when the hospital applies to renew its license. For purposes of this section, the term "alternate-site testing" means any laboratory testing done under the administrative control of a hospital, but performed out of the physical or administrative confines of the central laboratory.

Section 26. Paragraph (f) of subsection (1) of section 395.0161, Florida Statutes, is amended to read:

395.0161 Licensure inspection.—

(1) In addition to the requirement of s. 408.811, the agency shall make or cause to be made such inspections and investigations as it deems necessary, including:

~~(f) Inspections of mobile surgical facilities at each time a facility establishes a new location, prior to the admission of patients. However, such inspections shall not be required when a mobile surgical facility is moved temporarily to a location where medical treatment will not be provided.~~

Section 27. Subsection (3) of section 395.0163, Florida Statutes, is amended to read:

395.0163 Construction inspections; plan submission and approval; fees.—

~~(3) In addition to the requirements of s. 408.811, the agency shall inspect a mobile surgical facility at initial~~



286602

~~licensure and at each time the facility establishes a new location, prior to admission of patients. However, such inspections shall not be required when a mobile surgical facility is moved temporarily to a location where medical treatment will not be provided.~~

Section 28. Subsection (2), paragraph (c) of subsection (6), and subsections (16) and (17) of section 395.0197, Florida Statutes, are amended to read:

395.0197 Internal risk management program.—

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager, ~~licensed under s. 395.10974,~~ who is responsible for implementation and oversight of such facility's internal risk management program and who demonstrates competence, by education or experience, in all of the following areas: ~~as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.~~

(a) Applicable standards of health care risk management.

(b) Applicable federal, state, and local health and safety laws and rules.

(c) General risk management administration.

(d) Patient care.

(e) Medical care.

(f) Personal and social care.

(g) Accident prevention.



286602

(h) Departmental organization and management.

(i) Community interrelationships.

(j) Medical terminology.

(6)

(c) The report submitted to the agency shall also contain the name ~~and license number~~ of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(16) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, ~~licensed under s. 395.10974,~~ for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed



286602

within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(17) A privilege against civil liability is hereby granted to any ~~licensed~~ risk manager or licensed facility with regard to information furnished pursuant to this chapter, unless the ~~licensed~~ risk manager or facility acted in bad faith or with malice in providing such information.

Section 29. Section 395.1046, Florida Statutes, is repealed.

Section 30. Subsections (2) and (3) of section 395.1055, Florida Statutes, are amended, and paragraph (i) is added to subsection (1), to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(i) All hospitals providing pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care services, psychiatric services, or comprehensive medical rehabilitation meet the minimum licensure requirements adopted by the agency. Such licensure requirements must include quality of care, nurse staffing, physician staffing, physical plant, equipment, emergency transportation, and data reporting standards.

(2) Separate standards may be provided for general and specialty hospitals, ambulatory surgical centers, ~~mobile surgical facilities,~~ and statutory rural hospitals as defined in s. 395.602.



286602

(3) The agency shall adopt rules with respect to the care and treatment of patients residing in distinct part nursing units of hospitals which are certified for participation in Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act skilled nursing facility program. Such rules shall take into account the types of patients treated in hospital skilled nursing units, including typical patient acuity levels and the average length of stay in such units, and shall be limited to the appropriate portions of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (December 22, 1987), Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended. The agency shall require level 2 background screening as specified in s. 408.809(1)(e) pursuant to s. 408.809 and chapter 435 for personnel of distinct part nursing units.

Section 31. Section 395.10971, Florida Statutes, is repealed.

Section 32. Section 395.10972, Florida Statutes, is repealed.

Section 33. Section 395.10973, Florida Statutes, is amended to read:

395.10973 Powers and duties of the agency.—It is the function of the agency to:

(1) Adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part and part II of chapter 408 conferring duties upon it.

~~(2) Develop, impose, and enforce specific standards within the scope of the general qualifications established by this part which must be met by individuals in order to receive licenses as~~



286602

~~health care risk managers. These standards shall be designed to ensure that health care risk managers are individuals of good character and otherwise suitable and, by training or experience in the field of health care risk management, qualified in accordance with the provisions of this part to serve as health care risk managers, within statutory requirements.~~

~~(3) Develop a method for determining whether an individual meets the standards set forth in s. 395.10974.~~

~~(4) Issue licenses to qualified individuals meeting the standards set forth in s. 395.10974.~~

~~(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency to the effect that a certified health care risk manager has failed to comply with the requirements or standards adopted by rule by the agency or to comply with the provisions of this part.~~

~~(6) Establish procedures for providing periodic reports on persons certified or disciplined by the agency under this part.~~

~~(2)(7)~~ Develop a model risk management program for health care facilities which will satisfy the requirements of s. 395.0197.

~~(3)(8)~~ Enforce the special-occupancy provisions of the Florida Building Code which apply to hospitals, intermediate residential treatment facilities, and ambulatory surgical centers in conducting any inspection authorized by this chapter and part II of chapter 408.

Section 34. Section 395.10974, Florida Statutes, is repealed.

Section 35. Section 395.10975, Florida Statutes, is repealed.



286602

Section 36. Subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

~~(a) "Emergency care hospital" means a medical facility which provides:~~

~~1. Emergency medical treatment; and~~

~~2. Inpatient care to ill or injured persons prior to their transportation to another hospital or provides inpatient medical care to persons needing care for a period of up to 96 hours. The 96-hour limitation on inpatient care does not apply to respite, skilled nursing, hospice, or other nonacute care patients.~~

~~(b) "Essential access community hospital" means any facility which:~~

~~1. Has at least 100 beds;~~

~~2. Is located more than 35 miles from any other essential access community hospital, rural referral center, or urban hospital meeting criteria for classification as a regional referral center;~~

~~3. Is part of a network that includes rural primary care hospitals;~~

~~4. Provides emergency and medical backup services to rural primary care hospitals in its rural health network;~~

~~5. Extends staff privileges to rural primary care hospital physicians in its network; and~~

~~6. Accepts patients transferred from rural primary care hospitals in its network.~~

~~(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002(13), that is~~



286602

~~inactive in that it cannot be occupied by acute care inpatients.~~

(a) ~~(d)~~ "Rural area health education center" means an area health education center (AHEC), as authorized by Pub. L. No. 94-484, which provides services in a county with a population density of up to ~~no greater than~~ 100 persons per square mile.

(b) ~~(e)~~ "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 175 licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.



286602

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

~~(f) "Rural primary care hospital" means any facility meeting the criteria in paragraph (e) or s. 395.605 which provides:~~

~~1. Twenty-four-hour emergency medical care;~~
~~2. Temporary inpatient care for periods of 72 hours or less to patients requiring stabilization before discharge or transfer to another hospital. The 72-hour limitation does not apply to respite, skilled nursing, hospice, or other nonacute care patients; and~~

~~3. Has no more than six licensed acute care inpatient beds.~~

(c)(g) "Swing-bed" means a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42



286602

C.F.R. parts 405, 435, 440, 442, and 447.

Section 37. Section 395.603, Florida Statutes, is amended to read:

395.603 ~~Deactivation of general hospital beds;~~ Rural hospital impact statement.—

~~(1) The agency shall establish, by rule, a process by which a rural hospital, as defined in s. 395.602, that seeks licensure as a rural primary care hospital or as an emergency care hospital, or becomes a certified rural health clinic as defined in Pub. L. No. 95-210, or becomes a primary care program such as a county health department, community health center, or other similar outpatient program that provides preventive and curative services, may deactivate general hospital beds. Rural primary care hospitals and emergency care hospitals shall maintain the number of actively licensed general hospital beds necessary for the facility to be certified for Medicare reimbursement. Hospitals that discontinue inpatient care to become rural health care clinics or primary care programs shall deactivate all licensed general hospital beds. All hospitals, clinics, and programs with inactive beds shall provide 24-hour emergency medical care by staffing an emergency room. Providers with inactive beds shall be subject to the criteria in s. 395.1041. The agency shall specify in rule requirements for making 24-hour emergency care available. Inactive general hospital beds shall be included in the acute care bed inventory, maintained by the agency for certificate-of-need purposes, for 10 years from the date of deactivation of the beds. After 10 years have elapsed, inactive beds shall be excluded from the inventory. The agency shall, at the request of the licensee, reactivate the inactive~~



286602

~~general beds upon a showing by the licensee that licensure requirements for the inactive general beds are met.~~

~~(2)~~ In formulating and implementing policies and rules that may have significant impact on the ability of rural hospitals to continue to provide health care services in rural communities, the agency, the department, or the respective regulatory board adopting policies or rules regarding the licensure or certification of health care professionals shall provide a rural hospital impact statement. The rural hospital impact statement shall assess the proposed action in light of the following questions:

(1)~~(a)~~ Do the health personnel affected by the proposed action currently practice in rural hospitals or are they likely to in the near future?

(2)~~(b)~~ What are the current numbers of the affected health personnel in this state, their geographic distribution, and the number practicing in rural hospitals?

(3)~~(c)~~ What are the functions presently performed by the affected health personnel, and are such functions presently performed in rural hospitals?

(4)~~(d)~~ What impact will the proposed action have on the ability of rural hospitals to recruit the affected personnel to practice in their facilities?

(5)~~(e)~~ What impact will the proposed action have on the limited financial resources of rural hospitals through increased salaries and benefits necessary to recruit or retain such health personnel?

(6)~~(f)~~ Is there a less stringent requirement which could apply to practice in rural hospitals?



286602

(7)~~(g)~~ Will this action create staffing shortages, which could result in a loss to the public of health care services in rural hospitals or result in closure of any rural hospitals?

Section 38. Section 395.604, Florida Statutes, is repealed.

Section 39. Section 395.605, Florida Statutes, is repealed.

Section 40. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

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

(c) "Hospital" means a health care institution as defined in s. 395.002(12), but does not include any hospital operated by a state ~~the agency or the Department of Corrections.~~

Section 41. Paragraph (b) of subsection (2) of section 395.7015, Florida Statutes, is amended to read:

395.7015 Annual assessment on health care entities.—

(2) There is imposed an annual assessment against certain health care entities as described in this section:

(b) For the purpose of this section, "health care entities" include the following:

1. Ambulatory surgical centers ~~and mobile surgical facilities licensed under s. 395.003. This subsection shall only apply to mobile surgical facilities operating under contracts entered into on or after July 1, 1998.~~

2. ~~Clinical laboratories licensed under s. 483.091, excluding any hospital laboratory defined under s. 483.041(6), any clinical laboratory operated by the state or a political~~



286602

~~subdivision of the state, any clinical laboratory which
qualifies as an exempt organization under s. 501(c)(3) of the
Internal Revenue Code of 1986, as amended, and which receives 70
percent or more of its gross revenues from services to charity
patients or Medicaid patients, and any blood, plasma, or tissue
bank procuring, storing, or distributing blood, plasma, or
tissue either for future manufacture or research or distributed
on a nonprofit basis, and further excluding any clinical
laboratory which is wholly owned and operated by 6 or fewer
physicians who are licensed pursuant to chapter 458 or chapter
459 and who practice in the same group practice, and at which no
clinical laboratory work is performed for patients referred by
any health care provider who is not a member of the same group.~~

2.3. Diagnostic-imaging centers that are freestanding
outpatient facilities that provide specialized services for the
identification or determination of a disease through examination
and also provide sophisticated radiological services, and in
which services are rendered by a physician licensed by the Board
of Medicine under s. 458.311, s. 458.313, or s. 458.317, or by
an osteopathic physician licensed by the Board of Osteopathic
Medicine under s. 459.0055 or s. 459.0075. For purposes of this
paragraph, "sophisticated radiological services" means the
following: magnetic resonance imaging; nuclear medicine;
angiography; arteriography; computed tomography; positron
emission tomography; digital vascular imaging; bronchography;
lymphangiography; splenography; ultrasound, excluding ultrasound
providers that are part of a private physician's office practice
or when ultrasound is provided by two or more physicians
licensed under chapter 458 or chapter 459 who are members of the



286602

same professional association and who practice in the same medical specialties; and such other sophisticated radiological services, excluding mammography, as adopted in rule by the board.

Section 42. Subsection (1) of section 400.0625, Florida Statutes, is amended to read:

400.0625 Minimum standards for clinical laboratory test results and diagnostic X-ray results.—

(1) Each nursing home, as a requirement for issuance or renewal of its license, shall require that all clinical laboratory tests performed for the nursing home be performed by a ~~clinical~~ laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder ~~licensed under the provisions of chapter 483, except for such self-testing procedures as are approved by the agency by rule. Results of clinical laboratory tests performed prior to admission which meet the minimum standards provided in s. 483.181(3) shall be accepted in lieu of routine examinations required upon admission and clinical laboratory tests which may be ordered by a physician for residents of the nursing home.~~

Section 43. Subsection (1) and paragraphs (b), (e), and (f) of subsection (4) of section 400.464, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and entities licensed or



286602

registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in order to operate a home health agency in this state. A license issued on or after July 1, 2017, must specify the home health services the organization is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services that require licensure pursuant to this part without such services being specified on the face of the license issued on or after July 1, 2017, constitutes unlicensed activity as prohibited under s. 408.812.

(4)

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

(e) Any person who owns, operates, or maintains an unlicensed home health agency and who, ~~within 10 working days~~ after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a



286602

separate offense.

(f) Any home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812 ~~\$500 for each day of noncompliance.~~

(6) Any person, entity, or organization providing home health services which is exempt from licensure under subsection (5) may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that specifies its name or names and addresses, a statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant for a certificate of exemption \$100 or the actual cost of processing the certificate.

Section 44. Subsections (7) through (10) of section 400.471, Florida Statutes, are redesignated as subsections (6) through (9), respectively, and subsection (2) and present subsections (6) and (10) of that section are amended, to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care services must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided, either directly by the applicant or through contractual arrangements with existing providers.



286602

(b) The number and discipline of professional staff to be employed.

~~(c) Completion of questions concerning volume data on the renewal application as determined by rule.~~

(c)~~(d)~~ A business plan, signed by the applicant, which details the home health agency's methods to obtain patients and its plan to recruit and maintain staff.

(d)~~(e)~~ Evidence of contingency funding as required under s. 408.8065 ~~equal to 1 month's average operating expenses during the first year of operation.~~

(e)~~(f)~~ A balance sheet, income and expense statement, and statement of cash flows for the first 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant has demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. An applicant may not project an operating margin of 15 percent or greater for any month in the first year of operation. All documents required under this paragraph must be prepared in accordance with generally accepted accounting principles and compiled and signed by a certified public accountant.

(f)~~(g)~~ All other ownership interests in health care entities for each controlling interest, as defined in part II of chapter 408.

(g)~~(h)~~ In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an



286602

968 accrediting organization that is recognized by the agency as
969 having standards comparable to those required by this part and
970 part II of chapter 408. A home health agency that ~~is not~~
971 ~~Medicare or Medicaid certified and~~ does not provide skilled care
972 is exempt from this paragraph. Notwithstanding s. 408.806, an
973 initial applicant that has applied for accreditation must
974 provide proof of accreditation that is not conditional or
975 provisional and a survey demonstrating compliance with the
976 requirements of this part, part II of chapter 408, and
977 applicable rules from an accrediting organization that is
978 recognized by the agency as having standards comparable to those
979 required by this part and part II of chapter 408 within 120 days
980 after the date of the agency's receipt of the application for
981 licensure ~~or the application shall be withdrawn from further~~
982 ~~consideration~~. Such accreditation must be continuously
983 maintained by the home health agency to maintain licensure. The
984 agency shall accept, in lieu of its own periodic licensure
985 survey, the submission of the survey of an accrediting
986 organization that is recognized by the agency if the
987 accreditation of the licensed home health agency is not
988 provisional and if the licensed home health agency authorizes
989 releases of, and the agency receives the report of, the
990 accrediting organization.

991 ~~(6) The agency may not issue a license designated as~~
992 ~~certified to a home health agency that fails to satisfy the~~
993 ~~requirements of a Medicare certification survey from the agency.~~

994 (9) ~~(10)~~ The agency may not issue a renewal license for a
995 home health agency in any county having at least one licensed
996 home health agency and that has more than one home health agency



286602

per 5,000 persons, as indicated by the most recent population estimates published by the Legislature's Office of Economic and Demographic Research, if the applicant or any controlling interest has been administratively sanctioned by the agency during the 2 years prior to the submission of the licensure renewal application for one or more of the following acts:

(a) An intentional or negligent act that materially affects the health or safety of a client of the provider;

(b) Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the unlicensed facility or home to the agency within 72 hours after providing the services;

(c) Preparing or maintaining fraudulent patient records, such as, but not limited to, charting ahead, recording vital signs or symptoms which were not personally obtained or observed by the home health agency's staff at the time indicated, borrowing patients or patient records from other home health agencies to pass a survey or inspection, or falsifying signatures;

(d) Failing to provide at least one service directly to a patient for a period of 60 days;

(e) Demonstrating a pattern of falsifying documents relating to the training of home health aides or certified nursing assistants or demonstrating a pattern of falsifying health statements for staff who provide direct care to patients. A pattern may be demonstrated by a showing of at least three fraudulent entries or documents;

(f) Demonstrating a pattern of billing any payor for



286602

services not provided. A pattern may be demonstrated by a showing of at least three billings for services not provided within a 12-month period;

(g) Demonstrating a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, ~~except unless a reduction in service is mandated by Medicare, Medicaid, or a state program~~ or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidents, regardless of the patient or service, in which the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period;

(h) Giving remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395, chapter 429, or this chapter from whom the home health agency receives referrals or gives remuneration as prohibited in s. 400.474(6)(a);

(i) Giving cash, or its equivalent, to a Medicare or Medicaid beneficiary;

(j) Demonstrating a pattern of billing the Medicaid program for services to Medicaid recipients which are medically unnecessary as determined by a final order. A pattern may be demonstrated by a showing of at least two such medically unnecessary services within one Medicaid program integrity audit period;

(k) Providing services to residents in an assisted living facility for which the home health agency does not receive fair



286602

market value remuneration; or

(1) Providing staffing to an assisted living facility for which the home health agency does not receive fair market value remuneration.

Section 45. Subsection (5) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.—

(5) The agency shall impose a fine of \$5,000 against a home health agency that demonstrates a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the patient's legal representative, or the plan of care for that patient, except ~~unless a reduction in service is mandated by Medicare, Medicaid, or a state program~~ or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period. The agency shall impose the fine for each occurrence. The agency may also impose additional administrative fines under s. 400.484 for the direct or indirect harm to a patient, or deny, revoke, or suspend the license of the home health agency for a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the plan of care for that patient.

Section 46. Paragraph (c) of subsection (2) of section 400.476, Florida Statutes, is amended to read:

400.476 Staffing requirements; notifications; limitations on staffing services.—

(2) DIRECTOR OF NURSING.—



286602

(c) A home health agency that provides skilled nursing care ~~must is not Medicare or Medicaid certified and does not provide skilled care or provides only physical, occupational, or speech therapy is not required to have a director of nursing and is exempt from paragraph (b).~~

Section 47. Section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection; violations ~~deficiencies~~; fines.—

(1) In addition to the requirements of s. 408.811, the agency may make such inspections and investigations as are necessary in order to determine the state of compliance with this part, part II of chapter 408, and applicable rules.

(2) The agency shall impose fines for various classes of violations ~~deficiencies~~ in accordance with the following schedule:

(a) Class I violations are defined in s. 408.813 ~~A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury.~~ Upon finding a class I violation ~~deficiency~~, the agency shall impose an administrative fine in the amount of \$15,000 for each occurrence and each day that the violation ~~deficiency~~ exists.

(b) Class II violations are defined in s. 408.813 ~~A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient.~~ Upon finding a class II violation ~~deficiency~~, the agency shall impose an administrative fine in the amount of



286602

\$5,000 for each occurrence and each day that the violation
~~deficiency~~ exists.

(c) Class III violations are defined in s. 408.813 ~~A class~~
~~III deficiency is any act, omission, or practice that has an~~
~~indirect, adverse effect on the health, safety, or security of a~~
~~patient.~~ Upon finding an uncorrected or repeated class III
violation ~~deficiency~~, the agency shall impose an administrative
fine not to exceed \$1,000 for each occurrence and each day that
the uncorrected or repeated violation ~~deficiency~~ exists.

(d) Class IV violations are defined in s. 408.813 ~~A class~~
~~IV deficiency is any act, omission, or practice related to~~
~~required reports, forms, or documents which does not have the~~
~~potential of negatively affecting patients.~~ These violations are
of a type that the agency determines do not threaten the health,
safety, or security of patients. Upon finding an uncorrected or
repeated class IV violation ~~deficiency~~, the agency shall impose
an administrative fine not to exceed \$500 for each occurrence
and each day that the uncorrected or repeated violation
~~deficiency~~ exists.

(3) In addition to any other penalties imposed pursuant to
this section or part, the agency may assess costs related to an
investigation that results in a successful prosecution,
excluding costs associated with an attorney's time.

Section 48. Subsection (4) of section 400.497, Florida
Statutes, is amended to read:

400.497 Rules establishing minimum standards.—The agency
shall adopt, publish, and enforce rules to implement part II of
chapter 408 and this part, including, as applicable, ss. 400.506
and 400.509, which must provide reasonable and fair minimum



286602

standards relating to:

(4) Licensure application and renewal and certificates of exemption.

Section 49. Subsection (5) and paragraph (a) of subsection (15) of section 400.506, Florida Statutes, are amended to read:
400.506 Licensure of nurse registries; requirements; penalties.—

(5) (a) In addition to the requirements of s. 408.812, any person who owns, operates, or maintains an unlicensed nurse registry and who, ~~within 10 working days~~ after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(b) If a nurse registry fails to cease operation after agency notification, the agency may impose a fine in accordance with s. 408.812 ~~of \$500 for each day of noncompliance.~~

(15) (a) The agency may deny, suspend, or revoke the license of a nurse registry and shall impose a fine of \$5,000 against a nurse registry that:

1. Provides services to residents in an assisted living facility for which the nurse registry does not receive fair market value remuneration.

2. Provides staffing to an assisted living facility for which the nurse registry does not receive fair market value remuneration.

3. Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were executed within the last 5 years.



286602

~~4. Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or this chapter and from whom the nurse registry receives referrals. A nurse registry is exempt from this subparagraph if it does not bill the Florida Medicaid program or the Medicare program or share a controlling interest with any entity licensed, registered, or certified under part II of chapter 408 that bills the Florida Medicaid program or the Medicare program.~~

~~5. Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff. A nurse registry is exempt from this subparagraph if it does not bill the Florida Medicaid program or the Medicare program or share a controlling interest with any entity licensed, registered, or certified under part II of chapter 408 that bills the Florida Medicaid program or the Medicare program.~~

Section 50. Subsection (1) of section 400.606, Florida Statutes, is amended to read:

400.606 License; application; renewal; conditional license or permit; certificate of need.—

(1) In addition to the requirements of part II of chapter 408, the initial application and change of ownership application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:



286602

(a) The estimated average number of terminally ill persons to be served monthly.

(b) The geographic area in which hospice services will be available.

(c) A listing of services which are or will be provided, either directly by the applicant or through contractual arrangements with existing providers.

(d) Provisions for the implementation of hospice home care within 3 months after licensure.

(e) Provisions for the implementation of hospice homelike inpatient care within 12 months after licensure.

(f) The number and disciplines of professional staff to be employed.

(g) The name and qualifications of any existing or potential contractee.

(h) A plan for attracting and training volunteers.

~~If the applicant is an existing licensed health care provider, the application must be accompanied by a copy of the most recent profit-loss statement and, if applicable, the most recent licensure inspection report.~~

Section 51. Subsection (6) of section 400.925, Florida Statutes, is amended to read:

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

(6) "Home medical equipment" includes any product as defined by the Federal Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits, or any products reimbursed under the Florida Medicaid durable medical equipment program.



286602

Home medical equipment includes:

(a) Oxygen and related respiratory equipment; ~~manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner;~~

(b) Motorized scooters;

(c) Personal transfer systems; and

(d) Specialty beds, for use by a person with a medical need; and

(e) Manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner.

Section 52. Subsection (4) of section 400.931, Florida Statutes, is amended to read:

400.931 Application for license; fee.—

(4) When a change of the general manager of a home medical equipment provider occurs, the licensee must notify the agency of the change within the timeframes established in part II of chapter 408 and applicable rules ~~45 days~~.

Section 53. Subsection (2) of section 400.933, Florida Statutes, is amended to read:

400.933 Licensure inspections and investigations.—

(2) The agency shall accept, in lieu of its own periodic inspections for licensure, submission of the following:

(a) The survey or inspection of an accrediting organization, provided the accreditation of the licensed home medical equipment provider is not provisional and provided the



286602

licensed home medical equipment provider authorizes release of,
and the agency receives the report of, the accrediting
organization; or

(b) A copy of a valid medical oxygen retail establishment
permit issued by the Department of Business and Professional
Regulation Health, pursuant to chapter 499.

Section 54. Subsection (2) of section 400.980, Florida
Statutes, is amended to read:

400.980 Health care services pools.—

(2) The requirements of part II of chapter 408 apply to the
provision of services that require licensure or registration
pursuant to this part and part II of chapter 408 and to entities
registered by or applying for such registration from the agency
pursuant to this part. Registration or a license issued by the
agency is required for the operation of a health care services
pool in this state. In accordance with s. 408.805, an applicant
or licensee shall pay a fee for each license application
submitted using this part, part II of chapter 408, and
applicable rules. The agency shall adopt rules and provide forms
required for such registration and shall impose a registration
fee in an amount sufficient to cover the cost of administering
this part and part II of chapter 408. In addition to the
requirements in part II of chapter 408, the registrant must
provide the agency with any change of information contained on
the original registration application within the timeframes
established in this part, part II of chapter 408, and applicable
rules ~~14 days prior to the change.~~

Section 55. Paragraphs (a) through (d) of subsection (4) of
section 400.9905, Florida Statutes, are amended to read:



286602

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332 ~~383.335~~, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483~~, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332 ~~383.335~~, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483~~, chapter 484, or chapter 651; end-stage



286602

renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332 ~~383.335~~, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483~~, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332 ~~383.335~~, chapter 390, chapter 394, chapter 397, this chapter except part X,



286602

chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483~~, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 56. Subsection (6) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(6) Any person or entity providing health care services which is not a clinic, as defined under s. 400.9905, may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that sets forth its name or names and addresses, a statement of the reasons why it cannot be defined as a clinic, and other information deemed necessary by the agency. An exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant for a certificate of exemption in an amount equal to \$100 or the actual cost of processing the certificate, whichever is less. An entity seeking a certificate of exemption must publish and maintain a schedule of charges for the medical services offered



286602

to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the entity and must include, but is not limited to, the 50 services most frequently provided by the entity. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. As a condition precedent to receiving a certificate of exemption, an applicant must provide to the agency documentation of compliance with these requirements.

Section 57. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birthing centers, ~~clinical laboratories except community nonprofit blood banks and clinical laboratories operated by practitioners for exclusive use regulated under s. 483.035,~~ home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be



286602

collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 58. Paragraphs (e) and (p) of subsection (3) of section 408.036, Florida Statutes, are amended to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):

~~(e) For mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.~~

~~(p)~~ For replacement of a licensed nursing home on the same site, or within 5 miles of the same site if within the same subdistrict, if the number of licensed beds does not increase except as permitted under paragraph (e) ~~(f)~~.

Section 59. Subsection (4) of section 408.061, Florida Statutes, is amended to read:

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

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, hospitals operated by state agencies, and nursing homes as defined in s. 408.07(13) and (36) ~~s. 408.07(14) and (37)~~, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be



286602

complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

Section 60. Subsection (11) of section 408.07, Florida Statutes, is amended to read:

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

~~(11) "Clinical laboratory" means a facility licensed under s. 483.091, excluding: any hospital laboratory defined under s. 483.041(6); any clinical laboratory operated by the state or a political subdivision of the state; any blood or tissue bank where the majority of revenues are received from the sale of blood or tissue and where blood, plasma, or tissue is procured from volunteer donors and donated, processed, stored, or distributed on a nonprofit basis; and any clinical laboratory which is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of that same group practice.~~

Section 61. Subsection (4) of section 408.20, Florida Statutes, is amended to read:



286602

408.20 Assessments; Health Care Trust Fund.—

(4) Hospitals operated by a state agency ~~the Department of Children and Families, the Department of Health, or the Department of Corrections~~ are exempt from the assessments required under this section.

Section 62. Section 408.7056, Florida Statutes, is repealed.

Section 63. Subsections (10), (11), and (27) of section 408.802, Florida Statutes, are amended to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

~~(10) Mobile surgical facilities, as provided under part I of chapter 395.~~

~~(11) Health care risk managers, as provided under part I of chapter 395.~~

~~(27) Clinical laboratories, as provided under part I of chapter 483.~~

Section 64. Subsections (12) and (13) of section 408.803, Florida Statutes, are renumbered as subsections (13) and (14), respectively, and a new subsection (12) is added to that section, to read:

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

(12) "Relative" means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew,



286602

niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister of a patient or client.

Section 65. Paragraph (c) of subsection (7) of section 408.806, Florida Statutes, is amended, and subsection (9) is added to that section, to read:

408.806 License application process.—

(7)

(c) If an inspection is required by the authorizing statute for a license application other than an initial application, the inspection must be unannounced. This paragraph does not apply to inspections required pursuant to ss. 383.324, 395.0161(4) and 429.67(6), ~~and 483.061(2).~~

(9) A licensee that holds a license for multiple providers licensed by the agency may request that all related license expiration dates be aligned. Upon such request, the agency may issue a license for an abbreviated licensure period with a prorated licensure fee.

Section 66. Paragraphs (d) and (e) of subsection (1) of section 408.809, Florida Statutes, are amended to read:

408.809 Background screening; prohibited offenses.—

(1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435:

~~(d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest~~



286602

~~who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application.~~

(e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or contracting with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee.

Section 67. Subsection (8) of section 408.810, Florida Statutes, is amended, and subsections (11), (12), and (13) are added to that section, to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(8) Upon application for initial licensure or change of ownership licensure, the applicant shall furnish satisfactory proof of the applicant's financial ability to operate in accordance with the requirements of this part, authorizing statutes, and applicable rules. The agency shall establish



286602

standards for this purpose, including information concerning the applicant's controlling interests. The agency shall also establish documentation requirements, to be completed by each applicant, that show anticipated provider revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the provider, and an applicant's access to contingency financing. A current certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability to operate. The agency may require a licensee to provide proof of financial ability to operate at any time if there is evidence of financial instability, including, but not limited to, unpaid expenses necessary for the basic operations of the provider. An applicant applying for change of ownership licensure is exempt from furnishing proof of financial ability to operate if the provider has been licensed for at least 5 years, and:

(a) The ownership change is a result of a corporate reorganization under which the controlling interest is unchanged and the applicant submits organizational charts that represent the current and proposed structure of the reorganized corporation; or

(b) The ownership change is due solely to the death of a person holding a controlling interest, and the surviving controlling interests continue to hold at least 51 percent of ownership after the change of ownership.

(11) The agency may adopt rules that govern the circumstances under which a controlling interest, an administrator, an employee, or a contractor, or a representative thereof, who is not a relative of the client may act as an agent



286602

of a client in authorizing consent for medical treatment,
assignment or benefits, and release of information. Such rules
may include requirements related to disclosure, bonding,
restrictions, and client protections.

(12) The licensee shall ensure that no person holds any
ownership interest, either directly or indirectly, regardless of
ownership structure, who:

(a) Has a disqualifying offense pursuant to s. 408.809; or

(b) Holds or has held any ownership interest, either
directly or indirectly, regardless of ownership structure, in a
provider that had a license revoked or an application denied
pursuant to s. 408.815.

(13) If the licensee is a publicly traded corporation or is
wholly owned, directly or indirectly, by a publicly traded
corporation, subsection (12) does not apply to those persons
whose sole relationship with the corporation is as a shareholder
of publicly traded shares. As used in this subsection, a
publicly traded corporation is a corporation that issues
securities traded on an exchange registered with the United
States Securities and Exchange Commission as a national
securities exchange.

Section 68. Section 408.812, Florida Statutes, is amended
to read:

408.812 Unlicensed activity.—

(1) A person or entity may not offer or advertise services
that require licensure as defined by this part, authorizing
statutes, or applicable rules to the public without obtaining a
valid license from the agency. A licenseholder may not advertise
or hold out to the public that he or she holds a license for



286602

other than that for which he or she actually holds the license.

(2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients, and constitutes abuse and neglect, as defined in s. 415.102. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If, after receiving notification from the agency, such person or entity fails to cease operation ~~and apply for a license under this part and authorizing statutes,~~ the person or entity is ~~shall be~~ subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of ~~continued~~ operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined \$1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke



286602

all licenses, ~~and~~ impose actions under s. 408.814, and
regardless of correction, impose a fine of \$1,000 per day,
unless otherwise specified by authorizing statutes, against each
licensee until such time as the appropriate license is obtained
or the unlicensed activity ceases ~~for the unlicensed operation.~~

(6) In addition to granting injunctive relief pursuant to
subsection (2), if the agency determines that a person or entity
is operating or maintaining a provider without obtaining a
license and determines that a condition exists that poses a
threat to the health, safety, or welfare of a client of the
provider, the person or entity is subject to the same actions
and fines imposed against a licensee as specified in this part,
authorizing statutes, and agency rules.

(7) Any person aware of the operation of an unlicensed
provider must report that provider to the agency.

Section 69. Subsections (10), (11) and (26) of section
408.820, Florida Statutes, are amended, and subsections (12)
through (25) and (27) and (28) are redesignated as subsections
(10) through (23) and (24) and (25), respectively, to read:

408.820 Exemptions.—Except as prescribed in authorizing
statutes, the following exemptions shall apply to specified
requirements of this part:

~~(10) Mobile surgical facilities, as provided under part I
of chapter 395, are exempt from s. 408.810(7)–(10).~~

~~(11) Health care risk managers, as provided under part I of
chapter 395, are exempt from ss. 408.806(7), 408.810(4)–(10),
and 408.811.~~

~~(26) Clinical laboratories, as provided under part I of
chapter 483, are exempt from s. 408.810(5)–(10).~~



286602

Section 70. Subsection (7) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory that meets the requirements for Medicare participation and is appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder ~~licensed under chapter 483, if required.~~

Section 71. Subsection (10) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make



286602

payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(10) The agency may consider whether the provider, or any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder having an ownership interest equal to 5 percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has:

(a) Made a false representation or omission of any material fact in making the application, including the submission of an application that conceals the controlling or ownership interest of any officer, director, agent, managing employee, affiliated person, or partner or shareholder who may not be eligible to participate;

(b) Been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in, Florida's Medicaid program or any other state's Medicaid program, or from participation in any other governmental or private health care or health insurance program;

~~(c) Been convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance~~



286602

~~program including the performance of management or
administrative services relating to the delivery of goods or
services under any such program;~~

~~(d) Been convicted under federal or state law of a criminal
offense related to the neglect or abuse of a patient in
connection with the delivery of any health care goods or
services;~~

~~(e) Been convicted under federal or state law of a criminal
offense relating to the unlawful manufacture, distribution,
prescription, or dispensing of a controlled substance;~~

~~(f) Been convicted of any criminal offense relating to
fraud, theft, embezzlement, breach of fiduciary responsibility,
or other financial misconduct;~~

~~(g) Been convicted under federal or state law of a crime
punishable by imprisonment of a year or more which involves
moral turpitude;~~

~~(h) Been convicted in connection with the interference or
obstruction of any investigation into any criminal offense
listed in this subsection;~~

~~(i) Been found to have violated federal or state laws,
rules, or regulations governing Florida's Medicaid program or
any other state's Medicaid program, the Medicare program, or any
other publicly funded federal or state health care or health
insurance program, and been sanctioned accordingly;~~

~~(c)-(j)~~ Been previously found by a licensing, certifying, or
professional standards board or agency to have violated the
standards or conditions relating to licensure or certification
or the quality of services provided; or

(d)-(k) Failed to pay any fine or overpayment properly



286602

assessed under the Medicaid program in which no appeal is pending or after resolution of the proceeding by stipulation or agreement, unless the agency has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

Section 72. Subsection (6) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.—In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(6) This section applies only to hospitals that were defined as statutory rural hospitals, or their successor-in-interest hospital, prior to January 1, 2001. Any additional hospital that is defined as a statutory rural hospital, or its successor-in-interest hospital, on or after January 1, 2001, is



286602

not eligible for programs under this section unless additional funds are appropriated each fiscal year specifically to the rural hospital disproportionate share and financial assistance programs in an amount necessary to prevent any hospital, or its successor-in-interest hospital, eligible for the programs prior to January 1, 2001, from incurring a reduction in payments because of the eligibility of an additional hospital to participate in the programs. A hospital, or its successor-in-interest hospital, which received funds pursuant to this section before January 1, 2001, and which qualifies under s.

395.602(2)(b) ~~s. 395.602(2)(c)~~, shall be included in the programs under this section and is not required to seek additional appropriations under this subsection.

Section 73. Paragraphs (a) and (b) of subsection (1) of section 409.975, Florida Statutes, are amended to read:

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

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

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential



286602

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

1. Federally qualified health centers.
2. Statutory teaching hospitals as defined in s. 408.07(44) ~~s. 408.07(45)~~.
3. Hospitals that are trauma centers as defined in s. 395.4001(14).
4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After



286602

1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.
2. Regional perinatal intensive care centers as defined in s. 383.16(2).
3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(27) ~~s. 395.002(28)~~.
4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.



286602

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 74. Subsections (5) and (17) of section 429.02, Florida Statutes, are amended to read:

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

(5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, regardless of whether operated for profit or not, which, undertakes through its ownership or management, provides to ~~provide~~ 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.

(17) "Personal services" means direct physical assistance with or supervision of the activities of daily living, and the self-administration of medication, or and other similar services which the department may define by rule. The term may ~~"Personal services"~~ shall not be construed to mean the provision of



286602

medical, nursing, dental, or mental health services.

Section 75. Paragraphs (b) and (d) of subsection (2) of section 429.04, Florida Statutes, are amended, and subsection (3) is added that section, to read:

429.04 Facilities to be licensed; exemptions.—

(2) The following are exempt from licensure under this part:

(b) Any facility or part of a facility licensed by the Agency for Persons with Disabilities under chapter 393, a mental health facility licensed under ~~or~~ chapter 394, a hospital licensed under chapter 395, a nursing home licensed under part II of chapter 400, an inpatient hospice licensed under part IV of chapter 400, a home for special services licensed under part V of chapter 400, an intermediate care facility licensed under part VIII of chapter 400, or a transitional living facility licensed under part XI of chapter 400.

(d) Any person who provides housing, meals, and one or more personal services on a 24-hour basis in the person's own home to not more than two adults who do not receive optional state supplementation. The person who provides the housing, meals, and personal services must own or rent the home and must have established the home as his or her permanent residence. For purposes of this paragraph, any person holding a homestead exemption at an address other than that at which the person asserts this exemption is presumed to not have established permanent residence ~~reside therein~~. This exemption does not apply to a person or entity that previously held a license issued by the agency which was revoked or for which renewal was denied by final order of the agency, or when the person or



286602

entity voluntarily relinquished the license during agency enforcement proceedings.

(3) Upon agency investigation of unlicensed activity, any person or entity that claims that it is exempt under this section must provide documentation substantiating entitlement to the exemption.

Section 76. Paragraphs (b) and (d) of subsection (1) of section 429.08, Florida Statutes, are amended to read:

429.08 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties.—

(1)

(b) ~~Except as provided under paragraph (d),~~ Any person who owns, rents, or otherwise maintains a building or property that operates, or maintains an unlicensed assisted living facility commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(d) In addition to the requirements of s. 408.812, any person who owns, operates, or maintains an unlicensed assisted living facility after receiving notice from the agency ~~due to a change in this part or a modification in rule within 6 months after the effective date of such change and who, within 10 working days after receiving notification from the agency, fails to cease operation or apply for a license under this part~~ commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

Section 77. Subsection(7) of section 429.19, Florida Statutes, is amended to read:



286602

429.19 Violations; imposition of administrative fines;
grounds.—

(7) In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or \$500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted ~~under s. 429.28(3)(c)~~ to verify the correction of the violations.

Section 78. 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 has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 79. Subsection (2) of section 429.24, Florida Statutes, is amended to read:

429.24 Contracts.—

(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and obligations of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation amended to, or



286602

implemented in, a resident's contract for which the resident was not previously charged, does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period:

(a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident.

(b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.

Section 80. Paragraph (b) of subsection (3) of section 429.256, Florida Statutes, is amended to read:

429.256 Assistance with self-administration of medication.—

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

(b) In the presence of the resident, reading aloud the name, medication, and dosage indicated on the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.



286602

Section 81. Paragraphs (e) and (j) of subsection (1) and paragraphs (c), (d), and (e) of 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:

(e) Freedom to participate in and benefit from community services and activities and to pursue ~~achieve~~ the highest possible level of independence, autonomy, and interaction within the community.

(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making appointments for health care services, the provision of or arrangement of transportation to health care appointments, and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.

(3)

~~(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.~~

~~(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history~~



286602

~~of any class I, class II, or class III violations that threaten the health, safety, or security of residents.~~

~~(c) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.~~

Section 82. Subsection (1) of section 429.294, Florida Statutes, is amended to read:

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility ~~within 10 days~~, in accordance with the provisions of s. 400.145, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

Section 83. Subsection (2) of section 429.34, Florida Statutes, is amended to read:

429.34 Right of entry and inspection.—

(2)(a) In addition to the requirements of s. 408.811, the agency may inspect and investigate facilities as necessary to determine compliance with this part, part II of chapter 408, and rules adopted thereunder. ~~The agency shall inspect each licensed assisted living facility at least once every 24 months to determine compliance with this chapter and related rules.~~ If an assisted living facility is cited for a class I violation or three or more class II violations arising from separate surveys



286602

within a 60-day period or due to unrelated circumstances during the same survey, the agency must conduct an additional licensure inspection within 6 months.

(b) During any calendar year in which a survey is not conducted, the agency may conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.

Section 84. Subsection (4) of section 429.52, Florida Statutes, is amended to read:

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

(4) Effective January 1, 2004, a new facility administrator must complete the required training and education, including the competency test, within 90 days of the date of employment ~~a reasonable time after being employed as an administrator, as determined by the department.~~ 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.

Section 85. Subsection (3) of section 435.04, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

435.04 Level 2 screening standards.—

(3) The security background investigations under this section must ensure that no person subject to this section has been arrested for and is awaiting final disposition of, been



286602

found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

(4) For the purpose of screening applicability to participate in the Medicaid program, the security background investigations under this section must ensure that a person subject to screening under this section has not been arrested for and is not awaiting final disposition of; has not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to; and has not been adjudicated delinquent and the record sealed or expunged for, any of the following offenses:

(a) Federal law or a law in any state which creates a criminal offense relating to:

1. The delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program, including the performance of management or administrative services relating to the delivery of goods or services under any such program;

2. Neglect or abuse of a patient in connection with the delivery of any health care good or service;

3. Unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

4. Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

5. Moral turpitude, if punishable by imprisonment of a year or more;

6. Section 817.569, criminal use of a public record or



286602

information contained in a public record;

7. Section 838.016, unlawful compensation or reward for
official behavior;

8. Section 838.021, corruption by threat against a public
servant;

9. Section 838.022, official misconduct;

10. Section 838.22, bid tampering;

11. Section 839.13, falsifying records;

12. Section 839.26, misuse of confidential information; or

13. Interfering with or obstructing an investigation into
any criminal offense identified in this subsection.

(b) Violation of a federal or state law, rule, or
regulation governing the Florida Medicaid program or any other
state Medicaid program, the Medicare program, or any other
publicly funded federal or state health care or health insurance
program, and has been sanctioned accordingly.

Section 86. Paragraph (a) of subsection (2) of section
435.12, Florida Statutes, is amended to read:

435.12 Care Provider Background Screening Clearinghouse.—

(2) (a) To ensure that the information in the clearinghouse
is current, the fingerprints of an employee required to be
screened by a specified agency and included in the clearinghouse
must be:

1. Retained by the Department of Law Enforcement pursuant
to s. 943.05(2)(g) and (h) and (3), and the Department of Law
Enforcement must report the results of searching those
fingerprints against state incoming arrest fingerprint
submissions to the Agency for Health Care Administration for
inclusion in the clearinghouse.



286602

2. Retained by the Federal Bureau of Investigation in the national retained print arrest notification program as soon as the Department of Law Enforcement begins participation in such program. Arrest prints will be searched against retained prints at the Federal Bureau of Investigation and notification of arrests will be forwarded to the Florida Department of Law Enforcement and reported to the Agency for Health Care Administration for inclusion in the clearinghouse.

3. Resubmitted for a Federal Bureau of Investigation national criminal history check every 5 years until such time as the fingerprints are retained by the Federal Bureau of Investigation.

4. Subject to retention on a 5-year renewal basis with fees collected at the time of initial submission or resubmission of fingerprints.

a. A person who passed a level 2 screening under s. 435.04 after December 31, 2012, by a specified agency may extend the screening renewal period until January 1, 2020, unless the Department of Law Enforcement begins participation in the national retained print arrest notification program before that date.

b. The retention of fingerprints by the Department of Law Enforcement pursuant to s. 943.05(2)(g) and (h) and (3) is extended until the earlier of January 1, 2020, or the date that the Department of Law Enforcement begins participation in the national retained print arrest notification program.

5. Submitted with a photograph of the person taken at the time the fingerprints are submitted.

Section 87. Subsection (4) of section 456.001, Florida



286602

Statutes, is amended to read:

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

(4) "Health care practitioner" means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III ~~or part IV~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 88. Paragraph (i) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(i) Medical physicists licensed under part III ~~IV~~ of chapter 483.

Section 89. Subsection (2) of section 458.307, Florida Statutes, is amended to read:

458.307 Board of Medicine.—

(2) Twelve members of the board must be licensed physicians in good standing in this state who are residents of the state and who have been engaged in the active practice or teaching of



286602

medicine for at least 4 years immediately preceding their appointment. One of the physicians must be on the full-time faculty of a medical school in this state, and one of the physicians must be in private practice and on the full-time staff of a statutory teaching hospital in this state as defined in s. 408.07. At least one of the physicians must be a graduate of a foreign medical school. The remaining three members must be residents of the state who are not, and never have been, licensed health care practitioners. One member must be a health care risk manager ~~licensed under s. 395.10974~~. At least one member of the board must be 60 years of age or older.

Section 90. Subsection (1) of section 458.345, Florida Statutes, is amended to read:

458.345 Registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.—

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(44) ~~s. 408.07(45)~~ or s. 395.805(2), who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed \$300 as set by the board. The department shall register any applicant the board certifies has met the following requirements:



286602

(a) Is at least 21 years of age.

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to certify an application for licensure pursuant to s. 458.331.

(c) Is a graduate of a medical school or college as specified in s. 458.311(1)(f).

Section 91. Subsection (1) of s. 459.021, Florida Statutes, is amended to read:

459.021 Registration of resident physicians, interns, and fellows; list of hospital employees; penalty.—

(1) Any person who holds a degree of Doctor of Osteopathic Medicine from a college of osteopathic medicine recognized and approved by the American Osteopathic Association who desires to practice as a resident physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(44) ~~s. 408.07(45)~~ or s. 395.805(2), who does not hold an active license issued under this chapter shall apply to the department to be registered, on an application provided by the department, before commencing such a training program and shall remit a fee not to exceed \$300 as set by the board.

Section 92. Part I of chapter 483, Florida Statutes, consisting of sections 483.011, 483.021, 483.031, 483.035, 483.041, 483.051, 483.061, 483.091, 483.101, 483.111, 483.172, 483.181, 483.191, 483.201, 483.221, 483.23, 483.245, and 483.26, is repealed.

Section 93. Section 483.294, Florida Statutes, is amended



286602

to read:

483.294 Inspection of centers.—In accordance with s. 408.811, the agency shall, ~~at least once annually,~~ inspect the premises and operations of all centers subject to licensure under this part.

Section 94. Subsections (3) and (5) of section 483.801, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

483.801 Exemptions.—This part applies to all clinical laboratories and clinical laboratory personnel within this state, except:

(3) Persons engaged in testing performed by laboratories that are wholly owned and operated by one or more practitioners licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, or chapter 466 who practice in the same group practice, and in which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of that group practice ~~regulated under s. 483.035(1) or exempt from regulation under s. 483.031(2).~~

(5) Advanced registered nurse practitioners licensed under part I of chapter 464 who perform provider-performed microscopy procedures (PPMP) in a ~~an exclusive-use~~ laboratory setting pursuant to subsection (3).

(6) Persons performing laboratory testing within a physician office practice for patients referred by a health care provider who is a member of the same physician office practice, if the laboratory or entity operating the laboratory within a physician office practice is under common ownership, directly or



286602

indirectly, with an entity licensed pursuant to chapter 395.

Section 95. Subsections (2), (3), and (4) of section 483.803, Florida Statutes, are amended to read:

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

(2) "Clinical laboratory" means the physical location in which one or more of the following services are performed to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition:

(a) Clinical laboratory services, which entail the examination of fluids or other materials taken from the human body.

(b) Anatomic laboratory services, which entail the examination of tissue taken from the human body.

(c) Cytology laboratory services, which entail the examination of cells from individual tissues or fluid taken from the human body ~~a clinical laboratory as defined in s. 483.041.~~

(3) "Clinical laboratory examination" means a procedure performed to deliver the services identified in subsection (2), including the oversight or interpretation of such services ~~clinical laboratory examination as defined in s. 483.041.~~

(4) "Clinical laboratory personnel" includes a clinical laboratory director, supervisor, technologist, blood gas analyst, or technician who performs or is responsible for laboratory test procedures, but the term does not include trainees, persons who perform screening for blood banks or plasmapheresis centers, phlebotomists, or persons employed by a clinical laboratory to perform manual pretesting duties or clerical, personnel, or other administrative responsibilities,



286602

~~or persons engaged in testing performed by laboratories
regulated under s. 483.035(1) or exempt from regulation under s.
483.031(2).~~

Section 96. Section 483.813, Florida Statutes, is amended
to read:

483.813 Clinical laboratory personnel license.—A person may
not conduct a clinical laboratory examination or report the
results of such examination unless such person is licensed under
this part to perform such procedures. However, this provision
does not apply to any practitioner of the healing arts
authorized to practice in this state ~~or to persons engaged in
testing performed by laboratories regulated under s. 483.035(1)
or exempt from regulation under s. 483.031(2).~~ The department
may grant a temporary license to any candidate it deems properly
qualified, for a period not to exceed 1 year.

Section 97. Subsection (2) of section 483.823, Florida
Statutes, is amended to read:

483.823 Qualifications of clinical laboratory personnel.—

(2) Personnel qualifications may require appropriate
education, training, or experience or the passing of an
examination in appropriate subjects or any combination of these,
but a ~~no~~ practitioner of the healing arts licensed to practice
in this state is not required to obtain any license ~~under this
part~~ or to pay any fee under this part ~~hereunder except the fee
required for clinical laboratory licensure.~~

Section 98. Paragraph (c) of subsection (7), paragraph (c)
of subsection (8), and paragraph (c) of subsection (9) of
section 491.003, Florida Statutes, are amended to read:

491.003 Definitions.—As used in this chapter:



286602

(7) The "practice of clinical social work" is defined as the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering. The purpose of such services is the prevention and treatment of undesired behavior and enhancement of mental health. The practice of clinical social work includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of clinical social work includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of clinical social work also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of clinical social work may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.



286602

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with ~~any provision of~~ the rules of the board, may ~~shall~~ not be construed to permit the performance of any act which clinical social workers are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483,~~ or radiological procedures, or use of electroconvulsive therapy. In addition, this definition ~~shall~~ may not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

(8) The term "practice of marriage and family therapy" means ~~is defined as~~ the use of scientific and applied marriage and family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems, including the context of marital formation and dissolution, and is based on marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic and marriage and family therapy theories and techniques. The practice of marriage and family therapy includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders or



286602

dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of marriage and family therapy includes, but is not limited to, marriage and family therapy, psychotherapy, including behavioral family therapy, hypnotherapy, and sex therapy. The practice of marriage and family therapy also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of marriage and family therapy may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with ~~any provision of~~ the rules of the board, ~~may shall~~ not be construed to permit the performance of any act that ~~which~~ marriage and family therapists are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483,~~ or radiological procedures, or the use of electroconvulsive therapy. In addition, this definition ~~may shall~~ not be construed to permit any person



286602

licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

(9) The term "practice of mental health counseling" means ~~is defined as~~ the use of scientific and applied behavioral science theories, methods, and techniques for the purpose of describing, preventing, and treating undesired behavior and enhancing mental health and human development and is based on the person-in-situation perspectives derived from research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation. The practice of mental health counseling includes methods of a psychological nature used to evaluate, assess, diagnose, and treat emotional and mental dysfunctions or disorders, ~~(whether cognitive, affective, or behavioral),~~ ~~behavioral disorders,~~ interpersonal relationships, sexual dysfunction, alcoholism, and substance abuse. The practice of mental health counseling includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of mental health counseling also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), behavioral disorders,



286602

sexual dysfunction, alcoholism, or substance abuse. The practice of mental health counseling may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, may ~~shall~~ not be construed to permit the performance of any act that ~~which~~ mental health counselors are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483,~~ or radiological procedures, or the use of electroconvulsive therapy. In addition, this definition may ~~shall~~ not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

Section 99. Paragraph (h) of subsection (4) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.—

(h) As used in this subsection:

1. "Health care provider" means hospitals licensed under chapter 395; physicians licensed under chapter 458; osteopathic physicians licensed under chapter 459; podiatric physicians licensed under chapter 461; dentists licensed under chapter 466;



286602

chiropractic physicians licensed under chapter 460; naturopaths licensed under chapter 462; nurses licensed under part I of chapter 464; midwives licensed under chapter 467; ~~clinical laboratories registered under chapter 483;~~ physician assistants licensed under chapter 458 or chapter 459; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part I of chapter 641; ambulatory surgical centers licensed under chapter 395; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine shall not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed under chapter 395, health maintenance organization certificated under part I of chapter 641, ambulatory surgical center licensed under chapter 395, or other medical facility as defined in subparagraph 2.

Section 100. Paragraph (h) of subsection (1) of section



286602

627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply ~~to a health insurance policy that is subject to the Subscriber Assistance Program under s. 408.7056~~ ~~or~~ to the types of benefits or coverages provided under s. 627.6513(1)-(14) issued in any market.

Section 101. Subsection (1) of section 627.6406, Florida Statutes, is amended to read:

627.6406 Maternity care.—

(1) Any policy of health insurance which ~~that~~ provides coverage for maternity care must also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed under ss. 383.30-383.332 ~~383.335~~.

Section 102. Paragraphs (b) and (e) of subsection (1) of section 627.64194, Florida Statutes, are amended to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

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

(b) "Facility" means a licensed facility as defined in s. 395.002(16) and an urgent care center as defined in s. 395.002(29) ~~s. 395.002(30)~~.



286602

(e) "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002(29) ~~s. 395.002(30)~~ is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate.

Section 103. Section 627.6513, Florida Statutes, is amended to read:

627.6513 Scope.—Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to ~~a group health insurance policy that is subject to the Subscriber Assistance Program in s. 408.7056 or to:~~

- (1) Coverage only for accident insurance, or disability income insurance, or any combination thereof.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Liability insurance, including general liability insurance and automobile liability insurance.
- (4) Workers' compensation or similar insurance.
- (5) Automobile medical payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.
- (8) Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care



286602

are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(9) Limited scope dental or vision benefits, if offered separately.

(10) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof, if offered separately.

(11) Other similar, limited benefits, if offered separately, as specified in rules adopted by the commission.

(12) Coverage only for a specified disease or illness, if offered as independent, noncoordinated benefits.

(13) Hospital indemnity or other fixed indemnity insurance, if offered as independent, noncoordinated benefits.

(14) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan, which are offered as a separate insurance policy and as independent, noncoordinated benefits.

Section 104. Subsection (1) of section 627.6574, Florida Statutes, is amended to read:

627.6574 Maternity care.—

(1) Any group, blanket, or franchise policy of health insurance which ~~that~~ provides coverage for maternity care must also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth



286602

centers licensed under ss. 383.30-383.332 ~~383.335~~.

Section 105. Paragraph (j) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements ~~shall~~ serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

~~(j) A health maintenance organization should receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals pursuant to s. 408.7056.~~

Section 106. Paragraph (a) of subsection (18) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(18) (a) Health maintenance contracts that provide coverage, benefits, or services for maternity care must provide, as an option to the subscriber, the services of nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed pursuant to ss. 383.30-383.332 ~~383.335~~, if such services are available within the service area.

Section 107. Section 641.312, Florida Statutes, is amended to read:

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association



286602

of Insurance Commissioners' Uniform Health Carrier External Review Model Act, issued by the National Association of Insurance Commissioners and dated April 2010. This section does not apply to ~~a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056 or to the~~ types of benefits or coverages provided under s. 627.6513(1)-(14) issued in any market.

Section 108. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.—

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the



286602

organization is liable; or

~~(c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to s. 408.7056; or~~

(c) ~~(d)~~ The agency issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057.

Section 109. Paragraph (c) of subsection (5) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.—

(5)

(c) For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber



286602

has unreasonably overutilized the second opinion privilege. A subscriber ~~thus~~ denied reimbursement under this section has ~~shall have~~ recourse to grievance procedures as specified in ss. ~~408.7056,~~ 641.495, and 641.511. The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion is ~~shall be~~ controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization is ~~shall be~~ at the subscriber's expense.

Section 110. Subsection (1), paragraph (e) of subsection (3), paragraph (d) of subsection (4), paragraphs (g) and (h) of subsection (6), and subsections (7) through (12) of section 641.511, Florida Statutes, are amended to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, ~~and may submit the grievance for review to the Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process.~~ An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

(3) Each organization's grievance procedure, as required



286602

under subsection (1), must include, at a minimum:

(e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure ~~and as an alternative to the Subscriber Assistance Program~~. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber's contract.

(4)

~~(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.~~

(6)

~~(g) In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.~~

(g) ~~(h)~~ An organization shall not provide an expedited retrospective review of an adverse determination.

~~(7) Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the office pursuant to s. 408.7056(12).~~

(7) ~~(8)~~ The agency shall investigate all reports of



286602

unresolved quality of care grievances received from:

~~(a)~~ annual and quarterly grievance reports submitted by the organization to the office.

~~(b)~~ Review requests of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.

~~(9)(a)~~ The agency shall advise subscribers with grievances to follow their organization's formal grievance process for resolution prior to review by the Subscriber Assistance Program. The subscriber may, however, submit a copy of the grievance to the agency at any time during the process.

~~(b)~~ Requiring completion of the organization's grievance process before the Subscriber Assistance Program panel's review does not preclude the agency from investigating any complaint or grievance before the organization makes its final determination.

~~(10)~~ Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the Subscriber Assistance Program.

~~(8)(11)~~ Each organization, as part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of



286602

the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, ~~the Subscriber Assistance Program,~~ and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

(9) ~~(12)~~ The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.

Section 111. Subsection (1) of section 641.515, Florida Statutes, is amended to read:

641.515 Investigation by the agency.—

(1) The agency shall investigate further any quality of care issue contained in recommendations and reports submitted pursuant to s. ss. 408.7056 ~~and~~ 641.511. The agency shall also investigate further any information that indicates that the organization does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment pursuant to reports submitted under s. 641.512. Every organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. The agency shall have access to the organization's medical records of individuals and records of employed and contracted physicians, with the consent of the subscriber or by court order, as necessary to carry out the provisions of this part.



286602

Section 112. Subsection (2) of section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.—

(2) The risk management program shall be the responsibility of the governing authority or board of the organization. Every organization which has an annual premium volume of \$10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager, ~~certified under ss. 395.10971-395.10975, who is shall be~~ responsible for implementation of the organization's risk management program required by this section. A part-time risk manager ~~may shall~~ not be responsible for risk management programs in more than four organizations or facilities. Every organization ~~that which~~ does not directly provide health care in a building owned or leased by the organization and every organization with an annual premium volume of less than \$10 million shall designate an officer or employee of the organization to serve as the risk manager.

The gross data compiled under this section or s. 395.0197 shall be furnished by the agency upon request to organizations to be utilized for risk management purposes. The agency shall adopt rules necessary to carry out the provisions of this section.

Section 113. Section 641.60, Florida Statutes, is repealed.

Section 114. Section 641.65, Florida Statutes, is repealed.

Section 115. Section 641.67, Florida Statutes, is repealed.

Section 116. Section 641.68, Florida Statutes, is repealed.

Section 117. Section 641.70, Florida Statutes, is repealed.

Section 118. Section 641.75, Florida Statutes, is repealed.



286602

Section 119. Paragraph (b) of subsection (6) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of a practitioner committed in the course of providing medical services and medical care to a Medicaid recipient, regardless of the number of such practitioner defendants providing the services and care, noneconomic damages may not exceed \$300,000 per claimant, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. A practitioner providing medical services and medical care to a Medicaid recipient is not liable for more than \$200,000 in noneconomic damages, regardless of the number of claimants, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. The fact that a claimant proves that a practitioner acted in a wrongful manner does not preclude the application of the limitation on noneconomic damages prescribed elsewhere in this section. For purposes of this subsection:

(b) The term “practitioner,” in addition to the meaning prescribed in subsection (1), includes any hospital or ambulatory surgical center, ~~or mobile surgical facility~~ as defined and licensed under chapter 395.

Section 120. Subsection (4) of section 766.202, Florida Statutes, is amended to read:



286602

766.202 Definitions; ss. 766.201-766.212.—As used in ss. 766.201-766.212, the term:

(4) "Health care provider" means any hospital or ambulatory surgical center, ~~or mobile surgical facility~~ as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; ~~a clinical lab licensed under chapter 483~~; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

Section 121. Section 945.36, Florida Statutes, is amended to read:

945.36 ~~Exemption from health testing regulations for~~ Law enforcement personnel authorized to conduct ~~conducting~~ drug tests on inmates and releasees.—

(1) Any law enforcement officer, state or county probation officer, or employee of the Department of Corrections, who is certified by the Department of Corrections pursuant to subsection (2) may administer, ~~is exempt from part I of chapter 483, for the limited purpose of administering~~ a urine screen drug test to:

(a) Persons during incarceration;

(b) Persons released as a condition of probation for either a felony or misdemeanor;

(c) Persons released as a condition of community control;



286602

- (d) Persons released as a condition of conditional release;
(e) Persons released as a condition of parole;
(f) Persons released as a condition of provisional release;
(g) Persons released as a condition of pretrial release; or
(h) Persons released as a condition of control release.

(2) The Department of Corrections shall develop a procedure for certification of any law enforcement officer, state or county probation officer, or employee of the Department of Corrections to perform a urine screen drug test on the persons specified in subsection (1).

Section 122. Paragraph (b) of subsection (2) of section 1009.65, Florida Statutes, is amended to read:

1009.65 Medical Education Reimbursement and Loan Repayment Program.—

(2) From the funds available, the Department of Health shall make payments to selected medical professionals as follows:

(b) All payments are ~~shall be~~ contingent on continued proof of primary care practice in an area defined in s. 395.602(2)(b) ~~s. 395.602(2)(c)~~, or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement. Correctional facilities, state hospitals, and other state institutions that employ medical personnel shall be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

Section 123. Subsection (2) of section 1011.52, Florida



286602

Statutes, is amended to read:

1011.52 Appropriation to first accredited medical school.—

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

(a) Must be primarily operated and established to offer,
afford, and render a medical education to residents of the state
qualifying for admission to such institution;

(b) Must be operated by a municipality or county of this
state, or by a nonprofit organization heretofore or hereafter
established exclusively for educational purposes;

(c) Must, upon the formation and establishment of an
accredited medical school, transmit and file with the Department
of Education documentary proof evidencing the facts that such
institution has been certified and approved by the council on
medical education and hospitals of the American Medical
Association and has adequately met the requirements of that
council in regard to its administrative facilities,
administrative plant, clinical facilities, curriculum, and all
other such requirements as may be necessary to qualify with the
council as a recognized, approved, and accredited medical
school;

(d) Must certify to the Department of Education the name,
address, and educational history of each student approved and
accepted for enrollment in such institution for the ensuing
school year; and

(e) Must have in place an operating agreement with a
government-owned hospital that is located in the same county as
the medical school and that is a statutory teaching hospital as



286602

defined in s. 408.07(44) ~~s. 408.07(45)~~. The operating agreement must ~~shall~~ provide for the medical school to maintain the same level of affiliation with the hospital, including the level of services to indigent and charity care patients served by the hospital, which was in place in the prior fiscal year. Each year, documentation demonstrating that an operating agreement is in effect shall be submitted jointly to the Department of Education by the hospital and the medical school prior to the payment of moneys from the annual appropriation.

Section 124. This act shall take effect July 1, 2017.

===== 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 health care facility regulation;
creating s. 154.13, F.S.; providing that a designated
facility owned or operated by a public health trust
and located within the boundaries of a municipality is
under the exclusive jurisdiction of the county
creating the public health trust; amending ss.
381.0031, 381.004, 384.31, 395.009, 400.0625, and
409.905, F.S.; eliminating state licensure
requirements for clinical laboratories; requiring
clinical laboratories to be federally certified;
amending s. 383.313, F.S.; revising requirements that
a birth center perform certain laboratory tests;
repealing s. 383.335, F.S., relating to partial



286602

2998 exemptions from licensure requirements for certain
2999 facilities that provide obstetrical and gynecological
3000 surgical services; amending s. 395.002, F.S.; revising
3001 and deleting definitions; creating s. 395.0091, F.S.;
3002 authorizing the Agency for Health Care Administration
3003 to adopt rules establishing criteria for alternate-
3004 site laboratory testing; defining the term "alternate-
3005 site testing"; amending ss. 395.0161 and 395.0163,
3006 F.S.; deleting licensure and inspection requirements
3007 for mobile surgical facilities to conform to changes
3008 made by the act; amending s. 408.809, F.S.; making
3009 additional persons subject to background screening
3010 requirements; amending s. 409.907, F.S.; removing the
3011 agency's authority to consider certain factors in
3012 determining whether to enter into, and in maintaining,
3013 a Medicaid provider agreement; amending s. 435.04
3014 F.S.; providing that security background
3015 investigations must ensure that a person has not been
3016 arrested for, and is not awaiting final disposition
3017 of, certain offenses; specifying offenses under
3018 federal law or any state law that security background
3019 investigations must screen for; requiring that
3020 security background investigations screen for
3021 violations of federal or state law, rule, or
3022 regulation governing any state Medicaid program, the
3023 Medicare program, or any other publicly funded federal
3024 or state health care or health insurance program;
3025 amending s. 395.0197, F.S.; requiring the manager of a
3026 hospital or ambulatory surgical center internal risk



286602

3027 management program to demonstrate competence in
3028 certain administrative and health care service areas;
3029 conforming provisions to changes made by the act;
3030 repealing s. 395.1046, F.S., relating to hospital
3031 complaint investigation procedures; amending s.
3032 395.1055, F.S.; requiring hospitals that provide
3033 specified services to meet agency licensure
3034 requirements; conforming a provision to changes made
3035 by the act; repealing ss. 395.10971 and 395.10972,
3036 F.S., relating to the purpose and establishment of the
3037 Health Care Risk Manager Advisory Council; amending s.
3038 395.10973, F.S.; deleting duties of the agency
3039 relating to health care risk managers, to conform to
3040 changes made by the act; repealing s. 395.10974, F.S.,
3041 relating to licensure of health care risk managers;
3042 repealing s. 395.10975, F.S., relating to grounds for
3043 denial, suspension, or revocation of a health care
3044 risk manager's license; amending s. 395.602, F.S.;
3045 deleting definitions; amending s. 395.603, F.S.;
3046 deleting provisions relating to deactivation of
3047 general hospital beds by certain rural and emergency
3048 care hospitals; repealing s. 395.604, F.S., relating
3049 to other rural hospital programs; repealing s.
3050 395.605, F.S., relating to emergency care hospitals;
3051 amending s. 395.701, F.S.; revising the definition of
3052 the term "hospital" to exclude hospitals operated by
3053 state agencies; amending s. 400.464, F.S.; requiring
3054 that a license issued on or after a specified date to
3055 a home health agency specify the services the



286602

3056 organization is authorized to perform and whether the
3057 services constitute skilled are; providing that the
3058 provision or advertising of certain services
3059 constitutes unlicensed activity; providing that
3060 certain persons, entities or organizations providing
3061 home health services may voluntarily apply for a
3062 certificate of exemption from licensure; requiring
3063 that certain information be provided to the agency;
3064 specifying the duration of the certificate of
3065 exemption; providing that the certificate is
3066 nontransferable; authorizing the agency to charge a
3067 fee for the certificate, not to exceed a certain
3068 amount; amending s. 400.471, F.S.; revising home
3069 health agency licensure requirements; providing
3070 requirements for proof of accreditation for home
3071 health agencies applying for change of ownership or
3072 the addition of skilled care services; amending s.
3073 400.474, F.S.; revising conditions for the imposition
3074 of a fine against a home health agency; amending s.
3075 400.476, F.S.; requiring a home health agency
3076 providing skilled nursing care to have a director of
3077 nursing; amending s. 400.484, F.S.; providing for the
3078 imposition of administrative fines on home health
3079 agencies for specified classes of violations; amending
3080 s. 400.497, F.S.; requiring the agency to adopt,
3081 publish, and enforce rules establishing standards for
3082 certificates of exemption; amending s. 400.506, F.S.;
3083 revising provisions imposing a fine on nurse
3084 registries that fail to cease operation after



286602

3085 notification by the agency; revising circumstances
3086 under which the agency may take certain action or must
3087 impose a fine; amending s. 400.606, F.S.; revising
3088 content requirements of the plan accompanying an
3089 initial or change-of-ownership application for a
3090 hospice; amending s. 400.925, F.S.; revising the
3091 definition of the term "home medical equipment";
3092 amending s. 400.931, F.S.; providing a timeframe for a
3093 home medical equipment provider to notify the agency
3094 of certain personnel changes; amending s. 400.933,
3095 F.S.; authorizing the agency to accept certain medical
3096 oxygen permits issued by the Department of Business
3097 and Professional Regulation in lieu of agency
3098 licensure inspections; amending s. 400.980, F.S.;
3099 revising the timeframe within which a health care
3100 services pool registrant must provide the agency with
3101 certain changes of information; amending s. 400.9935,
3102 F.S.; providing that a voluntary certificate of
3103 exemption is not valid for more than 2 years; amending
3104 s. 408.061, F.S.; excluding hospitals operated by
3105 state agencies from certain financial reporting
3106 requirements; conforming a cross-reference; amending
3107 s. 408.07, F.S.; deleting the term "clinical
3108 laboratory"; amending s. 408.20, F.S.; exempting
3109 hospitals operated by state agencies from assessments
3110 against the Health Care Trust Fund to fund certain
3111 agency activities; repealing s. 408.7056, F.S.,
3112 relating to the Subscriber Assistance Program;
3113 amending s. 408.803, F.S.; defining the term



286602

3114 "relative" for the Health Care Licensing Procedures
3115 Act; amending s. 408.806, F.S.; authorizing licensees
3116 who hold licenses for multiple providers to request
3117 that the agency align related license expiration
3118 dates; authorizing the agency to issue licenses for an
3119 abbreviated licensure period and to charge prorated
3120 fees; amending s. 408.810, F.S.; exempting an
3121 applicant for change of ownership from furnishing
3122 proof of financial ability to operate under certain
3123 conditions; authorizing the agency to adopt rules
3124 governing circumstances under which a controlling
3125 interest may act in certain legal capacities on behalf
3126 of a patient or client; amending s. 408.812, F.S.;
3127 providing that certain unlicensed activity by a
3128 provider constitutes abuse and neglect; authorizing
3129 the agency to impose a fine under certain
3130 circumstances; amending s. 408.820, F.S.; deleting
3131 certain exemptions from part II of ch. 408, F.S. for
3132 specified providers; amending s. 429.02, F.S.;
3133 revising definitions; amending s. 429.04, F.S.;
3134 providing additional exemptions from licensure as an
3135 assisted living facility; requiring a person or entity
3136 asserting the exemption to provide documentation that
3137 substantiates the claim; amending s. 429.08, F.S.;
3138 providing criminal penalties and fines for a person
3139 who rents or otherwise maintains a building or
3140 property that operates or maintains an unlicensed
3141 assisted living facility; amending s. 429.176, F.S.;
3142 prohibiting an assisted living facility from operating



286602

3143 without an administrator who has completed certain
3144 educational requirements for more than a specified
3145 period of time; amending s. 429.24, F.S.; providing
3146 that 30-day written notice of rate increase is not
3147 required in certain situations; amending s. 429.256,
3148 F.S.; requiring that certain information on a
3149 medication label be read aloud in the presence of a
3150 resident; amending s. 429.28, F.S.; revising the
3151 resident bill of rights to include assistance with
3152 obtaining access to adequate and appropriate health
3153 care; defining the term "adequate and appropriate
3154 health care"; deleting a requirement that the agency
3155 conduct at least one monitoring visit in certain
3156 circumstances; removing the authority of the agency to
3157 perform followup inspections in certain circumstances;
3158 removing the authority of the agency to conduct
3159 complaint investigations; amending s. 429.294, F.S.;
3160 deleting a specified timeframe within which a facility
3161 must provide certain records; amending s. 429.34,
3162 F.S.; authorizing the agency to perform inspections
3163 and investigations to ensure compliance; authorizing
3164 the agency to perform monitoring visits in certain
3165 circumstances; amending s. 429.52, F.S.; requiring a
3166 facility administrator to complete required training
3167 and education within a certain timeframe; amending s.
3168 435.12, F.S.; extending the screening renewal period
3169 for individuals screened after a certain date in
3170 certain circumstances; extending the period for which
3171 fingerprints must be retained by the Department of Law



286602

3172 Enforcement; repealing part I of ch. 483, F.S.,
3173 relating to clinical laboratories; amending s.
3174 483.294, F.S.; revising agency inspection schedules
3175 for multiphasic health testing centers; amending s.
3176 483.801, F.S.; providing an exemption from regulation
3177 for persons employed by certain laboratories; amending
3178 s. 483.803, F.S.; revising definitions; conforming a
3179 cross-reference; amending s. 641.511, F.S.; revising
3180 health maintenance organization subscriber grievance
3181 reporting requirements; repealing s. 641.60, F.S.,
3182 relating to the Statewide Managed Care Ombudsman
3183 Committee; repealing s. 641.65, F.S., relating to
3184 district managed care ombudsman committees; repealing
3185 s. 641.67, F.S., relating to a district managed care
3186 ombudsman committee, exemption from public records
3187 requirements, and exceptions; repealing s. 641.68,
3188 F.S., relating to a district managed care ombudsman
3189 committee and exemption from public meeting
3190 requirements; repealing s. 641.70, F.S., relating to
3191 agency duties relating to the Statewide Managed Care
3192 Ombudsman Committee and the district managed care
3193 ombudsman committees; repealing s. 641.75, F.S.,
3194 relating to immunity from liability and limitation on
3195 testimony; amending s. 945.36, F.S.; authorizing law
3196 enforcement personnel to conduct drug tests on certain
3197 inmates and releasees; amending ss. 20.43, 220.1845,
3198 376.30781, 376.86, 381.0034, 381.0405, 383.30,
3199 383.301, 383.302, 383.305, 383.309, 383.33, 385.211,
3200 394.4787, 395.001, 395.003, 395.7015, 400.9905,



286602

3201 408.033, 408.036, 408.802, 409.9116, 409.975, 429.19,
3202 456.001, 456.057, 458.307, 458.345, 459.021, 483.813,
3203 483.823, 491.003, 627.351, 627.602, 627.6406,
3204 627.64194, 627.6513, 627.6574, 641.185, 641.31,
3205 641.312, 641.3154, 641.51, 641.515, 641.55, 766.118,
3206 766.202, 1009.65, and 1011.52, F.S.; conforming
3207 provisions to changes made by the act; providing an
3208 effective date.

By Senator Grimsley

26-00433-17

20171760__

1 A bill to be entitled
 2 An act relating to health care facility regulation;
 3 amending ss. 381.0031, 381.004, 384.31, 395.009, and
 4 409.905, F.S.; eliminating state licensure
 5 requirements for clinical laboratories; requiring
 6 clinical laboratories to be federally certified;
 7 amending s. 383.313, F.S.; revising requirements for a
 8 birth center to perform certain laboratory tests;
 9 repealing s. 383.335, F.S., relating to partial
 10 exemptions from licensure requirements for certain
 11 facilities that provide obstetrical and gynecological
 12 surgical services; amending s. 395.002, F.S.; revising
 13 and deleting definitions; creating s. 395.0091, F.S.;
 14 authorizing the Agency for Health Care Administration
 15 to adopt rules establishing criteria for alternate-
 16 site laboratory testing; defining the term "alternate-
 17 site testing"; amending ss. 395.0161 and 395.0163,
 18 F.S.; deleting licensure and inspection requirements
 19 for mobile surgical facilities to conform to changes
 20 made by the act; amending s. 395.0197, F.S.; requiring
 21 the manager of a hospital or ambulatory surgical
 22 center internal risk management program to demonstrate
 23 competence in certain administrative and health care
 24 service areas; conforming references; repealing s.
 25 395.1046, F.S., relating to hospital complaint
 26 investigation procedures; amending s. 395.1055, F.S.;
 27 requiring hospitals providing specified services to
 28 meet agency licensure requirements; conforming a
 29 reference; repealing ss. 395.10971 and 395.10972,

Page 1 of 94

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

26-00433-17

20171760__

30 F.S., relating to the purpose and establishment of the
 31 Health Care Risk Manager Advisory Council; amending s.
 32 395.10973, F.S.; deleting duties of the agency
 33 relating to health care risk managers; repealing s.
 34 395.10974, F.S., relating to licensure of health care
 35 risk managers; repealing s. 395.10975, F.S., relating
 36 to grounds for denial, suspension, or revocation of a
 37 health care risk manager's license; amending s.
 38 395.602, F.S.; deleting definitions; amending s.
 39 395.603, F.S.; deleting provisions relating to
 40 deactivation of general hospital beds by certain rural
 41 and emergency care hospitals; repealing s. 395.604,
 42 F.S., relating to other rural hospital programs;
 43 repealing s. 395.605, F.S., relating to emergency care
 44 hospitals; amending s. 395.701, F.S.; revising the
 45 definition of the term "hospital" to exclude hospitals
 46 operated by state agencies; amending s. 400.464, F.S.;
 47 revising licensure requirements for a home health
 48 agency; providing conditions for advertising certain
 49 services that require licensure; providing for a fine;
 50 providing conditions for application for a certificate
 51 of exemption from licensure as a home health agency;
 52 specifying the duration of the certificate of
 53 exemption; authorizing a fee; amending s. 400.471,
 54 F.S.; revising home health agency licensure
 55 requirements; providing requirements for proof of
 56 accreditation for home health agencies applying for
 57 change of ownership or addition of skilled care
 58 services; amending s. 400.474, F.S.; revising

Page 2 of 94

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

26-00433-17

20171760__

59 conditions for the imposition of a fine against a home
 60 health agency; amending s. 400.476, F.S.; requiring a
 61 home health agency providing skilled nursing care to
 62 have a director of nursing; amending s. 400.484, F.S.;
 63 providing for the imposition of administrative fines
 64 on home health agencies for specified classes of
 65 violations; amending s. 400.497, F.S.; authorizing the
 66 agency to adopt rules establishing standards for
 67 certificate of exemption applications; amending s.
 68 400.506, F.S.; revising penalties for a nurse registry
 69 directed by the agency to cease operation; providing
 70 that registered nurses, licensed practical nurses,
 71 certified nursing assistants, companions or
 72 homemakers, and home health aides are independent
 73 contractors and not employees of the nurse registries
 74 that referred them; requiring a nurse registry to
 75 inform the patient, the patient's family, or a person
 76 acting on behalf of the patient that the referred
 77 caregiver is an independent contractor and that the
 78 nurse registry is not permitted to monitor, supervise,
 79 manage, or train the referred caregiver; revising
 80 provisions relating to activities for which the agency
 81 is authorized to deny, suspend, or revoke a nurse
 82 registry license and impose fines; providing that a
 83 nurse registry is not permitted to review or act upon
 84 certain records except under certain circumstances;
 85 amending s. 400.606, F.S.; revising content
 86 requirements of the plan accompanying an initial or
 87 change of ownership application for a hospice;

Page 3 of 94

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

26-00433-17

20171760__

88 amending s. 400.925, F.S.; revising the definition of
 89 the term "home medical equipment"; amending s.
 90 400.931, F.S.; providing a timeframe for a home
 91 medical equipment provider to notify the agency of
 92 certain personnel changes; amending s. 400.933, F.S.;
 93 authorizing the agency to accept certain medical
 94 oxygen permits issued by the Department of Business
 95 and Professional Regulation in lieu of agency
 96 licensure inspections; amending s. 400.980, F.S.;
 97 revising timeframe requirements for change of
 98 registration information submitted to the agency by a
 99 health care services pool; amending s. 408.061, F.S.;
 100 excluding hospitals operated by state agencies from
 101 certain financial reporting requirements; conforming a
 102 cross-reference; amending s. 408.07, F.S.; deleting
 103 the definition of the term "clinical laboratory";
 104 amending s. 408.20, F.S.; exempting hospitals operated
 105 by state agencies from assessments against the Health
 106 Care Trust Fund to fund certain agency activities;
 107 repealing s. 408.7056, F.S., relating to the
 108 Subscriber Assistance Program; amending s. 408.803,
 109 F.S.; defining the term "relative" for the Health Care
 110 Licensing Procedures Act; amending s. 408.806, F.S.;
 111 requiring additional information on a licensure
 112 application; authorizing the agency to issue licenses
 113 with an abbreviated licensure period and prorated fee
 114 for alignment of multiple provider license expiration
 115 dates; amending s. 408.810, F.S.; exempting an
 116 applicant for change of ownership from furnishing

Page 4 of 94

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

26-00433-17

20171760__

117 proof of ability to operate under certain conditions;
 118 authorizing the agency to adopt rules governing
 119 circumstances under which a controlling interest may
 120 act in certain legal capacities on behalf of a patient
 121 or client; amending s. 408.812, F.S.; citing failure
 122 to discharge residents by the license expiration date
 123 as unlicensed activity; providing that certain
 124 unlicensed activity by a provider constitutes abuse
 125 and neglect; requiring the agency to refer certain
 126 findings to the state attorney; requiring the agency
 127 to impose a fine under certain circumstances; amending
 128 s. 429.02, F.S.; revising definitions; amending s.
 129 429.04, F.S.; providing additional exemptions from
 130 licensure as an assisted living facility; imposing a
 131 burden of proof on the person or entity asserting the
 132 exemption; providing applicability; amending s.
 133 429.08, F.S.; providing criminal penalties and fines
 134 for ownership, rental, or maintenance of a real
 135 property used as an unlicensed assisted living
 136 facility; providing that engaging a third party to
 137 provide certain services at an unlicensed location
 138 constitutes unlicensed activity; amending s. 429.176,
 139 F.S.; prohibiting an assisted living facility from
 140 operating beyond a specified period without an
 141 administrator who has completed certain educational
 142 requirements; amending s. 429.41, F.S.; prohibiting an
 143 assisted living facility from providing personal
 144 services to nonresidents; repealing part I of ch. 483,
 145 F.S., relating to clinical laboratories; amending s.

Page 5 of 94

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

26-00433-17

20171760__

146 483.294, F.S.; revising agency inspection schedules
 147 for multiphasic health testing centers; amending s.
 148 483.801, F.S.; revising an exemption from regulation
 149 for persons employed by certain laboratories; amending
 150 s. 483.803, F.S.; deleting definitions; conforming
 151 provisions to changes made by the act; amending s.
 152 641.511, F.S.; revising health maintenance
 153 organization subscriber grievance reporting
 154 requirements; repealing s. 641.60, F.S., relating to
 155 the Statewide Managed Care Ombudsman Committee;
 156 amending s. 945.36, F.S.; authorizing law enforcement
 157 personnel to conduct drug tests on certain inmates and
 158 releasees; amending ss. 20.43, 220.1845, 376.30781,
 159 376.86, 381.0034, 385.211, 394.4787, 395.001, 395.003,
 160 395.7015, 400.0625, 400.9905, 408.033, 408.036,
 161 408.802, 408.820, 409.9116, 409.975, 456.001, 456.057,
 162 458.307, 458.345, 483.813, 491.003, 627.351, 627.602,
 163 627.64194, 627.6513, 641.185, 641.312, 641.3154,
 164 641.51, 641.515, 641.55, 641.70, 641.75, 766.118,
 165 766.202, and 1009.65, F.S.; conforming provisions to
 166 changes made by the act; providing effective dates.

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

169
 170 Section 1. Paragraph (g) of subsection (3) of section
 171 20.43, Florida Statutes, is amended to read:

172 20.43 Department of Health.—There is created a Department
 173 of Health.

174 (3) The following divisions of the Department of Health are

Page 6 of 94

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

26-00433-17 20171760__

175 established:

176 (g) Division of Medical Quality Assurance, which is

177 responsible for the following boards and professions established

178 within the division:

179 1. The Board of Acupuncture, created under chapter 457.

180 2. The Board of Medicine, created under chapter 458.

181 3. The Board of Osteopathic Medicine, created under chapter

182 459.

183 4. The Board of Chiropractic Medicine, created under

184 chapter 460.

185 5. The Board of Podiatric Medicine, created under chapter

186 461.

187 6. Naturopathy, as provided under chapter 462.

188 7. The Board of Optometry, created under chapter 463.

189 8. The Board of Nursing, created under part I of chapter

190 464.

191 9. Nursing assistants, as provided under part II of chapter

192 464.

193 10. The Board of Pharmacy, created under chapter 465.

194 11. The Board of Dentistry, created under chapter 466.

195 12. Midwifery, as provided under chapter 467.

196 13. The Board of Speech-Language Pathology and Audiology,

197 created under part I of chapter 468.

198 14. The Board of Nursing Home Administrators, created under

199 part II of chapter 468.

200 15. The Board of Occupational Therapy, created under part

201 III of chapter 468.

202 16. Respiratory therapy, as provided under part V of

203 chapter 468.

26-00433-17 20171760__

204 17. Dietetics and nutrition practice, as provided under

205 part X of chapter 468.

206 18. The Board of Athletic Training, created under part XIII

207 of chapter 468.

208 19. The Board of Orthotists and Prosthetists, created under

209 part XIV of chapter 468.

210 20. Electrolysis, as provided under chapter 478.

211 21. The Board of Massage Therapy, created under chapter

212 480.

213 ~~22. The Board of Clinical Laboratory Personnel, created~~

214 ~~under part III of chapter 483.~~

215 22.23. Medical physicists, as provided under part III ~~IV~~ of

216 chapter 483.

217 23.24. The Board of Opticianry, created under part I of

218 chapter 484.

219 24.25. The Board of Hearing Aid Specialists, created under

220 part II of chapter 484.

221 25.26. The Board of Physical Therapy Practice, created

222 under chapter 486.

223 26.27. The Board of Psychology, created under chapter 490.

224 27.28. School psychologists, as provided under chapter 490.

225 28.29. The Board of Clinical Social Work, Marriage and

226 Family Therapy, and Mental Health Counseling, created under

227 chapter 491.

228 29.30. Emergency medical technicians and paramedics, as

229 provided under part III of chapter 401.

230 Section 2. Paragraph (k) of subsection (2) of section

231 220.1845, Florida Statutes, is amended to read:

232 220.1845 Contaminated site rehabilitation tax credit.—

26-00433-17

20171760__

(2) AUTHORIZATION FOR TAX CREDIT; LIMITATIONS.—

(k) In order to encourage the construction and operation of a new health care facility as defined in s. 408.032 or s. 408.07, or a health care provider as defined in s. 408.07 ~~or s. 408.7056~~, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed \$500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 3. Paragraph (f) of subsection (3) of section 376.30781, Florida Statutes, is amended to read:

376.30781 Tax credits for rehabilitation of drycleaning-solvent-contaminated sites and brownfield sites in designated brownfield areas; application process; rulemaking authority; revocation authority.—

(3)

(f) In order to encourage the construction and operation of a new health care facility or a health care provider, as defined in s. 408.032 or s. 408.07, ~~or s. 408.7056~~, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed \$500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the

26-00433-17

20171760__

construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 4. Subsection (1) of section 376.86, Florida Statutes, is amended to read:

376.86 Brownfield Areas Loan Guarantee Program.—

(1) The Brownfield Areas Loan Guarantee Council is created to review and approve or deny, by a majority vote of its membership, the situations and circumstances for participation in partnerships by agreements with local governments, financial institutions, and others associated with the redevelopment of brownfield areas pursuant to the Brownfields Redevelopment Act for a limited state guaranty of up to 5 years of loan guarantees or loan loss reserves issued pursuant to law. The limited state loan guaranty applies only to 50 percent of the primary lenders loans for redevelopment projects in brownfield areas. If the redevelopment project is for affordable housing, as defined in s. 420.0004, in a brownfield area, the limited state loan guaranty applies to 75 percent of the primary lender's loan. If the redevelopment project includes the construction and operation of a new health care facility or a health care provider, as defined in s. 408.032 or s. 408.07, ~~or s. 408.7056~~, on a brownfield site and the applicant has obtained documentation in accordance with s. 376.30781 indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been

26-00433-17 20171760

issued for the operation of the health care facility or health care provider, the limited state loan guaranty applies to 75 percent of the primary lender's loan. A limited state guaranty of private loans or a loan loss reserve is authorized for lenders licensed to operate in the state upon a determination by the council that such an arrangement would be in the public interest and the likelihood of the success of the loan is great.

Section 5. Subsection (2) of section 381.0031, Florida Statutes, is amended to read:

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

(2) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of chapter 395; or any laboratory appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments of 1988 ~~licensed under chapter 483~~ that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

Section 6. Subsection (3) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(3) The department shall require, as a condition of granting a license under chapter 467 or part II ~~III~~ of chapter 483, that an applicant making initial application for licensure complete an educational course acceptable to the department on human immunodeficiency virus and acquired immune deficiency syndrome. Upon submission of an affidavit showing good cause, an

26-00433-17 20171760

applicant who has not taken a course at the time of licensure shall be allowed 6 months to complete this requirement.

Section 7. Paragraph (c) of subsection (4) of section 381.004, Florida Statutes, is amended to read:

381.004 HIV testing.—

(4) HUMAN IMMUNODEFICIENCY VIRUS TESTING REQUIREMENTS; REGISTRATION WITH THE DEPARTMENT OF HEALTH; EXEMPTIONS FROM REGISTRATION.—No county health department and no other person in this state shall conduct or hold themselves out to the public as conducting a testing program for acquired immune deficiency syndrome or human immunodeficiency virus status without first registering with the Department of Health, reregistering each year, complying with all other applicable provisions of state law, and meeting the following requirements:

(c) The program shall have all laboratory procedures performed in a laboratory appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments of 1988 ~~licensed under the provisions of chapter 483~~.

Section 8. Subsection (1) of section 383.313, Florida Statutes, is amended to read:

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center may perform simple laboratory tests, as defined by rule of the agency, and is exempt from the requirements of chapter 483, ~~provided no more than five physicians are employed by the birth center and testing is conducted exclusively in~~

26-00433-17 20171760__

349 ~~connection with the diagnosis and treatment of clients of the~~
350 ~~birth center.~~

351 Section 9. Section 383.335, Florida Statutes, is repealed.

352 Section 10. Section 384.31, Florida Statutes, is amended to
353 read:

354 384.31 Testing of pregnant women; duty of the attendant.—
355 Every person, including every physician licensed under chapter
356 458 or chapter 459 or midwife licensed under part I of chapter
357 464 or chapter 467, attending a pregnant woman for conditions
358 relating to pregnancy during the period of gestation and
359 delivery shall cause the woman to be tested for sexually
360 transmissible diseases, including HIV, as specified by
361 department rule. Testing shall be performed by a laboratory
362 appropriately certified by the Centers for Medicare and Medicaid
363 Services (CMS) under the federal Clinical Laboratory Improvement
364 Amendments of 1988 approved for such purposes under part I of
365 ~~chapter 483~~. The woman shall be informed of the tests that will
366 be conducted and of her right to refuse testing. If a woman
367 objects to testing, a written statement of objection, signed by
368 the woman, shall be placed in the woman's medical record and no
369 testing shall occur.

370 Section 11. Subsection (2) of section 385.211, Florida
371 Statutes, is amended to read:

372 385.211 Refractory and intractable epilepsy treatment and
373 research at recognized medical centers.—

374 (2) Notwithstanding chapter 893, medical centers recognized
375 pursuant to s. 381.925, or an academic medical research
376 institution legally affiliated with a licensed children's
377 specialty hospital as defined in s. 395.002(27) ~~395.002(28)~~ that

26-00433-17 20171760__

378 contracts with the Department of Health, may conduct research on
379 cannabidiol and low-THC cannabis. This research may include, but
380 is not limited to, the agricultural development, production,
381 clinical research, and use of liquid medical derivatives of
382 cannabidiol and low-THC cannabis for the treatment for
383 refractory or intractable epilepsy. The authority for recognized
384 medical centers to conduct this research is derived from 21
385 C.F.R. parts 312 and 316. Current state or privately obtained
386 research funds may be used to support the activities described
387 in this section.

388 Section 12. Subsection (7) of section 394.4787, Florida
389 Statutes, is amended to read:

390 394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and
391 394.4789.—As used in this section and ss. 394.4786, 394.4788,
392 and 394.4789:

393 (7) "Specialty psychiatric hospital" means a hospital
394 licensed by the agency pursuant to s. 395.002(27) ~~395.002(28)~~
395 and part II of chapter 408 as a specialty psychiatric hospital.

396 Section 13. Section 395.001, Florida Statutes, is amended
397 to read:

398 395.001 Legislative intent.—It is the intent of the
399 Legislature to provide for the protection of public health and
400 safety in the establishment, construction, maintenance, and
401 operation of hospitals ~~and~~, ambulatory surgical centers, ~~and~~
402 ~~mobile surgical facilities~~ by providing for licensure of same
403 and for the development, establishment, and enforcement of
404 minimum standards with respect thereto.

405 Section 14. Present subsections (22) through (33) of
406 section 395.002, Florida Statutes, are renumbered as subsections

26-00433-17

20171760

(21) through (32), respectively, and subsections (3) and (16) and present subsections (21) and (23) of that section are amended, to read:

395.002 Definitions.—As used in this chapter:

(3) "Ambulatory surgical center" ~~or "mobile surgical facility"~~ means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. ~~Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.~~

(16) "Licensed facility" means a hospital or, ambulatory surgical center, ~~or mobile surgical facility~~ licensed in accordance with this chapter.

~~(21) "Mobile surgical facility" is a mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter~~

26-00433-17

20171760

~~957 and in which inmate patients are admitted to and discharged from said facility within the same working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to chapter 957, and not to the general public.~~

(22)~~(23)~~ "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital or, ambulatory surgical, ~~or mobile surgical~~ care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44) ~~408.07(45)~~, reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

Section 15. Paragraphs (a) and (b) of subsection (1) and paragraph (b) of subsection (2) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1) (a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities

26-00433-17

20171760

licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital ~~or~~, ambulatory surgical center, ~~or mobile surgical facility~~ in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital," ~~or "ambulatory surgical center," or "mobile surgical facility"~~ unless such facility has first secured a license under the provisions of this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital," ~~or "ambulatory surgical center," or "mobile surgical facility"~~ as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. ~~408.07(44)~~ ~~408.07(45)~~, issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002(22) ~~395.002(23)~~. Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 16. Subsection (1) of section 395.009, Florida Statutes, is amended to read:

Page 17 of 94

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

26-00433-17

20171760

395.009 Minimum standards for clinical laboratory test results and diagnostic X-ray results; prerequisite for issuance or renewal of license.—

(1) As a requirement for issuance or renewal of its license, each licensed facility shall require that all clinical laboratory tests performed by or for the licensed facility be performed by a clinical laboratory appropriately certified by the Centers for Medicare and Medicaid Services (CMS) under the federal Clinical Laboratory Improvement Amendments of 1988 licensed under the provisions of chapter 483.

Section 17. Section 395.0091, Florida Statutes, is created to read:

395.0091 Alternate-site testing.—The agency, in consultation with the Board of Clinical Laboratory Personnel, shall adopt by rule the criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director. The elements to be addressed in the rule include, but are not limited to: a hospital internal needs assessment; a protocol of implementation, including tests to be performed and who will perform the tests; criteria to be used in selecting the method of testing to be used for alternate-site testing; minimum training and education requirements for those who will perform alternate-site testing, such as documented training, licensure, certification, or other medical professional backgrounds not limited to laboratory professionals; documented inservice training as well as initial and ongoing competency validation; an appropriate internal and external quality control protocol; an internal mechanism for identifying and tracking alternate-site testing by the central laboratory; and recordkeeping

Page 18 of 94

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

26-00433-17 20171760

523 requirements. Alternate-site testing locations must register
 524 when the hospital applies to renew its license. For purposes of
 525 this section, the term "alternate-site testing" means any
 526 laboratory testing done under the administrative control of a
 527 hospital but performed out of the physical or administrative
 528 confines of the central laboratory.

529 Section 18. Paragraph (f) of subsection (1) of section
 530 395.0161, Florida Statutes, is amended to read:

531 395.0161 Licensure inspection.—

532 (1) In addition to the requirement of s. 408.811, the
 533 agency shall make or cause to be made such inspections and
 534 investigations as it deems necessary, including:

535 ~~(f) Inspections of mobile surgical facilities at each time~~
 536 ~~a facility establishes a new location, prior to the admission of~~
 537 ~~patients. However, such inspections shall not be required when a~~
 538 ~~mobile surgical facility is moved temporarily to a location~~
 539 ~~where medical treatment will not be provided.~~

540 Section 19. Subsection (3) of section 395.0163, Florida
 541 Statutes, is amended to read:

542 395.0163 Construction inspections; plan submission and
 543 approval; fees.—

544 ~~(3) In addition to the requirements of s. 408.811, the~~
 545 ~~agency shall inspect a mobile surgical facility at initial~~
 546 ~~licensure and at each time the facility establishes a new~~
 547 ~~location, prior to admission of patients. However, such~~
 548 ~~inspections shall not be required when a mobile surgical~~
 549 ~~facility is moved temporarily to a location where medical~~
 550 ~~treatment will not be provided.~~

551 Section 20. Subsection (2), paragraph (c) of subsection

26-00433-17 20171760

552 (6), and subsections (16) and (17) of section 395.0197, Florida
 553 Statutes, are amended to read:

554 395.0197 Internal risk management program.—

555 (2) The internal risk management program is the
 556 responsibility of the governing board of the health care
 557 facility. Each licensed facility shall hire a risk manager,
 558 ~~licensed under s. 395.10974,~~ who is responsible for
 559 implementation and oversight of such facility's internal risk
 560 management program and who demonstrates competence, by education
 561 or experience, in the following areas: as required by this
 562 section. A risk manager must not be made responsible for more
 563 than four internal risk management programs in separate licensed
 564 facilities, unless the facilities are under one corporate
 565 ownership or the risk management programs are in rural
 566 hospitals.

567 (a) Applicable standards of health care risk management.

568 (b) Applicable federal, state, and local health and safety
 569 laws and rules.

570 (c) General risk management administration.

571 (d) Patient care.

572 (e) Medical care.

573 (f) Personal and social care.

574 (g) Accident prevention.

575 (h) Departmental organization and management.

576 (i) Community interrelationships.

577 (j) Medical terminology.

578 (6)

579 (c) The report submitted to the agency shall also contain
 580 the name ~~and license number~~ of the risk manager of the licensed

26-00433-17

20171760

581 facility, a copy of its policy and procedures which govern the
 582 measures taken by the facility and its risk manager to reduce
 583 the risk of injuries and adverse incidents, and the results of
 584 such measures. The annual report is confidential and is not
 585 available to the public pursuant to s. 119.07(1) or any other
 586 law providing access to public records. The annual report is not
 587 discoverable or admissible in any civil or administrative
 588 action, except in disciplinary proceedings by the agency or the
 589 appropriate regulatory board. The annual report is not available
 590 to the public as part of the record of investigation for and
 591 prosecution in disciplinary proceedings made available to the
 592 public by the agency or the appropriate regulatory board.
 593 However, the agency or the appropriate regulatory board shall
 594 make available, upon written request by a health care
 595 professional against whom probable cause has been found, any
 596 such records which form the basis of the determination of
 597 probable cause.

598 (16) There shall be no monetary liability on the part of,
 599 and no cause of action for damages shall arise against, any risk
 600 manager, ~~licensed under s. 395.10974,~~ for the implementation and
 601 oversight of the internal risk management program in a facility
 602 licensed under this chapter or chapter 390 as required by this
 603 section, for any act or proceeding undertaken or performed
 604 within the scope of the functions of such internal risk
 605 management program if the risk manager acts without intentional
 606 fraud.

607 (17) A privilege against civil liability is hereby granted
 608 to any ~~licensed~~ risk manager or licensed facility with regard to
 609 information furnished pursuant to this chapter, unless the

26-00433-17

20171760

610 ~~licensed~~ risk manager or facility acted in bad faith or with
 611 malice in providing such information.

612 Section 21. Section 395.1046, Florida Statutes, is
 613 repealed.

614 Section 22. Subsection (2) of section 395.1055, Florida
 615 Statutes, is amended, and paragraph (i) is added to subsection
 616 (1), to read:

617 395.1055 Rules and enforcement.—

618 (1) The agency shall adopt rules pursuant to ss. 120.536(1)
 619 and 120.54 to implement the provisions of this part, which shall
 620 include reasonable and fair minimum standards for ensuring that:

621 (i) All hospitals providing pediatric cardiac
 622 catheterization, pediatric open-heart surgery, organ
 623 transplantation, neonatal intensive care services, psychiatric
 624 services, or comprehensive medical rehabilitation meet the
 625 minimum licensure requirements adopted by the agency. Such
 626 licensure requirements shall include quality of care, nurse
 627 staffing, physician staffing, physical plant, equipment,
 628 emergency transportation, and data reporting standards.

629 (2) Separate standards may be provided for general and
 630 specialty hospitals, ambulatory surgical centers, ~~mobile~~
 631 ~~surgical facilities,~~ and statutory rural hospitals as defined in
 632 s. 395.602.

633 Section 23. Section 395.10971, Florida Statutes, is
 634 repealed.

635 Section 24. Section 395.10972, Florida Statutes, is
 636 repealed.

637 Section 25. Section 395.10973, Florida Statutes, is amended
 638 to read:

26-00433-17

20171760__

639 395.10973 Powers and duties of the agency.—It is the
 640 function of the agency to:

641 (1) Adopt rules pursuant to ss. 120.536(1) and 120.54 to
 642 implement the provisions of this part and part II of chapter 408
 643 conferring duties upon it.

644 ~~(2) Develop, impose, and enforce specific standards within~~
 645 ~~the scope of the general qualifications established by this part~~
 646 ~~which must be met by individuals in order to receive licenses as~~
 647 ~~health care risk managers. These standards shall be designed to~~
 648 ~~ensure that health care risk managers are individuals of good~~
 649 ~~character and otherwise suitable and, by training or experience~~
 650 ~~in the field of health care risk management, qualified in~~
 651 ~~accordance with the provisions of this part to serve as health~~
 652 ~~care risk managers, within statutory requirements.~~

653 ~~(3) Develop a method for determining whether an individual~~
 654 ~~meets the standards set forth in s. 395.10974.~~

655 ~~(4) Issue licenses to qualified individuals meeting the~~
 656 ~~standards set forth in s. 395.10974.~~

657 ~~(5) Receive, investigate, and take appropriate action with~~
 658 ~~respect to any charge or complaint filed with the agency to the~~
 659 ~~effect that a certified health care risk manager has failed to~~
 660 ~~comply with the requirements or standards adopted by rule by the~~
 661 ~~agency or to comply with the provisions of this part.~~

662 ~~(6) Establish procedures for providing periodic reports on~~
 663 ~~persons certified or disciplined by the agency under this part.~~

664 (2)(7) Develop a model risk management program for health
 665 care facilities which will satisfy the requirements of s.
 666 395.0197.

667 (3)(8) Enforce the special-occupancy provisions of the

26-00433-17

20171760__

668 Florida Building Code which apply to hospitals, intermediate
 669 residential treatment facilities, and ambulatory surgical
 670 centers in conducting any inspection authorized by this chapter
 671 and part II of chapter 408.

672 Section 26. Section 395.10974, Florida Statutes, is
 673 repealed.

674 Section 27. Section 395.10975, Florida Statutes, is
 675 repealed.

676 Section 28. Subsection (2) of section 395.602, Florida
 677 Statutes, is amended to read:

678 395.602 Rural hospitals.—

679 (2) DEFINITIONS.—As used in this part, the term:

680 (a) “Emergency care hospital” means a medical facility
 681 which provides:

682 1. Emergency medical treatment; and

683 2. Inpatient care to ill or injured persons prior to their
 684 transportation to another hospital or provides inpatient medical
 685 care to persons needing care for a period of up to 96 hours. The
 686 96-hour limitation on inpatient care does not apply to respite,
 687 skilled nursing, hospice, or other nonacute care patients.

688 (b) “Essential access community hospital” means any
 689 facility which:

690 1. ~~Has at least 100 beds;~~

691 2. ~~Is located more than 35 miles from any other essential~~
 692 ~~access community hospital, rural referral center, or urban~~
 693 ~~hospital meeting criteria for classification as a regional~~
 694 ~~referral center;~~

695 3. ~~Is part of a network that includes rural primary care~~
 696 ~~hospitals;~~

26-00433-17

20171760__

- 697 ~~4. Provides emergency and medical backup services to rural~~
 698 ~~primary care hospitals in its rural health network;~~
 699 ~~5. Extends staff privileges to rural primary care hospital~~
 700 ~~physicians in its network; and~~
 701 ~~6. Accepts patients transferred from rural primary care~~
 702 ~~hospitals in its network.~~
 703 ~~(e) "Inactive rural hospital bed" means a licensed acute~~
 704 ~~care hospital bed, as defined in s. 395.002(13), that is~~
 705 ~~inactive in that it cannot be occupied by acute care inpatients.~~
 706 (a)(d) "Rural area health education center" means an area
 707 health education center (AHEC), as authorized by Pub. L. No. 94-
 708 484, which provides services in a county with a population
 709 density of up to no greater than 100 persons per square mile.
 710 (b)(e) "Rural hospital" means an acute care hospital
 711 licensed under this chapter, having 100 or fewer licensed beds
 712 and an emergency room, which is:
 713 1. The sole provider within a county with a population
 714 density of up to 100 persons per square mile;
 715 2. An acute care hospital, in a county with a population
 716 density of up to 100 persons per square mile, which is at least
 717 30 minutes of travel time, on normally traveled roads under
 718 normal traffic conditions, from any other acute care hospital
 719 within the same county;
 720 3. A hospital supported by a tax district or subdistrict
 721 whose boundaries encompass a population of up to 100 persons per
 722 square mile;
 723 4. A hospital classified as a sole community hospital under
 724 42 C.F.R. s. 412.92 which has up to 175 licensed beds;
 725 5. A hospital with a service area that has a population of

26-00433-17

20171760__

- 726 up to 100 persons per square mile. As used in this subparagraph,
 727 the term "service area" means the fewest number of zip codes
 728 that account for 75 percent of the hospital's discharges for the
 729 most recent 5-year period, based on information available from
 730 the hospital inpatient discharge database in the Florida Center
 731 for Health Information and Transparency at the agency; or
 732 6. A hospital designated as a critical access hospital, as
 733 defined in s. 408.07.
 734
 735 Population densities used in this paragraph must be based upon
 736 the most recently completed United States census. A hospital
 737 that received funds under s. 409.9116 for a quarter beginning no
 738 later than July 1, 2002, is deemed to have been and shall
 739 continue to be a rural hospital from that date through June 30,
 740 2021, if the hospital continues to have up to 100 licensed beds
 741 and an emergency room. An acute care hospital that has not
 742 previously been designated as a rural hospital and that meets
 743 the criteria of this paragraph shall be granted such designation
 744 upon application, including supporting documentation, to the
 745 agency. A hospital that was licensed as a rural hospital during
 746 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
 747 rural hospital from the date of designation through June 30,
 748 2021, if the hospital continues to have up to 100 licensed beds
 749 and an emergency room.
 750 ~~(f) "Rural primary care hospital" means any facility~~
 751 ~~meeting the criteria in paragraph (e) or s. 395.605 which~~
 752 ~~provides:~~
 753 1. ~~Twenty-four hour emergency medical care;~~
 754 2. ~~Temporary inpatient care for periods of 72 hours or less~~

26-00433-17

20171760

to patients requiring stabilization before discharge or transfer to another hospital. The 72-hour limitation does not apply to respite, skilled nursing, hospice, or other nonacute care patients; and

~~3. Has no more than six licensed acute care inpatient beds.~~

(c)(g) "Swing-bed" means a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

Section 29. Section 395.603, Florida Statutes, is amended to read:

395.603 ~~Deactivation of general hospital beds~~; Rural hospital impact statement.—

~~(1) The agency shall establish, by rule, a process by which a rural hospital, as defined in s. 395.602, that seeks licensure as a rural primary care hospital or as an emergency care hospital, or becomes a certified rural health clinic as defined in Pub. L. No. 95-210, or becomes a primary care program such as a county health department, community health center, or other similar outpatient program that provides preventive and curative services, may deactivate general hospital beds. Rural primary care hospitals and emergency care hospitals shall maintain the number of actively licensed general hospital beds necessary for the facility to be certified for Medicare reimbursement. Hospitals that discontinue inpatient care to become rural health care clinics or primary care programs shall deactivate all licensed general hospital beds. All hospitals, clinics, and programs with inactive beds shall provide 24-hour emergency medical care by staffing an emergency room. Providers with~~

26-00433-17

20171760

~~inactive beds shall be subject to the criteria in s. 395.1041. The agency shall specify in rule requirements for making 24-hour emergency care available. Inactive general hospital beds shall be included in the acute care bed inventory, maintained by the agency for certificate of need purposes, for 10 years from the date of deactivation of the beds. After 10 years have elapsed, inactive beds shall be excluded from the inventory. The agency shall, at the request of the licensee, reactivate the inactive general beds upon a showing by the licensee that licensure requirements for the inactive general beds are met.~~

~~(2)~~ In formulating and implementing policies and rules that may have significant impact on the ability of rural hospitals to continue to provide health care services in rural communities, the agency, the department, or the respective regulatory board adopting policies or rules regarding the licensure or certification of health care professionals shall provide a rural hospital impact statement. The rural hospital impact statement shall assess the proposed action in light of the following questions:

(1)(a) Do the health personnel affected by the proposed action currently practice in rural hospitals or are they likely to in the near future?

(2)(b) What are the current numbers of the affected health personnel in this state, their geographic distribution, and the number practicing in rural hospitals?

(3)(c) What are the functions presently performed by the affected health personnel, and are such functions presently performed in rural hospitals?

(4)(d) What impact will the proposed action have on the

26-00433-17

20171760__

813 ability of rural hospitals to recruit the affected personnel to
814 practice in their facilities?

815 ~~(5)(e)~~ What impact will the proposed action have on the
816 limited financial resources of rural hospitals through increased
817 salaries and benefits necessary to recruit or retain such health
818 personnel?

819 ~~(6)(f)~~ Is there a less stringent requirement which could
820 apply to practice in rural hospitals?

821 ~~(7)(g)~~ Will this action create staffing shortages, which
822 could result in a loss to the public of health care services in
823 rural hospitals or result in closure of any rural hospitals?

824 Section 30. Section 395.604, Florida Statutes, is repealed.

825 Section 31. Section 395.605, Florida Statutes, is repealed.

826 Section 32. Paragraph (c) of subsection (1) of section
827 395.701, Florida Statutes, is amended to read:

828 395.701 Annual assessments on net operating revenues for
829 inpatient and outpatient services to fund public medical
830 assistance; administrative fines for failure to pay assessments
831 when due; exemption.—

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

833 (c) "Hospital" means a health care institution as defined
834 in s. 395.002(12), but does not include any hospital operated by
835 a state ~~the agency or the Department of Corrections.~~

836 Section 33. Paragraph (b) of subsection (2) of section
837 395.7015, Florida Statutes, is amended to read:

838 395.7015 Annual assessment on health care entities.—

839 (2) There is imposed an annual assessment against certain
840 health care entities as described in this section:

841 (b) For the purpose of this section, "health care entities"

26-00433-17

20171760__

842 include the following:

843 1. Ambulatory surgical centers ~~and mobile surgical~~
844 ~~facilities licensed under s. 395.003. This subsection shall only~~
845 ~~apply to mobile surgical facilities operating under contracts~~
846 ~~entered into on or after July 1, 1998.~~

847 2. ~~Clinical laboratories licensed under s. 483.091,~~
848 ~~excluding any hospital laboratory defined under s. 483.041(6),~~
849 ~~any clinical laboratory operated by the state or a political~~
850 ~~subdivision of the state, any clinical laboratory which~~
851 ~~qualifies as an exempt organization under s. 501(c)(3) of the~~
852 ~~Internal Revenue Code of 1986, as amended, and which receives 70~~
853 ~~percent or more of its gross revenues from services to charity~~
854 ~~patients or Medicaid patients, and any blood, plasma, or tissue~~
855 ~~bank procuring, storing, or distributing blood, plasma, or~~
856 ~~tissue either for future manufacture or research or distributed~~
857 ~~on a nonprofit basis, and further excluding any clinical~~
858 ~~laboratory which is wholly owned and operated by 6 or fewer~~
859 ~~physicians who are licensed pursuant to chapter 458 or chapter~~
860 ~~459 and who practice in the same group practice, and at which no~~
861 ~~clinical laboratory work is performed for patients referred by~~
862 ~~any health care provider who is not a member of the same group.~~

863 2.3. Diagnostic-imaging centers that are freestanding
864 outpatient facilities that provide specialized services for the
865 identification or determination of a disease through examination
866 and also provide sophisticated radiological services, and in
867 which services are rendered by a physician licensed by the Board
868 of Medicine under s. 458.311, s. 458.313, or s. 458.317, or by
869 an osteopathic physician licensed by the Board of Osteopathic
870 Medicine under s. 459.0055 or s. 459.0075. For purposes of this

26-00433-17 20171760
 paragraph, "sophisticated radiological services" means the following: magnetic resonance imaging; nuclear medicine; angiography; arteriography; computed tomography; positron emission tomography; digital vascular imaging; bronchography; lymphangiography; splenography; ultrasound, excluding ultrasound providers that are part of a private physician's office practice or when ultrasound is provided by two or more physicians licensed under chapter 458 or chapter 459 who are members of the same professional association and who practice in the same medical specialties; and such other sophisticated radiological services, excluding mammography, as adopted in rule by the board.

Section 34. Subsection (1) of section 400.0625, Florida Statutes, is amended to read:

400.0625 Minimum standards for clinical laboratory test results and diagnostic X-ray results.—

(1) Each nursing home, as a requirement for issuance or renewal of its license, shall require that all clinical laboratory tests performed for the nursing home be performed by a licensed clinical laboratory ~~licensed under the provisions of chapter 483~~, except for such self-testing procedures as are approved by the agency by rule. ~~Results of clinical laboratory tests performed prior to admission which meet the minimum standards provided in s. 483.181(3) shall be accepted in lieu of routine examinations required upon admission and clinical laboratory tests which may be ordered by a physician for residents of the nursing home.~~

Section 35. Subsection (1) and paragraphs (b), (e), and (f) of subsection (4) of section 400.464, Florida Statutes, are

26-00433-17 20171760
 amended, and subsection (6) is added to that section, to read:
 400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—
 (1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required in order to operate a home health agency in this state. A license issued after June 30, 2017, must specify the home health services that the organization is authorized to perform and indicate whether such specified services are considered skilled care. The provision or advertising of services which require licensure pursuant to this part without such services being specified on the face of the license issued after June 30, 2017, constitutes unlicensed activity as prohibited under s. 408.812.

(4)

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

26-00433-17

20171760

929 (e) Any person who owns, operates, or maintains an
 930 unlicensed home health agency and who, ~~within 10 working days~~
 931 after receiving notification from the agency, fails to cease
 932 operation and apply for a license under this part commits a
 933 misdemeanor of the second degree, punishable as provided in s.
 934 775.082 or s. 775.083. Each day of continued operation is a
 935 separate offense.

936 (f) Any home health agency that fails to cease operation
 937 after agency notification may be fined in accordance with s.
 938 408.812 \$500 for each day of noncompliance.

939 (6) Any person, entity, or organization providing home
 940 health services which is exempt from licensure under subsection
 941 (5) may voluntarily apply for a certificate of exemption from
 942 licensure under its exempt status with the agency on a form that
 943 sets forth its name or names and addresses, a statement of the
 944 reasons why it is exempt from licensure as a home health agency,
 945 and other information deemed necessary by the agency. A
 946 certificate of exemption is valid for a period of not more than
 947 2 years and is not transferable. The agency may charge an
 948 applicant for a certificate of exemption in an amount equal to
 949 \$100 or the actual cost of processing the certificate.

950 Section 36. Present subsections (7), (8), and (9) of
 951 section 400.471, Florida Statutes, are renumbered as subsections
 952 (6), (7), and (8), respectively, and subsection (2), present
 953 subsection (6), and paragraph (g) of subsection (10) are
 954 amended, to read:

955 400.471 Application for license; fee.—

956 (2) In addition to the requirements of part II of chapter
 957 408, the initial applicant, the applicant for a change of

26-00433-17

20171760

958 ownership, and the applicant for the addition of skilled care
 959 services, must file with the application satisfactory proof that
 960 the home health agency is in compliance with this part and
 961 applicable rules, including:

962 (a) A listing of services to be provided, either directly
 963 by the applicant or through contractual arrangements with
 964 existing providers.

965 (b) The number and discipline of professional staff to be
 966 employed.

967 ~~(e) Completion of questions concerning volume data on the~~
 968 ~~renewal application as determined by rule.~~

969 (c)(d) A business plan, signed by the applicant, which
 970 details the home health agency's methods to obtain patients and
 971 its plan to recruit and maintain staff.

972 (d)(e) Evidence of contingency funding as required under s.
 973 408.8065 equal to 1 month's average operating expenses during
 974 the first year of operation.

975 (e)(f) A balance sheet, income and expense statement, and
 976 statement of cash flows for the first 2 years of operation which
 977 provide evidence of having sufficient assets, credit, and
 978 projected revenues to cover liabilities and expenses. The
 979 applicant has demonstrated financial ability to operate if the
 980 applicant's assets, credit, and projected revenues meet or
 981 exceed projected liabilities and expenses. An applicant may not
 982 project an operating margin of 15 percent or greater for any
 983 month in the first year of operation. All documents required
 984 under this paragraph must be prepared in accordance with
 985 generally accepted accounting principles and compiled and signed
 986 by a certified public accountant.

26-00433-17

20171760__

987 ~~(f)(g)~~ All other ownership interests in health care
 988 entities for each controlling interest, as defined in part II of
 989 chapter 408.
 990 ~~(g)(h)~~ In the case of an application for initial licensure,
 991 an application for a change of ownership, or an application for
 992 the addition of skilled care services, documentation of
 993 accreditation, or an application for accreditation, from an
 994 accrediting organization that is recognized by the agency as
 995 having standards comparable to those required by this part and
 996 part II of chapter 408. A home health agency that ~~is not~~
 997 ~~Medicare or Medicaid certified~~ and does not provide skilled care
 998 is exempt from this paragraph. Notwithstanding s. 408.806, an
 999 initial applicant that has applied for accreditation must
 1000 provide proof of accreditation that is not conditional or
 1001 provisional and submit a survey demonstrating compliance with
 1002 the requirements of this part, part II of chapter 408, and
 1003 applicable rules from an accrediting organization that is
 1004 recognized by the agency as having standards comparable to those
 1005 required by this part and part II of chapter 408 within 120 days
 1006 after the date of the agency's receipt of the application for
 1007 licensure ~~or the application shall be withdrawn from further~~
 1008 ~~consideration~~. Such accreditation must be continuously
 1009 maintained by the home health agency to maintain licensure. The
 1010 agency shall accept, in lieu of its own periodic licensure
 1011 survey, the submission of the survey of an accrediting
 1012 organization that is recognized by the agency if the
 1013 accreditation of the licensed home health agency is not
 1014 provisional and if the licensed home health agency authorizes
 1015 releases of, and the agency receives the report of, the

Page 35 of 94

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

26-00433-17

20171760__

1016 accrediting organization.
 1017 ~~(6) The agency may not issue a license designated as~~
 1018 ~~certified to a home health agency that fails to satisfy the~~
 1019 ~~requirements of a Medicare certification survey from the agency.~~
 1020 ~~(9)(10)~~ The agency may not issue a renewal license for a
 1021 home health agency in any county having at least one licensed
 1022 home health agency and that has more than one home health agency
 1023 per 5,000 persons, as indicated by the most recent population
 1024 estimates published by the Legislature's Office of Economic and
 1025 Demographic Research, if the applicant or any controlling
 1026 interest has been administratively sanctioned by the agency
 1027 during the 2 years prior to the submission of the licensure
 1028 renewal application for one or more of the following acts:
 1029 (g) Demonstrating a pattern of failing to provide a service
 1030 specified in the home health agency's written agreement with a
 1031 patient or the patient's legal representative, or the plan of
 1032 care for that patient, except unless a reduction in service is
 1033 ~~mandated by Medicare, Medicaid, or a state program~~ or as
 1034 provided in s. 400.492(3). A pattern may be demonstrated by a
 1035 showing of at least three incidents, regardless of the patient
 1036 or service, in which the home health agency did not provide a
 1037 service specified in a written agreement or plan of care during
 1038 a 3-month period;
 1039 Section 37. Subsection (5) of section 400.474, Florida
 1040 Statutes, is amended to read:
 1041 400.474 Administrative penalties.—
 1042 (5) The agency shall impose a fine of \$5,000 against a home
 1043 health agency that demonstrates a pattern of failing to provide
 1044 a service specified in the home health agency's written

Page 36 of 94

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

26-00433-17

20171760

agreement with a patient or the patient's legal representative, or the plan of care for that patient, ~~except unless a reduction in service is mandated by Medicare, Medicaid, or a state program~~ or as provided in s. 400.492(3). A pattern may be demonstrated by a showing of at least three incidences, regardless of the patient or service, where the home health agency did not provide a service specified in a written agreement or plan of care during a 3-month period. The agency shall impose the fine for each occurrence. The agency may also impose additional administrative fines under s. 400.484 for the direct or indirect harm to a patient, or deny, revoke, or suspend the license of the home health agency for a pattern of failing to provide a service specified in the home health agency's written agreement with a patient or the plan of care for that patient.

Section 38. Paragraph (c) of subsection (2) of section 400.476, Florida Statutes, is amended to read:

400.476 Staffing requirements; notifications; limitations on staffing services.—

(2) DIRECTOR OF NURSING.—

(c) A home health agency that provides skilled nursing care ~~must is not Medicare or Medicaid certified and does not provide skilled care or provides only physical, occupational, or speech therapy is not required to~~ have a director of nursing ~~and is exempt from paragraph (b).~~

Section 39. Subsection (2) of section 400.484, Florida Statutes, is amended to read:

400.484 Right of inspection; violations deficiencies; fines.—

(2) The agency shall impose fines for various classes of

26-00433-17

20171760

violations deficiencies in accordance with the following schedule:

(a) Class I violations are defined in s. 408.813 ~~A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury.~~ Upon finding a class I violation deficiency, the agency shall impose an administrative fine in the amount of \$15,000 for each occurrence and each day that the violation deficiency exists.

(b) Class II violations are defined in s. 408.813 ~~A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient.~~ Upon finding a class II violation deficiency, the agency shall impose an administrative fine in the amount of \$5,000 for each occurrence and each day that the violation deficiency exists.

(c) Class III violations are defined in s. 408.813 ~~A class III deficiency is any act, omission, or practice that has an indirect, adverse effect on the health, safety, or security of a patient.~~ Upon finding an uncorrected or repeated class III violation deficiency, the agency shall impose an administrative fine not to exceed \$1,000 for each occurrence and each day that the uncorrected or repeated violation deficiency exists.

(d) Class IV violations are defined in s. 408.813 ~~A class IV deficiency is any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients.~~ These violations are of a type that the agency determines do not threaten the health,

26-00433-17 20171760__

safety, or security of patients. Upon finding an uncorrected or repeated class IV ~~violation deficiency~~, the agency shall impose an administrative fine not to exceed \$500 for each occurrence and each day that the uncorrected or repeated violation ~~deficiency~~ exists.

Section 40. Subsection (4) of section 400.497, Florida Statutes, is amended to read:

400.497 Rules establishing minimum standards.—The agency shall adopt, publish, and enforce rules to implement part II of chapter 408 and this part, including, as applicable, ss. 400.506 and 400.509, which must provide reasonable and fair minimum standards relating to:

(4) Licensure and certificate of exemption application and renewal.

Section 41. Subsection (5), paragraphs (d) and (e) of subsection (6), paragraph (a) of subsection (15), and subsections (19) and (20) of section 400.506, Florida Statutes, are amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(5) (a) In addition to the requirements of s. 408.812, any person who owns, operates, or maintains an unlicensed nurse registry and who, ~~within 10 working days~~ after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(b) If a nurse registry fails to cease operation after agency notification, the agency may impose a fine in accordance

26-00433-17 20171760__

with s. 408.812 ~~of \$500 for each day of noncompliance.~~

(6)

(d) A registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter by a nurse registry is deemed an independent contractor and not an employee of the nurse registry under any chapter, regardless of the obligations imposed on a nurse registry under this chapter or chapter 408.

(e) Upon referral of a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide for contract in a private residence or facility, the nurse registry shall advise the patient, the patient's family, or any other person acting on behalf of the patient, at the time of the contract for services, that the caregiver referred by the nurse registry is an independent contractor and that the it is not the obligation of a nurse registry is not permitted to monitor, supervise, manage, or train a caregiver referred for contract under this chapter.

(15) (a) The agency may deny, suspend, or revoke the license of a nurse registry and shall impose a fine of \$5,000 against a nurse registry that:

1. Provides services to residents in an assisted living facility for which the nurse registry does not receive fair market value remuneration.

2. Provides staffing to an assisted living facility for which the nurse registry does not receive fair market value remuneration.

3. Fails to provide the agency, upon request, with copies of all contracts with assisted living facilities which were

26-00433-17

20171760__

executed within the last 5 years.

~~4. Gives remuneration to a case manager, discharge planner, facility-based staff member, or third-party vendor who is involved in the discharge planning process of a facility licensed under chapter 395 or this chapter and from whom the nurse registry receives referrals. A nurse registry is exempt from this subparagraph if it does not bill the Florida Medicaid program or the Medicare program or share a controlling interest with any entity licensed, registered, or certified under part II of chapter 408 that bills the Florida Medicaid program or the Medicare program.~~

~~5. Gives remuneration to a physician, a member of the physician's office staff, or an immediate family member of the physician, and the nurse registry received a patient referral in the last 12 months from that physician or the physician's office staff. A nurse registry is exempt from this subparagraph if it does not bill the Florida Medicaid program or the Medicare program or share a controlling interest with any entity licensed, registered, or certified under part II of chapter 408 that bills the Florida Medicaid program or the Medicare program.~~

~~(19) It is not the obligation of~~ A nurse registry is not permitted to monitor, supervise, manage, or train a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter. In the event of a violation of this chapter or a violation of any other law of this state by a referred registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide, or a deficiency in credentials which comes to the attention of

26-00433-17

20171760__

the nurse registry, the nurse registry shall advise the patient to terminate the referred person's contract, providing the reason for the suggested termination; cease referring the person to other patients or facilities; and, if practice violations are involved, notify the licensing board. This section does not affect or negate any other obligations imposed on a nurse registry under chapter 408.

(20) Records required to be filed under this chapter with the nurse registry as a repository of records must be kept in accordance with rules adopted by the agency. The nurse registry is not permitted ~~has no obligation~~ to review or act upon such records except as specified in subsection (19).

Section 42. Subsection (1) of section 400.606, Florida Statutes, is amended to read:

400.606 License; application; renewal; conditional license or permit; certificate of need.—

(1) In addition to the requirements of part II of chapter 408, the initial application and change of ownership application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:

(a) The estimated average number of terminally ill persons to be served monthly.

(b) The geographic area in which hospice services will be available.

(c) A listing of services which are or will be provided, either directly by the applicant or through contractual arrangements with existing providers.

26-00433-17

20171760__

1219 (d) Provisions for the implementation of hospice home care
 1220 within 3 months after licensure.
 1221 (e) Provisions for the implementation of hospice homelike
 1222 inpatient care within 12 months after licensure.
 1223 (f) The number and disciplines of professional staff to be
 1224 employed.
 1225 (g) The name and qualifications of any existing or
 1226 potential contractee.
 1227 (h) A plan for attracting and training volunteers.
 1228
 1229 ~~If the applicant is an existing licensed health care provider,~~
 1230 ~~the application must be accompanied by a copy of the most recent~~
 1231 ~~profit loss statement and, if applicable, the most recent~~
 1232 ~~licensure inspection report.~~
 1233 Section 43. Subsection (6) of section 400.925, Florida
 1234 Statutes, is amended to read:
 1235 400.925 Definitions.—As used in this part, the term:
 1236 (6) "Home medical equipment" includes any product as
 1237 defined by the Federal Drug Administration's Drugs, Devices and
 1238 Cosmetics Act, any products reimbursed under the Medicare Part B
 1239 Durable Medical Equipment benefits, or any products reimbursed
 1240 under the Florida Medicaid durable medical equipment program.
 1241 Home medical equipment includes:
 1242 (a) Oxygen and related respiratory equipment; manual,
 1243 ~~motorized, or customized wheelchairs and related seating and~~
 1244 ~~positioning, but does not include prosthetics or orthotics or~~
 1245 ~~any splints, braces, or aids custom fabricated by a licensed~~
 1246 ~~health care practitioner;~~
 1247 (b) Motorized scooters;

26-00433-17

20171760__

1248 (c) Personal transfer systems; and
 1249 (d) Specialty beds, for use by a person with a medical
 1250 need; and
 1251 (e) Manual, motorized, or customized wheelchairs and
 1252 related seating and positioning, but does not include
 1253 prosthetics, orthotics, or any splints, braces, or aids custom
 1254 fabricated by a licensed health care practitioner.
 1255 Section 44. Subsection (4) of section 400.931, Florida
 1256 Statutes, is amended to read:
 1257 400.931 Application for license; fee.—
 1258 (4) When a change of the general manager of a home medical
 1259 equipment provider occurs, the licensee must notify the agency
 1260 of the change within the timeframes established in part II of
 1261 chapter 408 and applicable rules 45 days.
 1262 Section 45. Subsection (2) of section 400.933, Florida
 1263 Statutes, is amended to read:
 1264 400.933 Licensure inspections and investigations.—
 1265 (2) The agency shall accept, in lieu of its own periodic
 1266 inspections for licensure, submission of the following:
 1267 (a) The survey or inspection of an accrediting
 1268 organization, provided the accreditation of the licensed home
 1269 medical equipment provider is not provisional and provided the
 1270 licensed home medical equipment provider authorizes release of,
 1271 and the agency receives the report of, the accrediting
 1272 organization; or
 1273 (b) A copy of a valid medical oxygen retail establishment
 1274 permit issued by the Department of Business and Professional
 1275 Regulation Health, pursuant to chapter 499.
 1276 Section 46. Subsection (2) of section 400.980, Florida

26-00433-17

20171760__

Statutes, is amended to read:

400.980 Health care services pools.—

(2) The requirements of part II of chapter 408 apply to the provision of services that require licensure or registration pursuant to this part and part II of chapter 408 and to entities registered by or applying for such registration from the agency pursuant to this part. Registration or a license issued by the agency is required for the operation of a health care services pool in this state. In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted using this part, part II of chapter 408, and applicable rules. The agency shall adopt rules and provide forms required for such registration and shall impose a registration fee in an amount sufficient to cover the cost of administering this part and part II of chapter 408. In addition to the requirements in part II of chapter 408, the registrant must provide the agency with any change of information contained on the original registration application within the timeframes established in this part, part II of chapter 408, and applicable rules ~~14 days prior to the change.~~

Section 47. Paragraphs (a) through (d) of subsection (4) of section 400.9905, Florida Statutes, are amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

Page 45 of 94

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

26-00433-17

20171760__

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ~~ss. 383.30-383.332~~ ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483,~~ chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ~~ss. 383.30-383.332~~ ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, ~~part I of chapter 483,~~ chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

Page 46 of 94

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

26-00433-17

20171760

1335 (c) Entities that are owned, directly or indirectly, by an
 1336 entity licensed or registered by the state pursuant to chapter
 1337 395; entities that are owned, directly or indirectly, by an
 1338 entity licensed or registered by the state and providing only
 1339 health care services within the scope of services authorized
 1340 pursuant to their respective licenses under ss. 383.30-383.332
 1341 ~~ss. 383.30-383.335~~, chapter 390, chapter 394, chapter 397, this
 1342 chapter except part X, chapter 429, chapter 463, chapter 465,
 1343 chapter 466, chapter 478, ~~part I of chapter 483~~, chapter 484, or
 1344 chapter 651; end-stage renal disease providers authorized under
 1345 42 C.F.R. part 405, subpart U; providers certified under 42
 1346 C.F.R. part 485, subpart B or subpart H; or any entity that
 1347 provides neonatal or pediatric hospital-based health care
 1348 services by licensed practitioners solely within a hospital
 1349 under chapter 395.

1350 (d) Entities that are under common ownership, directly or
 1351 indirectly, with an entity licensed or registered by the state
 1352 pursuant to chapter 395; entities that are under common
 1353 ownership, directly or indirectly, with an entity licensed or
 1354 registered by the state and providing only health care services
 1355 within the scope of services authorized pursuant to their
 1356 respective licenses under ss. 383.30-383.332 ~~ss. 383.30-383.335~~,
 1357 chapter 390, chapter 394, chapter 397, this chapter except part
 1358 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter
 1359 478, ~~part I of chapter 483~~, chapter 484, or chapter 651; end-
 1360 stage renal disease providers authorized under 42 C.F.R. part
 1361 405, subpart U; providers certified under 42 C.F.R. part 485,
 1362 subpart B or subpart H; or any entity that provides neonatal or
 1363 pediatric hospital-based health care services by licensed

26-00433-17

20171760

1364 practitioners solely within a hospital licensed under chapter
 1365 395.

1366
 1367 Notwithstanding this subsection, an entity shall be deemed a
 1368 clinic and must be licensed under this part in order to receive
 1369 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
 1370 627.730-627.7405, unless exempted under s. 627.736(5)(h).

1371 Section 48. Paragraph (a) of subsection (2) of section
 1372 408.033, Florida Statutes, is amended to read:

1373 408.033 Local and state health planning.—

1374 (2) FUNDING.—

1375 (a) The Legislature intends that the cost of local health
 1376 councils be borne by assessments on selected health care
 1377 facilities subject to facility licensure by the Agency for
 1378 Health Care Administration, including abortion clinics, assisted
 1379 living facilities, ambulatory surgical centers, birthing
 1380 centers, ~~clinical laboratories except community nonprofit blood~~
 1381 ~~banks and clinical laboratories operated by practitioners for~~
 1382 ~~exclusive use regulated under s. 483.035~~, home health agencies,
 1383 hospices, hospitals, intermediate care facilities for the
 1384 developmentally disabled, nursing homes, health care clinics,
 1385 and multiphasic testing centers and by assessments on
 1386 organizations subject to certification by the agency pursuant to
 1387 chapter 641, part III, including health maintenance
 1388 organizations and prepaid health clinics. Fees assessed may be
 1389 collected prospectively at the time of licensure renewal and
 1390 prorated for the licensure period.

1391 Section 49. Paragraph (e) and present paragraph (p) of
 1392 subsection (3) of section 408.036, Florida Statutes, are amended

26-00433-17

20171760__

1393 to read:

1394 408.036 Projects subject to review; exemptions.—

1395 (3) EXEMPTIONS.—Upon request, the following projects are
1396 subject to exemption from the provisions of subsection (1):

1397 ~~(e) For mobile surgical facilities and related health care~~
1398 ~~services provided under contract with the Department of~~
1399 ~~Corrections or a private correctional facility operating~~
1400 ~~pursuant to chapter 957.~~

1401 (o) (p) For replacement of a licensed nursing home on the
1402 same site, or within 5 miles of the same site if within the same
1403 subdistrict, if the number of licensed beds does not increase
1404 except as permitted under paragraph (e) ~~(f)~~.

1405 Section 50. Subsection (4) of section 408.061, Florida
1406 Statutes, is amended to read:

1407 408.061 Data collection; uniform systems of financial
1408 reporting; information relating to physician charges;
1409 confidential information; immunity.—

1410 (4) Within 120 days after the end of its fiscal year, each
1411 health care facility, excluding continuing care facilities as
1412 defined in s. 408.07(13), hospitals operated by state agencies,
1413 and nursing homes as defined in s. 408.07(36) 408.07(14) and
1414 (37), shall file with the agency, on forms adopted by the agency
1415 and based on the uniform system of financial reporting, its
1416 actual financial experience for that fiscal year, including
1417 expenditures, revenues, and statistical measures. Such data may
1418 be based on internal financial reports which are certified to be
1419 complete and accurate by the provider. However, hospitals'
1420 actual financial experience shall be their audited actual
1421 experience. Every nursing home shall submit to the agency, in a

26-00433-17

20171760__

1422 format designated by the agency, a statistical profile of the
1423 nursing home residents. The agency, in conjunction with the
1424 Department of Elderly Affairs and the Department of Health,
1425 shall review these statistical profiles and develop
1426 recommendations for the types of residents who might more
1427 appropriately be placed in their homes or other noninstitutional
1428 settings.

1429 Section 51. Subsection (11) of section 408.07, Florida
1430 Statutes, is amended to read:

1431 408.07 Definitions.—As used in this chapter, with the
1432 exception of ss. 408.031-408.045, the term:

1433 ~~(11) "Clinical laboratory" means a facility licensed under~~
1434 ~~s. 483.091, excluding: any hospital laboratory defined under s.~~
1435 ~~483.041(6); any clinical laboratory operated by the state or a~~
1436 ~~political subdivision of the state; any blood or tissue bank~~
1437 ~~where the majority of revenues are received from the sale of~~
1438 ~~blood or tissue and where blood, plasma, or tissue is procured~~
1439 ~~from volunteer donors and donated, processed, stored, or~~
1440 ~~distributed on a nonprofit basis; and any clinical laboratory~~
1441 ~~which is wholly owned and operated by physicians who are~~
1442 ~~licensed pursuant to chapter 458 or chapter 459 and who practice~~
1443 ~~in the same group practice, and at which no clinical laboratory~~
1444 ~~work is performed for patients referred by any health care~~
1445 ~~provider who is not a member of that same group practice.~~

1446 Section 52. Subsection (4) of section 408.20, Florida
1447 Statutes, is amended to read:

1448 408.20 Assessments; Health Care Trust Fund.—

1449 (4) Hospitals operated by state agencies ~~the Department of~~
1450 ~~Children and Families, the Department of Health, or the~~

26-00433-17 20171760__

1451 ~~Department of Corrections~~ are exempt from the assessments
1452 required under this section.

1453 Section 53. Section 408.7056, Florida Statutes, is
1454 repealed.

1455 Section 54. Subsections (10), (11), and (27) of section
1456 408.802, Florida Statutes, are amended to read:

1457 408.802 Applicability.—The provisions of this part apply to
1458 the provision of services that require licensure as defined in
1459 this part and to the following entities licensed, registered, or
1460 certified by the agency, as described in chapters 112, 383, 390,
1461 394, 395, 400, 429, 440, 483, and 765:

1462 ~~(10) Mobile surgical facilities, as provided under part I~~
1463 ~~of chapter 395.~~

1464 ~~(11) Health care risk managers, as provided under part I of~~
1465 ~~chapter 395.~~

1466 ~~(27) Clinical laboratories, as provided under part I of~~
1467 ~~chapter 483.~~

1468 Section 55. Present subsections (12) and (13) of section
1469 408.803, Florida Statutes, are renumbered as subsections (13)
1470 and (14), respectively, and a new subsection (12) is added to
1471 that section, to read:

1472 408.803 Definitions.—As used in this part, the term:

1473 (12) "Relative" means an individual who is the father,
1474 mother, stepfather, stepmother, son, daughter, brother, sister,
1475 grandmother, grandfather, great-grandmother, great-grandfather,
1476 grandson, granddaughter, uncle, aunt, first cousin, nephew,
1477 niece, husband, wife, father-in-law, mother-in-law, son-in-law,
1478 daughter-in-law, brother-in-law, sister-in-law, stepson,
1479 stepdaughter, stepbrother, stepsister, half-brother, or half-

26-00433-17 20171760__

1480 sister of a patient or client.

1481 Section 56. Paragraph (a) of subsection (1) and paragraph
1482 (c) of subsection (7) of section 408.806, Florida Statutes, are
1483 amended, and subsection (9) is added to that section, to read:

1484 408.806 License application process.—

1485 (1) An application for licensure must be made to the agency
1486 on forms furnished by the agency, submitted under oath or
1487 attestation, and accompanied by the appropriate fee in order to
1488 be accepted and considered timely. The application must contain
1489 information required by authorizing statutes and applicable
1490 rules and must include:

1491 (a) The name, address, and social security number, or
1492 individual taxpayer identification number if a social security
1493 number cannot legally be obtained, of:

1494 1. The applicant;

1495 2. The administrator or a similarly titled person who is
1496 responsible for the day-to-day operation of the provider;

1497 3. The financial officer or similarly titled person who is
1498 responsible for the financial operation of the licensee or
1499 provider; and

1500 4. Each controlling interest if the applicant or
1501 controlling interest is an individual.

1502 The licensee shall ensure that no person has any ownership
1503 interest in the licensee, directly or indirectly, regardless of
1504 ownership structure, who is ineligible pursuant to s.
1505 408.809(4). The licensee shall ensure that no person holds or
1506 has held any ownership interest, directly or indirectly,
1507 regardless of ownership structure, in a provider that has had a
1508

26-00433-17 20171760

1509 license or change of ownership application denied, revoked, or
 1510 excluded pursuant to s. 408.815.

1511 (7)

1512 (c) If an inspection is required by the authorizing statute
 1513 for a license application other than an initial application, the
 1514 inspection must be unannounced. This paragraph does not apply to
 1515 inspections required pursuant to ss. 383.324, 395.0161(4), and
 1516 429.67(6), and 483.061(2).

1517 (9) A licensee that holds a license for multiple providers
 1518 licensed by the agency may request that all related license
 1519 expiration dates be aligned. The agency may issue a license for
 1520 an abbreviated licensure period with a prorated licensure fee.

1521 Section 57. Subsection (8) of section 408.810, Florida
 1522 Statutes, is amended, and subsection (11) is added to that
 1523 section to read:

1524 408.810 Minimum licensure requirements.—In addition to the
 1525 licensure requirements specified in this part, authorizing
 1526 statutes, and applicable rules, each applicant and licensee must
 1527 comply with the requirements of this section in order to obtain
 1528 and maintain a license.

1529 (8) Upon application for initial licensure or change of
 1530 ownership licensure, the applicant shall furnish satisfactory
 1531 proof of the applicant's financial ability to operate in
 1532 accordance with the requirements of this part, authorizing
 1533 statutes, and applicable rules. The agency shall establish
 1534 standards for this purpose, including information concerning the
 1535 applicant's controlling interests. The agency shall also
 1536 establish documentation requirements, to be completed by each
 1537 applicant, that show anticipated provider revenues and

26-00433-17 20171760

1538 expenditures, the basis for financing the anticipated cash-flow
 1539 requirements of the provider, and an applicant's access to
 1540 contingency financing. A current certificate of authority,
 1541 pursuant to chapter 651, may be provided as proof of financial
 1542 ability to operate. The agency may require a licensee to provide
 1543 proof of financial ability to operate at any time if there is
 1544 evidence of financial instability, including, but not limited
 1545 to, unpaid expenses necessary for the basic operations of the
 1546 provider. An applicant applying for change of ownership
 1547 licensure is exempt from furnishing proof of the applicant's
 1548 financial ability to operate if the provider has been licensed
 1549 for at least 5 years and:

1550 (a) The licensee change is a result of a corporate
 1551 reorganization under which the controlling interest is unchanged
 1552 and the applicant submits organization charts that represent the
 1553 current and proposed structure of the reorganized corporation;
 1554 or

1555 (b) The licensee change is due solely to the death of a
 1556 controlling interest, and the surviving controlling interests
 1557 continue to hold at least 51 percent of ownership after the
 1558 change of ownership.

1559 (11) The agency may adopt rules that govern the
 1560 circumstances under which a controlling interest, an
 1561 administrator, an employee, a contractor, or a representative
 1562 thereof who is not a relative of the patient or client may act
 1563 as a legal representative, agent, health care surrogate, power
 1564 of attorney, or guardian of a patient or client. Such rules may
 1565 include requirements related to disclosure, bonding,
 1566 restrictions, and client protections.

26-00433-17

20171760

1567 Section 58. Section 408.812, Florida Statutes, is amended
 1568 to read:
 1569 408.812 Unlicensed activity.—
 1570 (1) A person or entity may not offer or advertise services
 1571 that require licensure as defined by this part, authorizing
 1572 statutes, or applicable rules to the public without obtaining a
 1573 valid license from the agency. A licenseholder may not advertise
 1574 or hold out to the public that he or she holds a license for
 1575 other than that for which he or she actually holds the license.
 1576 (2) The operation or maintenance of an unlicensed provider
 1577 or the performance of any services that require licensure
 1578 without proper licensure is a violation of this part and
 1579 authorizing statutes. Unlicensed activity constitutes harm that
 1580 materially affects the health, safety, and welfare of clients
 1581 and constitutes abuse and neglect as defined in s. 415.102. The
 1582 agency or any state attorney may, in addition to other remedies
 1583 provided in this part, bring an action for an injunction to
 1584 restrain such violation, or to enjoin the future operation or
 1585 maintenance of the unlicensed provider or the performance of any
 1586 services in violation of this part and authorizing statutes,
 1587 until compliance with this part, authorizing statutes, and
 1588 agency rules has been demonstrated to the satisfaction of the
 1589 agency.
 1590 (3) It is unlawful for any person or entity to own,
 1591 operate, or maintain an unlicensed provider. If after receiving
 1592 notification from the agency, such person or entity fails to
 1593 cease operation ~~and apply for a license under this part and~~
 1594 ~~authorizing statutes,~~ the person or entity shall be subject to
 1595 penalties as prescribed by authorizing statutes and applicable

Page 55 of 94

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

26-00433-17

20171760

1596 rules. Each day of ~~continued~~ operation is a separate offense.
 1597 (4) Any person or entity that fails to cease operation
 1598 after agency notification may be fined \$1,000 for each day of
 1599 noncompliance.
 1600 (5) When a controlling interest or licensee has an interest
 1601 in more than one provider and fails to license a provider
 1602 rendering services that require licensure, the agency may revoke
 1603 all licenses and impose actions under s. 408.814 and, regardless
 1604 of correction, impose a fine of \$1,000 per day, unless otherwise
 1605 specified by authorizing statutes, against each licensee until
 1606 such time as the appropriate license is obtained or the
 1607 unlicensed activity ceases for the unlicensed operation.
 1608 (6) In addition to granting injunctive relief pursuant to
 1609 subsection (2), if the agency determines that a person or entity
 1610 is operating or maintaining a provider without obtaining a
 1611 license and determines that a condition exists that poses a
 1612 threat to the health, safety, or welfare of a client of the
 1613 provider, the person or entity is subject to the same actions
 1614 and fines imposed against a licensee as specified in this part,
 1615 authorizing statutes, and agency rules.
 1616 (7) Any person aware of the operation of an unlicensed
 1617 provider must report that provider to the agency.
 1618 Section 59. Subsections (10), (11), (26), and (27) of
 1619 section 408.820, Florida Statutes, are amended to read:
 1620 408.820 Exemptions.—Except as prescribed in authorizing
 1621 statutes, the following exemptions shall apply to specified
 1622 requirements of this part:
 1623 ~~(10) Mobile surgical facilities, as provided under part I~~
 1624 ~~of chapter 395, are exempt from s. 408.810(7)-(10).~~

Page 56 of 94

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

26-00433-17

20171760__

1625 ~~(11) Health care risk managers, as provided under part I of~~
 1626 ~~chapter 395, are exempt from ss. 408.806(7), 408.810(4)-(10),~~
 1627 ~~and 408.811.~~

1628 ~~(26) Clinical laboratories, as provided under part I of~~
 1629 ~~chapter 483, are exempt from s. 408.810(5)-(10).~~

1630 ~~(24)-(27)~~ Multiphasic health testing centers, as provided
 1631 under part I ~~II~~ of chapter 483, are exempt from s. 408.810(5)-
 1632 (10).

1633 Section 60. Subsection (7) of section 409.905, Florida
 1634 Statutes, is amended to read:

1635 409.905 Mandatory Medicaid services.—The agency may make
 1636 payments for the following services, which are required of the
 1637 state by Title XIX of the Social Security Act, furnished by
 1638 Medicaid providers to recipients who are determined to be
 1639 eligible on the dates on which the services were provided. Any
 1640 service under this section shall be provided only when medically
 1641 necessary and in accordance with state and federal law.
 1642 Mandatory services rendered by providers in mobile units to
 1643 Medicaid recipients may be restricted by the agency. Nothing in
 1644 this section shall be construed to prevent or limit the agency
 1645 from adjusting fees, reimbursement rates, lengths of stay,
 1646 number of visits, number of services, or any other adjustments
 1647 necessary to comply with the availability of moneys and any
 1648 limitations or directions provided for in the General
 1649 Appropriations Act or chapter 216.

1650 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay
 1651 for medically necessary diagnostic laboratory procedures ordered
 1652 by a licensed physician or other licensed practitioner of the
 1653 healing arts which are provided for a recipient in a laboratory

26-00433-17

20171760__

1654 that meets the requirements for Medicare participation and
 1655 appropriately certified by the Centers for Medicare and Medicaid
 1656 Services (CMS) under the federal Clinical Laboratory Improvement
 1657 Amendments of 1988 is licensed under chapter 483, if required.

1658 Section 61. Subsection (6) of section 409.9116, Florida
 1659 Statutes, is amended to read:

1660 409.9116 Disproportionate share/financial assistance
 1661 program for rural hospitals.—In addition to the payments made
 1662 under s. 409.911, the Agency for Health Care Administration
 1663 shall administer a federally matched disproportionate share
 1664 program and a state-funded financial assistance program for
 1665 statutory rural hospitals. The agency shall make
 1666 disproportionate share payments to statutory rural hospitals
 1667 that qualify for such payments and financial assistance payments
 1668 to statutory rural hospitals that do not qualify for
 1669 disproportionate share payments. The disproportionate share
 1670 program payments shall be limited by and conform with federal
 1671 requirements. Funds shall be distributed quarterly in each
 1672 fiscal year for which an appropriation is made. Notwithstanding
 1673 the provisions of s. 409.915, counties are exempt from
 1674 contributing toward the cost of this special reimbursement for
 1675 hospitals serving a disproportionate share of low-income
 1676 patients.

1677 (6) This section applies only to hospitals that were
 1678 defined as statutory rural hospitals, or their successor-in-
 1679 interest hospital, prior to January 1, 2001. Any additional
 1680 hospital that is defined as a statutory rural hospital, or its
 1681 successor-in-interest hospital, on or after January 1, 2001, is
 1682 not eligible for programs under this section unless additional

26-00433-17 20171760__

1683 funds are appropriated each fiscal year specifically to the
 1684 rural hospital disproportionate share and financial assistance
 1685 programs in an amount necessary to prevent any hospital, or its
 1686 successor-in-interest hospital, eligible for the programs prior
 1687 to January 1, 2001, from incurring a reduction in payments
 1688 because of the eligibility of an additional hospital to
 1689 participate in the programs. A hospital, or its successor-in-
 1690 interest hospital, which received funds pursuant to this section
 1691 before January 1, 2001, and which qualifies under s.
 1692 395.602(2)(b) ~~395.602(2)(e)~~, shall be included in the programs
 1693 under this section and is not required to seek additional
 1694 appropriations under this subsection.

1695 Section 62. Paragraphs (a) and (b) of subsection (1) of
 1696 section 409.975, Florida Statutes, are amended to read:
 1697 409.975 Managed care plan accountability.—In addition to
 1698 the requirements of s. 409.967, plans and providers
 1699 participating in the managed medical assistance program shall
 1700 comply with the requirements of this section.

1701 (1) PROVIDER NETWORKS.—Managed care plans must develop and
 1702 maintain provider networks that meet the medical needs of their
 1703 enrollees in accordance with standards established pursuant to
 1704 s. 409.967(2)(c). Except as provided in this section, managed
 1705 care plans may limit the providers in their networks based on
 1706 credentials, quality indicators, and price.

1707 (a) Plans must include all providers in the region that are
 1708 classified by the agency as essential Medicaid providers, unless
 1709 the agency approves, in writing, an alternative arrangement for
 1710 securing the types of services offered by the essential
 1711 providers. Providers are essential for serving Medicaid

26-00433-17 20171760__

1712 enrollees if they offer services that are not available from any
 1713 other provider within a reasonable access standard, or if they
 1714 provided a substantial share of the total units of a particular
 1715 service used by Medicaid patients within the region during the
 1716 last 3 years and the combined capacity of other service
 1717 providers in the region is insufficient to meet the total needs
 1718 of the Medicaid patients. The agency may not classify physicians
 1719 and other practitioners as essential providers. The agency, at a
 1720 minimum, shall determine which providers in the following
 1721 categories are essential Medicaid providers:

1722 1. Federally qualified health centers.

1723 2. Statutory teaching hospitals as defined in s. 408.07(44)
 1724 ~~408.07(45)~~.

1725 3. Hospitals that are trauma centers as defined in s.
 1726 395.4001(14).

1727 4. Hospitals located at least 25 miles from any other
 1728 hospital with similar services.

1729 Managed care plans that have not contracted with all essential
 1730 providers in the region as of the first date of recipient
 1731 enrollment, or with whom an essential provider has terminated
 1732 its contract, must negotiate in good faith with such essential
 1733 providers for 1 year or until an agreement is reached, whichever
 1734 is first. Payments for services rendered by a nonparticipating
 1735 essential provider shall be made at the applicable Medicaid rate
 1736 as of the first day of the contract between the agency and the
 1737 plan. A rate schedule for all essential providers shall be
 1738 attached to the contract between the agency and the plan. After
 1739 1 year, managed care plans that are unable to contract with
 1740

26-00433-17

20171760

essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.
2. Regional perinatal intensive care centers as defined in s. 383.16(2).
3. Hospitals licensed as specialty children's hospitals as defined in s. ~~395.002(27)~~ 395.002(28).
4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

26-00433-17

20171760

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 63. Subsections (5) and (17) of section 429.02, Florida Statutes, are amended to read:

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

(5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which, undertakes through its ownership or management, provides ~~to provide~~ 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.

(17) "Personal services" means direct physical assistance with or supervision of the activities of daily living, ~~and~~ the self-administration of medication, or ~~and~~ other similar services which the department may define by rule. "Personal services" may ~~shall~~ not be construed to mean the provision of medical, nursing, dental, or mental health services, or, with the

26-00433-17 20171760

1799 exception of authorized adult day care services provided within
 1800 a licensed assisted living facility, personal services to
 1801 individuals who are not residents of the facility.

1802 Section 64. Paragraphs (b) and (d) of subsection (2) of
 1803 section 429.04, Florida Statutes, are amended, and subsection
 1804 (3) is added to that section, to read:

1805 429.04 Facilities to be licensed; exemptions.—

1806 (2) The following are exempt from licensure under this
 1807 part:

1808 (b) Any facility or part of a facility licensed by the
 1809 Agency for Persons with Disabilities under chapter 393, a mental
 1810 health facility licensed under ~~or~~ chapter 394, a hospital
 1811 licensed under chapter 395, a nursing home licensed under part
 1812 II of chapter 400, an inpatient hospice licensed under part IV
 1813 of chapter 400, a home for special services licensed under part
 1814 V of chapter 400, an intermediate care facility licensed under
 1815 part VIII of chapter 400, or a transitional living facility
 1816 licensed under part XI of chapter 400.

1817 (d) Any person who provides housing, meals, and one or more
 1818 personal services on a 24-hour basis in the person's own home to
 1819 not more than two adults who do not receive optional state
 1820 supplementation. The person who provides the housing, meals, and
 1821 personal services must own or rent the home and must have
 1822 established the home as the person's permanent residence. Any
 1823 person holding a homestead exemption at an address other than
 1824 that at which the person asserts this exemption shall be
 1825 presumed to not have established permanent residence under this
 1826 exemption reside therein. This exemption does not apply to a
 1827 person or entity who previously held licensure issued by the

26-00433-17 20171760

1828 agency and such licensure was revoked or the licensure renewal
 1829 was denied by final order of the agency, or when the person or
 1830 entity voluntarily relinquished licensure during agency
 1831 enforcement proceedings.

1832 (3) Upon agency investigation of unlicensed activity, any
 1833 person or entity asserting an exemption pursuant to this section
 1834 shall have the burden of providing documentation substantiating
 1835 that the person or entity is entitled to the licensure
 1836 exemption.

1837 Section 65. Paragraphs (b) and (d) of subsection (1) of
 1838 section 429.08, Florida Statutes, are amended, to read:

1839 429.08 Unlicensed facilities; referral of person for
 1840 residency to unlicensed facility; penalties.—

1841 (1)

1842 (b) ~~Except as provided under paragraph (d),~~ Any person who
 1843 owns, rents, or otherwise maintains a building or property that
 1844 operates, or maintains an unlicensed assisted living facility
 1845 commits a felony of the third degree, punishable as provided in
 1846 s. 775.082, s. 775.083, or s. 775.084. Each day of continued
 1847 operation is a separate offense.

1848 (d) In addition to the requirements of s. 408.812, any
 1849 person who owns, operates, or maintains an unlicensed assisted
 1850 living facility after receiving notice from the agency due to a
 1851 change in this part or a modification in rule within 6 months
 1852 after the effective date of such change and who, within 10
 1853 working days after receiving notification from the agency, fails
 1854 to cease operation or apply for a license under this part
 1855 commits a felony of the third degree, punishable as provided in
 1856 s. 775.082, s. 775.083, or s. 775.084. Each day of continued

26-00433-17 20171760__

1857 operation is a separate offense.

1858 Section 66. Section 429.176, Florida Statutes, is amended
1859 to read:

1860 429.176 Notice of change of administrator.—If, during the
1861 period for which a license is issued, the owner changes
1862 administrators, the owner must notify the agency of the change
1863 within 10 days and provide documentation within 90 days that the
1864 new administrator has completed the applicable core educational
1865 requirements under s. 429.52. A facility may not be operated for
1866 more than 120 consecutive days without an administrator who has
1867 completed the core educational requirements.

1868 Section 67. Paragraph (h) of subsection (1) of section
1869 429.41, Florida Statutes, is amended to read:

1870 429.41 Rules establishing standards.—

1871 (1) It is the intent of the Legislature that rules
1872 published and enforced pursuant to this section shall include
1873 criteria by which a reasonable and consistent quality of
1874 resident care and quality of life may be ensured and the results
1875 of such resident care may be demonstrated. Such rules shall also
1876 ensure a safe and sanitary environment that is residential and
1877 noninstitutional in design or nature. It is further intended
1878 that reasonable efforts be made to accommodate the needs and
1879 preferences of residents to enhance the quality of life in a
1880 facility. Uniform firesafety standards for assisted living
1881 facilities shall be established by the State Fire Marshal
1882 pursuant to s. 633.206. The agency, in consultation with the
1883 department, may adopt rules to administer the requirements of
1884 part II of chapter 408. In order to provide safe and sanitary
1885 facilities and the highest quality of resident care

26-00433-17 20171760__

1886 accommodating the needs and preferences of residents, the
1887 department, in consultation with the agency, the Department of
1888 Children and Families, and the Department of Health, shall adopt
1889 rules, policies, and procedures to administer this part, which
1890 must include reasonable and fair minimum standards in relation
1891 to:

1892 (h) The care and maintenance of residents, which must
1893 include, but is not limited to:

1894 1. The supervision of residents;

1895 2. The provision of personal services. With the exception
1896 of authorized adult day care services provided within a licensed
1897 assisted living facility, an assisted living facility may not
1898 provide personal services to individuals who are not residents
1899 of the facility;

1900 3. The provision of, or arrangement for, social and leisure
1901 activities;

1902 4. The arrangement for appointments and transportation to
1903 appropriate medical, dental, nursing, or mental health services,
1904 as needed by residents;

1905 5. The management of medication;

1906 6. The nutritional needs of residents;

1907 7. Resident records; and

1908 8. Internal risk management and quality assurance.

1909 Section 68. Subsection (4) of section 456.001, Florida
1910 Statutes, is amended to read:

1911 456.001 Definitions.—As used in this chapter, the term:

1912 (4) "Health care practitioner" means any person licensed
1913 under chapter 457; chapter 458; chapter 459; chapter 460;
1914 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;

26-00433-17 20171760__

chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III ~~or part IV~~ of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

Section 69. Paragraphs (h) and (i) of subsection (2) of section 456.057, Florida Statutes, are amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished; disclosure of information.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(h) Clinical laboratory personnel licensed under part II ~~III~~ of chapter 483.

(i) Medical physicists licensed under part III ~~IV~~ of chapter 483.

Section 70. Subsection (2) of section 458.307, Florida Statutes, is amended to read:

458.307 Board of Medicine.—

(2) Twelve members of the board must be licensed physicians in good standing in this state who are residents of the state and who have been engaged in the active practice or teaching of medicine for at least 4 years immediately preceding their appointment. One of the physicians must be on the full-time faculty of a medical school in this state, and one of the

26-00433-17 20171760__

physicians must be in private practice and on the full-time staff of a statutory teaching hospital in this state as defined in s. 408.07. At least one of the physicians must be a graduate of a foreign medical school. The remaining three members must be residents of the state who are not, and never have been, licensed health care practitioners. One member must be a health care risk manager ~~licensed under s. 395.10974~~. At least one member of the board must be 60 years of age or older.

Section 71. Subsection (1) of section 458.345, Florida Statutes, is amended to read:

458.345 Registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.—

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(44) ~~408.07(45)~~ or s. 395.805(2), who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed \$300 as set by the board. The department shall register any applicant the board certifies has met the following requirements:

(a) Is at least 21 years of age.

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to

26-00433-17 20171760__

1973 certify an application for licensure pursuant to s. 458.331.
 1974 (c) Is a graduate of a medical school or college as
 1975 specified in s. 458.311(1)(f).
 1976 Section 72. Part I of chapter 483, Florida Statutes,
 1977 consisting of sections 483.011, 483.021, 483.031, 483.035,
 1978 483.041, 483.051, 483.061, 483.091, 483.101, 483.111, 483.172,
 1979 483.181, 483.191, 483.201, 483.221, 483.23, 483.245, and 483.26,
 1980 is repealed.
 1981 Section 73. Section 483.294, Florida Statutes, is amended
 1982 to read:
 1983 483.294 Inspection of centers.—In accordance with s.
 1984 408.811, the agency shall, ~~at least once annually,~~ inspect the
 1985 premises and operations of all centers subject to licensure
 1986 under this part.
 1987 Section 74. Subsection (3) of section 483.801, Florida
 1988 Statutes, is amended to read:
 1989 483.801 Exemptions.—This part applies to all clinical
 1990 laboratories and clinical laboratory personnel within this
 1991 state, except:
 1992 (3) Persons engaged in testing performed by laboratories
 1993 that are wholly owned and operated by one or more practitioners
 1994 who are licensed under chapter 458, chapter 459, chapter 460,
 1995 chapter 461, chapter 462, chapter 463, or chapter 466 and who
 1996 practice in the same group practice, and in which no clinical
 1997 laboratory work is performed for patients referred by any health
 1998 care provider who is not a member of the same group regulated
 1999 under s. 483.035(1) or exempt from regulation under s.
 2000 483.031(2).
 2001 Section 75. Subsections (2), (3), and (4) of section

26-00433-17 20171760__

2002 483.803, Florida Statutes, are amended to read:
 2003 483.803 Definitions.—As used in this part, the term:
 2004 ~~(2) "Clinical laboratory" means a clinical laboratory as~~
 2005 ~~defined in s. 483.041.~~
 2006 ~~(3) "Clinical laboratory examination" means a clinical~~
 2007 ~~laboratory examination as defined in s. 483.041.~~
 2008 ~~(2)(4)~~ "Clinical laboratory personnel" includes a clinical
 2009 laboratory director, supervisor, technologist, blood gas
 2010 analyst, or technician who performs or is responsible for
 2011 laboratory test procedures, but the term does not include
 2012 trainees, persons who perform screening for blood banks or
 2013 plasmapheresis centers, phlebotomists, or persons employed by a
 2014 clinical laboratory to perform manual pretesting duties or
 2015 clerical, personnel, or other administrative responsibilities,
 2016 ~~or persons engaged in testing performed by laboratories~~
 2017 ~~regulated under s. 483.035(1) or exempt from regulation under s.~~
 2018 ~~483.031(2).~~
 2019 Section 76. Section 483.813, Florida Statutes, is amended
 2020 to read:
 2021 483.813 Clinical laboratory personnel license.—A person may
 2022 not conduct a clinical laboratory examination or report the
 2023 results of such examination unless such person is licensed under
 2024 this part to perform such procedures. However, this provision
 2025 does not apply to any practitioner of the healing arts
 2026 authorized to practice in this state ~~or to persons engaged in~~
 2027 ~~testing performed by laboratories regulated under s. 483.035(1)~~
 2028 ~~or exempt from regulation under s. 483.031(2).~~ The department
 2029 may grant a temporary license to any candidate it deems properly
 2030 qualified, for a period not to exceed 1 year.

26-00433-17

20171760__

Section 77. Paragraph (c) of subsection (7), paragraph (c) of subsection (8), and paragraph (c) of subsection (9) of section 491.003, Florida Statutes, are amended to read:

491.003 Definitions.—As used in this chapter:

(7) The “practice of clinical social work” is defined as the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering. The purpose of such services is the prevention and treatment of undesired behavior and enhancement of mental health. The practice of clinical social work includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of clinical social work includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of clinical social work also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders,

Page 71 of 94

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

26-00433-17

20171760__

alcoholism, or substance abuse. The practice of clinical social work may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(c) The terms “diagnose” and “treat,” as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, shall not be construed to permit the performance of any act which clinical social workers are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures ~~pursuant to chapter 483~~, or radiological procedures, or use of electroconvulsive therapy. In addition, this definition shall not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as “psychological,” except to relate specifically to the definition of practice authorized in this subsection.

(8) The “practice of marriage and family therapy” is defined as the use of scientific and applied marriage and family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems, including the context of marital formation and dissolution, and is based on marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic

Page 72 of 94

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

26-00433-17

20171760__

2089 and marriage and family therapy theories and techniques. The
 2090 practice of marriage and family therapy includes methods of a
 2091 psychological nature used to evaluate, assess, diagnose, treat,
 2092 and prevent emotional and mental disorders or dysfunctions
 2093 (whether cognitive, affective, or behavioral), sexual
 2094 dysfunction, behavioral disorders, alcoholism, and substance
 2095 abuse. The practice of marriage and family therapy includes, but
 2096 is not limited to, marriage and family therapy, psychotherapy,
 2097 including behavioral family therapy, hypnotherapy, and sex
 2098 therapy. The practice of marriage and family therapy also
 2099 includes counseling, behavior modification, consultation,
 2100 client-centered advocacy, crisis intervention, and the provision
 2101 of needed information and education to clients, when using
 2102 methods of a psychological nature to evaluate, assess, diagnose,
 2103 treat, and prevent emotional and mental disorders and
 2104 dysfunctions (whether cognitive, affective, or behavioral),
 2105 sexual dysfunction, behavioral disorders, alcoholism, or
 2106 substance abuse. The practice of marriage and family therapy may
 2107 also include clinical research into more effective
 2108 psychotherapeutic modalities for the treatment and prevention of
 2109 such conditions.

2110 (c) The terms "diagnose" and "treat," as used in this
 2111 chapter, when considered in isolation or in conjunction with any
 2112 provision of the rules of the board, shall not be construed to
 2113 permit the performance of any act which marriage and family
 2114 therapists are not educated and trained to perform, including,
 2115 but not limited to, admitting persons to hospitals for treatment
 2116 of the foregoing conditions, treating persons in hospitals
 2117 without medical supervision, prescribing medicinal drugs as

26-00433-17

20171760__

2118 defined in chapter 465, authorizing clinical laboratory
 2119 procedures ~~pursuant to chapter 483~~, or radiological procedures,
 2120 or use of electroconvulsive therapy. In addition, this
 2121 definition shall not be construed to permit any person licensed,
 2122 provisionally licensed, registered, or certified pursuant to
 2123 this chapter to describe or label any test, report, or procedure
 2124 as "psychological," except to relate specifically to the
 2125 definition of practice authorized in this subsection.

2126 (9) The "practice of mental health counseling" is defined
 2127 as the use of scientific and applied behavioral science
 2128 theories, methods, and techniques for the purpose of describing,
 2129 preventing, and treating undesired behavior and enhancing mental
 2130 health and human development and is based on the person-in-
 2131 situation perspectives derived from research and theory in
 2132 personality, family, group, and organizational dynamics and
 2133 development, career planning, cultural diversity, human growth
 2134 and development, human sexuality, normal and abnormal behavior,
 2135 psychopathology, psychotherapy, and rehabilitation. The practice
 2136 of mental health counseling includes methods of a psychological
 2137 nature used to evaluate, assess, diagnose, and treat emotional
 2138 and mental dysfunctions or disorders (whether cognitive,
 2139 affective, or behavioral), behavioral disorders, interpersonal
 2140 relationships, sexual dysfunction, alcoholism, and substance
 2141 abuse. The practice of mental health counseling includes, but is
 2142 not limited to, psychotherapy, hypnotherapy, and sex therapy.
 2143 The practice of mental health counseling also includes
 2144 counseling, behavior modification, consultation, client-centered
 2145 advocacy, crisis intervention, and the provision of needed
 2146 information and education to clients, when using methods of a

26-00433-17

20171760

psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), behavioral disorders, sexual dysfunction, alcoholism, or substance abuse. The practice of mental health counseling may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, shall not be construed to permit the performance of any act which mental health counselors are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures pursuant to chapter 483, or radiological procedures, or use of electroconvulsive therapy. In addition, this definition shall not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

Section 78. Paragraph (h) of subsection (4) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.—

(h) As used in this subsection:

1. "Health care provider" means hospitals licensed under

26-00433-17

20171760

chapter 395; physicians licensed under chapter 458; osteopathic physicians licensed under chapter 459; podiatric physicians licensed under chapter 461; dentists licensed under chapter 466; chiropractic physicians licensed under chapter 460; naturopaths licensed under chapter 462; nurses licensed under part I of chapter 464; midwives licensed under chapter 467; ~~clinical laboratories registered under chapter 483~~; physician assistants licensed under chapter 458 or chapter 459; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part I of chapter 641; ambulatory surgical centers licensed under chapter 395; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine shall not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed under chapter 395, health maintenance organization certificated under part I of chapter 641, ambulatory surgical center licensed under

26-00433-17 20171760__

chapter 395, or other medical facility as defined in subparagraph 2.

Section 79. Paragraph (h) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply to a health insurance policy that is subject to the Subscriber Assistance Program under s. 408.7056 or to the types of benefits or coverages provided under s. 627.6513(1)-(14) issued in any market.

Section 80. Paragraphs (b) and (e) of subsection (1) of section 627.64194, Florida Statutes, are amended to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

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

(b) "Facility" means a licensed facility as defined in s. 395.002(16) and an urgent care center as defined in s. 395.002(29) ~~s. 395.002(30)~~.

(e) "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center

26-00433-17 20171760__

defined in s. 395.002(29) ~~395.002(30)~~ is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate.

Section 81. Section 627.6513, Florida Statutes, is amended to read:

627.6513 Scope.—Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to a ~~group health insurance policy that is subject to the Subscriber Assistance Program in s. 408.7056 or to:~~

- (1) Coverage only for accident insurance, or disability income insurance, or any combination thereof.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Liability insurance, including general liability insurance and automobile liability insurance.
- (4) Workers' compensation or similar insurance.
- (5) Automobile medical payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.
- (8) Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.
- (9) Limited scope dental or vision benefits, if offered

26-00433-17 20171760__

2263 separately.

2264 (10) Benefits for long-term care, nursing home care, home
2265 health care, or community-based care, or any combination
2266 thereof, if offered separately.

2267 (11) Other similar, limited benefits, if offered
2268 separately, as specified in rules adopted by the commission.

2269 (12) Coverage only for a specified disease or illness, if
2270 offered as independent, noncoordinated benefits.

2271 (13) Hospital indemnity or other fixed indemnity insurance,
2272 if offered as independent, noncoordinated benefits.

2273 (14) Benefits provided through a Medicare supplemental
2274 health insurance policy, as defined under s. 1882(g)(1) of the
2275 Social Security Act, coverage supplemental to the coverage
2276 provided under 10 U.S.C. chapter 55, and similar supplemental
2277 coverage provided to coverage under a group health plan, which
2278 are offered as a separate insurance policy and as independent,
2279 noncoordinated benefits.

2280 Section 82. Effective January 1, 2018, paragraph (j) of
2281 subsection (1) of section 641.185, Florida Statutes, is amended
2282 to read:

2283 641.185 Health maintenance organization subscriber
2284 protections.—

2285 (1) With respect to the provisions of this part and part
2286 III, the principles expressed in the following statements shall
2287 serve as standards to be followed by the commission, the office,
2288 the department, and the Agency for Health Care Administration in
2289 exercising their powers and duties, in exercising administrative
2290 discretion, in administrative interpretations of the law, in
2291 enforcing its provisions, and in adopting rules:

Page 79 of 94

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

26-00433-17 20171760__

2292 ~~(j) A health maintenance organization should receive timely~~
2293 ~~and, if necessary, urgent review by an independent state~~
2294 ~~external review organization for unresolved grievances and~~
2295 ~~appeals pursuant to s. 408.7056.~~

2296 Section 83. Effective January 1, 2018, section 641.312,
2297 Florida Statutes, is amended to read:

2298 641.312 Scope.—The Office of Insurance Regulation may adopt
2299 rules to administer the provisions of the National Association
2300 of Insurance Commissioners' Uniform Health Carrier External
2301 Review Model Act, issued by the National Association of
2302 Insurance Commissioners and dated April 2010. This section does
2303 not apply to ~~a health maintenance contract that is subject to~~
2304 ~~the Subscriber Assistance Program under s. 408.7056 or to the~~
2305 types of benefits or coverages provided under s. 627.6513(1)-
2306 (14) issued in any market.

2307 Section 84. Effective January 1, 2018, subsection (4) of
2308 section 641.3154, Florida Statutes, is amended to read:

2309 641.3154 Organization liability; provider billing
2310 prohibited.—

2311 (4) A provider or any representative of a provider,
2312 regardless of whether the provider is under contract with the
2313 health maintenance organization, may not collect or attempt to
2314 collect money from, maintain any action at law against, or
2315 report to a credit agency a subscriber of an organization for
2316 payment of services for which the organization is liable, if the
2317 provider in good faith knows or should know that the
2318 organization is liable. This prohibition applies during the
2319 pendency of any claim for payment made by the provider to the
2320 organization for payment of the services and any legal

Page 80 of 94

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

26-00433-17 20171760

proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable; or

~~(c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to s. 408.7056; or~~

(c) ~~(d)~~ The agency issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057.

Section 85. Effective January 1, 2018, paragraph (c) of subsection (5) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.—

(5)

(c) For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion

26-00433-17 20171760

services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in ss. ~~408.7056~~, 641.495, and 641.511. The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization shall be at the subscriber's expense.

Section 86. Effective January 1, 2018, section 641.511, Florida Statutes, is amended to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. ~~Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the Subscriber Assistance Program panel as provided in s. 408.7056~~

26-00433-17

20171760__

~~after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.~~

(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.

(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:

(a) An explanation of how to pursue redress of a grievance.

(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the Subscriber Assistance Program and its toll-free telephone number.

(c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance.

(d) A procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved.

26-00433-17

20171760__

(e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure ~~and as an alternative to the Subscriber Assistance Program~~. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber's contract.

(f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.

(g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.

(4) (a) With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization

26-00433-17 20171760__

shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

~~(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.~~

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations

26-00433-17 20171760__

that administer small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1.

(6) (a) An organization shall establish written procedures for the expedited review of an urgent grievance. A request for an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, "subscriber" includes the legal representative of a subscriber.

(b) Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.

(c) In an expedited review, all necessary information, including the organization's decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.

(d) In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on

26-00433-17 20171760

2495 behalf of the subscriber, as expeditiously as the subscriber's
2496 medical condition requires, but in no event more than 72 hours
2497 after receipt of the request for review. If the expedited review
2498 is a concurrent review determination, the service shall be
2499 continued without liability to the subscriber until the
2500 subscriber has been notified of the determination.

2501 (e) An organization shall provide written confirmation of
2502 its decision concerning an expedited review within 2 working
2503 days after providing notification of that decision, if the
2504 initial notification was not in writing.

2505 (f) An organization shall provide reasonable access, not to
2506 exceed 24 hours after receiving a request for an expedited
2507 review, to a clinical peer who can perform the expedited review.

2508 ~~(g) In any case when the expedited review process does not~~
2509 ~~resolve a difference of opinion between the organization and the~~
2510 ~~subscriber or the provider acting on behalf of the subscriber,~~
2511 ~~the subscriber or the provider acting on behalf of the~~
2512 ~~subscriber may submit a written grievance to the Subscriber~~
2513 ~~Assistance Program.~~

2514 (g) (h) An organization shall not provide an expedited
2515 retrospective review of an adverse determination.

2516 ~~(7) Each organization shall send to the agency a copy of~~
2517 ~~its quarterly grievance reports submitted to the office pursuant~~
2518 ~~to s. 408.7056(12).~~

2519 (7) (8) The agency shall investigate all reports of
2520 unresolved quality of care grievances received from

2521 ~~(a)~~ annual and quarterly grievance reports submitted by the
2522 organization to the office.

2523 ~~(b) Review requests of subscribers whose grievances remain~~

26-00433-17 20171760

2524 ~~unresolved after the subscriber has followed the full grievance~~
2525 ~~procedure of the organization.~~

2526 ~~(9) (a) The agency shall advise subscribers with grievances~~
2527 ~~to follow their organization's formal grievance process for~~
2528 ~~resolution prior to review by the Subscriber Assistance Program.~~
2529 ~~The subscriber may, however, submit a copy of the grievance to~~
2530 ~~the agency at any time during the process.~~

2531 ~~(b) Requiring completion of the organization's grievance~~
2532 ~~process before the Subscriber Assistance Program panel's review~~
2533 ~~does not preclude the agency from investigating any complaint or~~
2534 ~~grievance before the organization makes its final determination.~~

2535 ~~(10) Each organization must notify the subscriber in a~~
2536 ~~final decision letter that the subscriber may request review of~~
2537 ~~the organization's decision concerning the grievance by the~~
2538 ~~Subscriber Assistance Program, as provided in s. 408.7056, if~~
2539 ~~the grievance is not resolved to the satisfaction of the~~
2540 ~~subscriber. The final decision letter must inform the subscriber~~
2541 ~~that the request for review must be made within 365 days after~~
2542 ~~receipt of the final decision letter, must explain how to~~
2543 ~~initiate such a review, and must include the addresses and toll-~~
2544 ~~free telephone numbers of the agency and the Subscriber~~
2545 ~~Assistance Program.~~

2546 (8) (11) Each organization, as part of its contract with any
2547 provider, must require the provider to post a consumer
2548 assistance notice prominently displayed in the reception area of
2549 the provider and clearly noticeable by all patients. The
2550 consumer assistance notice must state the addresses and toll-
2551 free telephone numbers of the Agency for Health Care
2552 Administration, ~~the Subscriber Assistance Program, and the~~

26-00433-17

20171760

Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

~~(9)(12)~~ The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.

Section 87. Effective January 1, 2018, subsection (1) of section 641.515, Florida Statutes, is amended to read:

641.515 Investigation by the agency.—

(1) The agency shall investigate further any quality of care issue contained in recommendations and reports submitted pursuant to ~~ss. 408.7056 and s.~~ 641.511. The agency shall also investigate further any information that indicates that the organization does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment pursuant to reports submitted under s. 641.512. Every organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. The agency shall have access to the organization's medical records of individuals and records of employed and contracted physicians, with the consent of the subscriber or by court order, as necessary to carry out the provisions of this part.

Section 88. Effective January 1, 2018, subsection (2) of section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.—

(2) The risk management program shall be the responsibility

26-00433-17

20171760

of the governing authority or board of the organization. Every organization which has an annual premium volume of \$10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager, ~~certified under ss. 395.10971-395.10975,~~ who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every organization which does not directly provide health care in a building owned or leased by the organization and every organization with an annual premium volume of less than \$10 million shall designate an officer or employee of the organization to serve as the risk manager.

The gross data compiled under this section or s. 395.0197 shall be furnished by the agency upon request to organizations to be utilized for risk management purposes. The agency shall adopt rules necessary to carry out the provisions of this section.

Section 89. Section 641.60, Florida Statutes, is repealed.

Section 90. Section 641.70, Florida Statutes, is amended to read:

641.70 Agency duties relating to ~~the Statewide Managed Care Ombudsman Committee and~~ the district managed care ombudsman committees.—

(1) The agency shall adopt rules that specify:

(a) Procedures by which ~~the statewide committee and~~ district committees receive reports of enrollee complaints from the agency.

26-00433-17

20171760__

(b) Procedures by which enrollee information shall be made available ~~to members of the statewide committee and to the~~ district committees.

(c) Procedures by which recommendations made by the committees shall be considered for incorporation into policies and procedures of the agency.

~~(d) Procedures by which statewide committee members shall be reimbursed for authorized expenditures.~~

~~(d) (e)~~ Any other procedures that are necessary to administer this section and ~~ss. 641.60 and s. 641.65.~~

(2) The Agency for Health Care Administration shall provide a meeting place for district committees in agency offices and shall provide the necessary administrative support to assist ~~the statewide committee and~~ district committees, within available resources.

(3) The secretary of the agency shall ensure the full cooperation and assistance of agency employees with ~~members of the statewide committee and~~ district committees.

Section 91. Subsection (3) of section 641.75, Florida Statutes, is amended to read:

641.75 Immunity from liability; limitation on testimony.—

(3) Members of any state or district ombudsman committee shall not be required to testify in any court with respect to matters held to be confidential except as may be necessary to enforce ss. 641.61-641.75 ~~641.60-641.75~~.

Section 92. Paragraph (b) of subsection (6) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A

26-00433-17

20171760__

PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of a practitioner committed in the course of providing medical services and medical care to a Medicaid recipient, regardless of the number of such practitioner defendants providing the services and care, noneconomic damages may not exceed \$300,000 per claimant, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. A practitioner providing medical services and medical care to a Medicaid recipient is not liable for more than \$200,000 in noneconomic damages, regardless of the number of claimants, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. The fact that a claimant proves that a practitioner acted in a wrongful manner does not preclude the application of the limitation on noneconomic damages prescribed elsewhere in this section. For purposes of this subsection:

(b) The term "practitioner," in addition to the meaning prescribed in subsection (1), includes any hospital or ambulatory surgical center, ~~or mobile surgical facility~~ as defined and licensed under chapter 395.

Section 93. Subsection (4) of section 766.202, Florida Statutes, is amended to read:

766.202 Definitions; ss. 766.201-766.212.—As used in ss. 766.201-766.212, the term:

(4) "Health care provider" means any hospital or ambulatory surgical center, ~~or mobile surgical facility~~ as

26-00433-17 20171760__

defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; ~~a clinical lab licensed under chapter 483~~; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

Section 94. Subsection (1) of section 945.36, Florida Statutes, is amended to read:

945.36 ~~Exemption from health testing regulations for Law enforcement personnel authorized to conduct conducting~~ drug tests on inmates and releasees.—

(1) Any law enforcement officer, state or county probation officer, or employee of the Department of Corrections, who is certified by the Department of Corrections pursuant to subsection (2), may administer ~~is exempt from part I of chapter 483, for the limited purpose of administering~~ a urine screen drug test to:

- (a) Persons during incarceration;
- (b) Persons released as a condition of probation for either a felony or misdemeanor;
- (c) Persons released as a condition of community control;
- (d) Persons released as a condition of conditional release;
- (e) Persons released as a condition of parole;
- (f) Persons released as a condition of provisional release;
- (g) Persons released as a condition of pretrial release; or

26-00433-17 20171760__

(h) Persons released as a condition of control release.

Section 95. Paragraph (b) of subsection (2) of section 1009.65, Florida Statutes, is amended to read:

1009.65 Medical Education Reimbursement and Loan Repayment Program.—

(2) From the funds available, the Department of Health shall make payments to selected medical professionals as follows:

(b) All payments shall be contingent on continued proof of primary care practice in an area defined in s. 395.602 (2) (b) ~~395.602 (2) (e)~~, or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement. Correctional facilities, state hospitals, and other state institutions that employ medical personnel shall be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

Section 96. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2017.