The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, February 9, 2016
TIME: 10:00 a.m.—12:00 noon
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 206** Clemens (Identical H 111)	Jury Service; Providing that certain persons permanently incapable of caring for themselves may be permanently excused from jury service upon request; providing requirements for such a request, etc. JU 01/20/2016 Favorable HP 02/09/2016 Favorable RC	Favorable Yeas 8 Nays 0
2	**SB 236** Grimsley	Certificates of Need for Rural Hospitals; Revising the criteria for exempting a rural hospital or the not-for-profit operator of rural hospitals from the requirement to obtain a certificate of need for the construction of a new or replacement facility within the primary service area, etc. HP 02/09/2016 Favorable AHS FP	Favorable Yeas 8 Nays 0
3	**SB 858** Legg (Similar CS/H 373, Compare H 7097)	Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor Interns; Revising clinical social worker, marriage and family therapist, and mental health counselor intern registration requirements; revising requirements for supervision of registered interns; deleting specified education and experience requirements; establishing validity periods and providing for expiration of intern registrations; establishing requirements for a subsequent intern registration and for an applicant who has held a provisional license; requiring a licensed mental health professional to be on the premises when a registered intern provides services in clinical social work, marriage and family therapy, or mental health counseling, etc. HP 02/09/2016 Favorable AHS FP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 946** Grimsley (Compare H 1241, S 152)	Authorized Practices of Advanced Registered Nurse Practitioners and Licensed Physician Assistants; Authorizing an advanced registered nurse practitioner to order medication for administration to patients in specified facilities; authorizing a licensed practitioner to authorize a licensed physician assistant or advanced registered nurse practitioner to order controlled substances for administration to patients in specified facilities under certain circumstances, etc. HP 02/09/2016 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 0
5	**CS/SB 1142** Banking and Insurance / Hays (Compare H 915)	Treatments for Stable Patients; Requiring a pharmacy benefits manager or a specified individual or group insurance policy to continue to cover a drug for specified insureds under certain circumstances; prohibiting certain actions by a pharmacy benefits manager or an individual or group policy with respect to a drug for a certain insured except under certain circumstances; expanding a list of conditions that certain health benefit plans must comply with, etc. BI 02/01/2016 Fav/CS HP 02/09/2016 Favorable AP	Favorable Yeas 8 Nays 0
6	**SB 1240** Sobel (Similar H 1117)	Children's Medical Services Eligibility and Enrollment; Revising eligibility requirements for the Children's Medical Services program; requiring the Department of Health to use an assessment instrument to determine clinical eligibility for the Children's Medical Services program; requiring the department to provide notice to a parent or guardian of a child who has been determined clinically ineligible for the Children's Medical Services program of the parent's or guardian's appeal rights under ch. 120, F.S., etc. HP 02/09/2016 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1306** Grimsley (Identical H 1063, Compare H 1061, Linked S 1316)	Public Records and Meetings/Nurse Licensure Compact; Providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Nursing pursuant to the Nurse Licensure Compact; providing an exemption from public meeting requirements for certain meetings of the Interstate Commission of Nurse Licensure Compact Administrators; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such a meeting; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity, etc. HP 02/09/2016 Temporarily Postponed GO RC	Temporarily Postponed
8	**SB 1316** Grimsley (Similar H 1061, Compare H 1063, Linked S 1306)	Nurse Licensure Compact; Creating the Nurse Licensure Compact; providing for the recognition of nursing licenses in party states; providing requirements for obtaining and retaining a multistate license; providing the effect of the act on a current licensee; requiring all party states to participate in a coordinated licensure information system; providing for the development of the system, reporting procedures, and the exchange of certain information between party states; establishing the Interstate Commission of Nurse Licensure Compact Administrators; requiring the Florida Center for Nursing to analyze and make future projections of the supply and demand for nurses, etc. HP 02/09/2016 Favorable AHS AP	Favorable Yeas 7 Nays 1
9	**SB 1370** Grimsley (Identical H 1245)	Medicaid Provider Overpayments; Authorizing the Agency for Health Care Administration to certify that a Medicaid provider is out of business and that overpayments made to a provider cannot be collected under state law, etc. HP 02/09/2016 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
10	**SB 1472** Ring (Similar H 1161)	Prescription Medication; Revising requirements for a written prescription for a medicinal drug issued by a licensed health care practitioner to include notification of the medical condition for which the drug is prescribed; revising requirements for the dispensing of a controlled substance by a licensed pharmacist to include notification of the medical condition for which the controlled substance is prescribed, etc. HP 02/09/2016 Fav/CS AHS FP	Fav/CS Yeas 8 Nays 0
11	**SB 1518** Grimsley (Similar CS/CS/H 1269, Compare H 437)	Adult Cardiovascular Services; Expanding rulemaking criteria for the Agency for Health Care Administration for licensure of hospitals performing percutaneous coronary intervention; repealing provisions relating to exemptions for certificate of need projects subject to review relating to adult open-heart services in a hospital and percutaneous coronary intervention, etc. HP 02/09/2016 Fav/CS AHS AP	Fav/CS Yeas 8 Nays 0
12	**SB 1620** Hutson (Compare H 1315)	Concussions and Head Injuries In Children; Requiring certain nurses, physicians, and physician assistants to complete continuing education relating to concussions and head injuries in children, etc. HP 02/09/2016 Temporarily Postponed AHS FP	Temporarily Postponed
	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 Committee on Health Policy

BILL:	SB 206
INTRODUCER:	Senator Clemens
SUBJECT:	Jury Service
DATE:	February 4, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McAloon	Cibula	JU	**Favorable**
2.	Stovall	Stovall	HP	**Favorable**
3.			RC	

I. Summary:

SB 206 authorizes a person to be permanently excused from jury service upon written request due to mental illness, intellectual disability, senility, or other physical or mental incapacity. The person's request must be accompanied by a written statement from a doctor verifying the disability. The clerk of the court may approve or deny the request for permanent excuse from jury service.

II. Present Situation:

Background on Jury Selection

To be selected for a jury pool in Florida, a person must be chosen at random from a list of names provided quarterly to the clerk of court by the Department of Highway Safety and Motor Vehicles.[1] All persons on the jury list are required to be United States citizens and legal residents of Florida. Additionally, all persons must be at least 18 years of age and have a driver's license or identification card issued by the Department of Motor Vehicles.[2]

The Florida Statutes set out two processes for developing a group of persons who may be summoned to court. First, the clerk, under the supervision of a judge, may randomly select from a list of people necessary for a given session.[3] Alternatively, the court may request authority of the Florida Supreme Court to operate a special selection process using a mechanical, electronic, or electrical device.[4] The court has procedures in place to ensure that once a potential juror is selected, he or she is given proper notice of the summons to ensure compliance, or the person

[1] Section 40.011, F.S. The Clerk of the Court may also add to the list the name of any person who is 18 years of age or older, a U.S. citizen, and a legal resident of the state who requests to be added upon execution of an affidavit.
[2] Section 40.01, F.S.
[3] Section 40.221, F.S.
[4] Section 40.225, F.S.

may face penalties imposed by the court.[5] Once the potential jurors are summoned, they may be placed into the jury pool from which the jury in any given case will be chosen.[6]

Persons Disqualified or Excused from Jury Service

There are two opportunities for a person who has been summoned for jury service to be excused. First, when a person receives a summons for jury service, he or she may provide an excuse from a list of acceptable statutory excuses for why he or she cannot serve. The person will send this notification to the clerk's office. Second, a potential juror may also raise one of the statutory excuses once the person has reported for jury service. Section 40.013, F.S., specifies persons who are disqualified from jury service, persons whom a judge may excuse from jury service, and persons who must be excused from jury service upon request.

Persons who are disqualified from jury service include:
- A person who is under prosecution for a crime, or a felon, unless the person's civil rights have been restored.[7]
- The Governor and Lieutenant Governor, Cabinet officers, clerks of court, and judges.[8]
- Full-time federal, state, or local law enforcement officers and investigative personnel of law enforcement agencies.[9]
- A person interested in any issue to be tried in a case on which the person would serve as a juror.[10]
- A person who would be serving as a juror within 1 year of the last day of previous jury service.[11]
- Any person who does not possess sufficient knowledge of reading, writing or arithmetic to understand a civil case, if the civil case requires such knowledge.[12]

Persons who may be excused include:
- A practicing attorney, a practicing physician, or a person who is physically infirm.[13]
- Any person upon showing of hardship, extreme inconvenience, or public necessity.[14]

Persons who must be excused upon request include:
- An expectant mother or parent who is not employed full time and who has custody of a child under 6 years of age.[15]
- A person 70 years of age or older.[16]

[5] Section 40.23, F.S.
[6] Section 40.231, F.S.
[7] Section 40.013(1), F.S.
[8] Section 40.013(2)(a), F.S.
[9] Section 40.013(2)(b), F.S.
[10] Section 40.013(3), F.S.
[11] Section 40.013(7), F.S.
[12] Fla. R. Civ. P. 1.431(c)(3).
[13] Section 40.013(5), F.S.
[14] Section 40.013(6), F.S.
[15] Section 40.013(4), F.S.
[16] Section 40.013(8), F.S.

- A person who is responsible for the care of a person who, because of mental illness, intellectual disability, senility, or other physical or mental incapacity, is incapable of caring for himself or herself.[17]

Persons Permanently Excused from Jury Service

Currently, only individuals 70 years of age or older can request to be permanently excused.[18] The request must be in writing.[19] Individuals who are permanently excused can also request to be added back into the jury pool as long as they are otherwise qualified.[20]

Persons Excused for Care of Disabled Individual

The Florida Statutes provide a mandatory exemption from jury service, upon request, for any person who is responsible for the care of a person who is mentally ill, intellectually disabled, senile, or has other physical or mental incapacity, and is incapable of caring for himself or herself.[21] An individual who cares for a person with a listed condition must be excused from jury service upon request.[22] However, the statute currently does not contain an exemption from jury service for the person who is permanently incapable for caring for himself or herself.

Florida Rules of Civil Procedure

The Florida Rules of Civil Procedure require that a juror be excused in a civil trial if the individual does not possess sufficient knowledge of reading, writing or arithmetic to understand the case, if the case requires such knowledge.[23] However, the rule only applies to civil cases and only arises through a challenge for cause.

III. Effect of Proposed Changes:

SB 206 creates a permanent exemption from jury duty upon request for a person who is permanently incapable for caring for himself or herself. The permanent incapacity must be due to "mental illness, intellectual disability, senility, or other physical or mental incapacity." The request must include a letter from a physician verifying the permanent incapacity. The clerk, in his or her discretion, may decide to issue the permanent exemption from jury service.

The bill takes effect July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[17] Section 40.013(9), F.S.
[18] Section 40.013(8), F.S.
[19] *Id*.
[20] *Id*.
[21] Section 40.013(9), F.S.
[22] *Id*.
[23] Fla. R. Civ. P. 1.431(c)(3).

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:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The language of the bill provides that a person *may* be permanently excused upon request. This gives the clerk the discretion in making the ultimate decision. In comparison, existing s. 40.013(8), F.S., provides that an individual 70 years of age or older *shall* be permanently excused upon request.

VIII. Statutes Affected:

This bill substantially amends section 40.013 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 Clemens

27-00366-16 2016206__

A bill to be entitled

An act relating to jury service; amending s. 40.013, F.S.; providing that certain persons permanently incapable of caring for themselves may be permanently excused from jury service upon request; providing requirements for such a request; providing an effective date.

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

Section 1. Present subsection (9) of section 40.013, Florida Statutes, is redesignated as subsection (10), and a new subsection (9) is added to that section, to read:

40.013 Persons disqualified or excused from jury service.—

(9) Any person who, because of mental illness, intellectual disability, senility, or other physical or mental incapacity, is permanently incapable of caring for himself or herself may be permanently excused from jury service upon request if the request is accompanied by a written statement to that effect from a physician licensed pursuant to chapter 458 or chapter 459.

Section 2. This act shall take effect July 1, 2016.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Transportation, Tourism, and Economic Development, *Vice Chair*
Banking and Insurance
Criminal Justice
Education Pre-K-12
Ethics and Elections
Fiscal Policy

SENATOR JEFF CLEMENS
27th District

January 20, 2016

Senator Aaron Bean, Chair
Senate Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chair Bean:

I respectfully request that SB 206 – Jury Service be added to the agenda for the next Senate Committee on Health Policy meeting.

SB 206 will allow permanently disabled citizens to be permanently excused from jury service upon request with a written statement from a medical doctor.

Please feel free to contact me with any questions. Thank you, in advance, for your consideration.

Sincerely,

Senator Jeff Clemens
Florida Senate District 27

REPLY TO:
❒ 508 Lake Avenue, Unit C, Lake Worth, Florida 33460 (561) 540-1140 FAX: (561) 540-1143
❒ 226 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5027

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

206
Bill Number (if applicable)

Topic Jury

Amendment Barcode (if applicable)

Name Greg Pound

Job Title

Address 9166 Sunrise Dr.
Street

Phone

Largo Fla. 33773
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Pinellas County Florida Government Corruption

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 236
INTRODUCER:	Senators Grimsley and Gaetz
SUBJECT:	Certificates of Need for Rural Hospitals
DATE:	February 4, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 236 modifies the eligibility criteria for a rural hospital to construct a new or a replacement facility without first obtaining a certification of need (CON). The population density threshold is raised from less than 30 to less than 100 persons per square mile, which coincides with the population density in the definition of a rural hospital. The bill deletes the requirements that a new hospital be located in a county with a population between 15,000 and 18,000 and that the replacement, or new, facility be located within 10 miles of the site of the currently licensed rural hospital.

II. Present Situation:

Florida's CON Program

Overview

In Florida, a CON is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service, including hospices. The Florida CON program has three levels of review: full, expedited and exempt.[1] Unless a project is exempt from the CON program, it must undergo a full comparative review. Expedited review is primarily targeted towards nursing home projects.

Full CON Review Process

Full CON review is a lengthy and difficult process that starts with the AHCA determining need for a specific facility type or service. Upon determining that a need exists, AHCA accepts applications for CON based on batching cycles. At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with AHCA.[2] A letter of intent must

[1] Section 408.036, F.S.
[2] Section 408.039(2)(a), F.S.

describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.[3] Applications for CON review must be submitted by the specified deadline for the particular batch cycle.[4] The AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[5] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[6]

Within 60 days of receipt of the completed applications for that batch, the AHCA must issue a State Agency Action Report and Notice of Intent to grant a CON for a project in its entirety, to grant a CON for identifiable portions of a project, or to deny a CON for a project.[7] The AHCA must then publish the decision, within 14 days, in the Florida Administrative Register.[8] If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent become a final order of the AHCA.[9]

An applicant for CON review must submit a fee to the AHCA at the time of application submission. The minimum CON application filing fee is $10,000.[10] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure, however the total fee may not exceed $50,000.[11]

Projects Subject to Full CON Review

Section 408.036(1) lists projects that are required to undergo a full comparative CON review, including:

- The addition of beds by new contraction or alteration in a community nursing home or intermediate care facility for the developmentally disabled;
- The new construction or establishment of additional health care facilities,[12] including the replacement of a health care facility that is not located within 1 mile of the existing health care facility, if the number of beds in each licensed bed category will not increase;
- The conversion from one type of health care facility to another, including from a general hospital to a specialty hospital;
- The establishment of a hospice or hospice in patient facility;
- An increase in the number of beds for comprehensive rehabilitation; and
- The establishment of tertiary health services,[13] including inpatient comprehensive rehabilitation.

[3] Section 408.039(2)(c), F.S.
[4] Rule 59C-1.008(1)(g), F.A.C.
[5] Section 408.039(3)(a), F.S.
[6] Id.
[7] Section 408.039(4)(b), F.S.
[8] Section 408.039(4)(c), F.S.
[9] Section 408.039(4)(d), F.S.
[10] Section 408.038, F.S.
[11] Id.
[12] Section 408.032, F.S., defines "health care facility" as a hospital, long-term care hospital, skilled nursing facility, hospice, or intermediate care facility for the developmentally disabled.
[13] Tertiary health services include: pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care units, comprehensive rehabilitation, medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service, heart transplantation, kidney

Projects Subject to Expedited CON Review

Section 408.036(2), F.S., permits certain projects to undergo expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include the transfer of a CON and certain replacements, relocations, and new construction of nursing homes.[14]

Exemptions from CON Review

Section 408.036(3), F.S., provides many exemptions to CON review, including exemptions for certain hospice and nursing home projects. Exempted projects must only submit an application for exemption to the AHCA and pay a $250 fee. Exempted hospital projects and general exemptions include:

Hospital Exemptions

- Adding hospice services or swing beds[15] in a rural hospital, the total of which does not exceed one-half of its licensed beds;
- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, F.S., so long as the conversion of the beds does not involve the construction of new facilities;
- Adding hospital beds licensed under ch. 395, F.S., for comprehensive rehabilitation, the total of which may not exceed 10 total beds or 10 percent of the licensed capacity, whichever is greater;
- Establishing a Level II neonatal intensive care unit (NICU) if the unit has at least 10 beds, and if the hospital had a minimum of 1,500 births during the previous 12 months;
- Establishing a Level III NICU if the unit has at least 15 beds, and if the hospital had a Level II NICU and a minimum of at least 3,500 births during the previous 12 months;
- Establishing a Level III NICU if the unit has at least five beds, and is a verified trauma center,[16] and if the applicant has a Level II NICU;
- Establishing an adult open heart surgery program in a hospital located within the boundaries of a health service planning district, which:[17]
    - Has experienced an annual net out-migration of at least 600 open heart surgery cases for three consecutive years; and
    - Has a population that exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent;

transplantation, liver transplantation, bone marrow transplantation, lung transplantation, pancreas and islet cells transplantation, heart/lung transplantation, adult open heart surgery, neonatal and pediatric cardiac and vascular surgery, and pediatric oncology and hematology. See s. 408.032(17), F.S., and Rule 59C-1.002(41), F.A.C.

[14] See s. 408.036(2), F.S.

[15] Section 395.602(2)(g), F.S., defines "swing bed" as 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.

[16] Section 395.4001(14), F.S., defines "trauma center" as a hospital that has been verified by the Department of Health to be in substantial compliance with the requirements in s. 395.4025, F.S., and has been approved to operate as a Level I trauma center, Level II trauma center, or pediatric trauma center, or is designated as a Level II trauma center pursuant to s. 395.4025(14), F.S.

[17] This exemption is obsolete and is replaced by a licensure process under s. 408.0361, F.S.

- For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart-surgery program;[18]
- For the addition of mental health services or beds if the applicant commits to providing services to Medicaid or charity care patients as a level equal to, or greater than, the district average; and
- Constructing a new hospital or replacement facility by a statutory rural hospital or a not-for-profit operator of rural hospitals in a county with a population between 15,000 and 18,000 and a density of less than 30 persons per square mile, if the new or replacement facility is located within 10 miles of the currently licensed rural hospital and within the current primary service area.[19,20]

General Exemptions

Renewing a CON for a licensed facility that lost its CON due to failing to renew its license under certain circumstances.

Rural Hospitals

A rural hospital is an acute care hospital having 100 or fewer licensed beds and an emergency room, which is:[21]

- The sole provider within a county with a population density of up to 100 persons per square mile;
- In a county with a population density of up to 100 persons per square mile, which is at least 30 minutes travel time[22] from any other acute care hospital within the same county;
- Supported by a tax district or sub-district whose boundaries encompass a population of up to 100 persons per square mile;
- In a service area[23] that has a population of up to 100 persons per square mile; or
- Designated as a critical access hospital in s. 408.07(15), F.S.[24]

Currently, there are 24 rural hospitals in Florida.[25]

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[18] Id.

[19] *See* s. 395.6025, F.S.

[20] Service area for this provision is defined as 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 at the AHCA.

[21] Section 395.602(2)(e), F.S.

[22] On normally traveled roads under normal traffic conditions.

[23] *Supra* note 20.

[24] Section 408.07(15), F.S., defines a critical access hospital as a hospital that meets the definition of "critical access hospital" in s. 1861(mm)(1) of the Social Security Act, and that is certified by the Secretary of Health and Human Services as a critical access hospital. There are 13 designated critical access hospitals in Florida: Florida Hospital-Wauchula; Shands Hospital at Live Oak; Campbellton-Graceville Hospital; Lake Butler Hospital Hand Surgery Center; Calhoun - Liberty Hospital in Blountstown; George E. Weems Hospital in Apalachicola; Doctor's Memorial Hospital – Bonifay; Northwest Florida Community Hospital in Chipley; Hendry RMC in Clewiston; Shands at Starke; Madison County Memorial Hospital; Fisherman's Hospital in Marathon, and Mariners Hospital in Tavernier. *See* Flex Monitoring Team - Complete list of CAHs, available at: http://www.flexmonitoring.org/data/critical-access-hospital-locations/, (last visited February 2, 2016).

[25] Agency for Health Care Administration, *Senate Bill 236 Analysis* (September 9, 2015) (on file with the Senate Committee on Health Policy)

County	Hospital
Baker	Ed Fraser Memorial Hospital
Bradford	Shands Starke Regional Medical Center
Calhoun	Calhoun-Liberty Hospital
Columbia	Shands Lake Shore Regional Medical Center
DeSoto	DeSoto Memorial Hospital
Franklin	George E Weems Memorial Hospital
Gadsden	Capital Regional Medical Center, Gadsden Memorial Campus
Gulf	Sacred Heart Hospital on the Gulf
Hardee	Florida Hospital Wauchula
Hendry	Hendry Regional Medical Center
Holmes	Doctors Memorial Hospital
Jackson	Campbellton-Graceville Hospital
Jackson	Jackson Hospital
Levy	Regional General Hospital Williston
Madison	Madison County Memorial Hospital
Monroe	Fishermen's Hospital
Monroe	Mariners Hospital
Okeechobee	Raulerson Hospital
Suwannee	Shands Live Oak Regional Medical Center
Taylor	Doctors' Memorial Hospital
Union	Lake Butler Hospital
Walton	Healthmark Regional Medical Center
Walton	Sacred Heart Hospital On The Emerald Coast
Washington	Northwest Florida Community Hospital

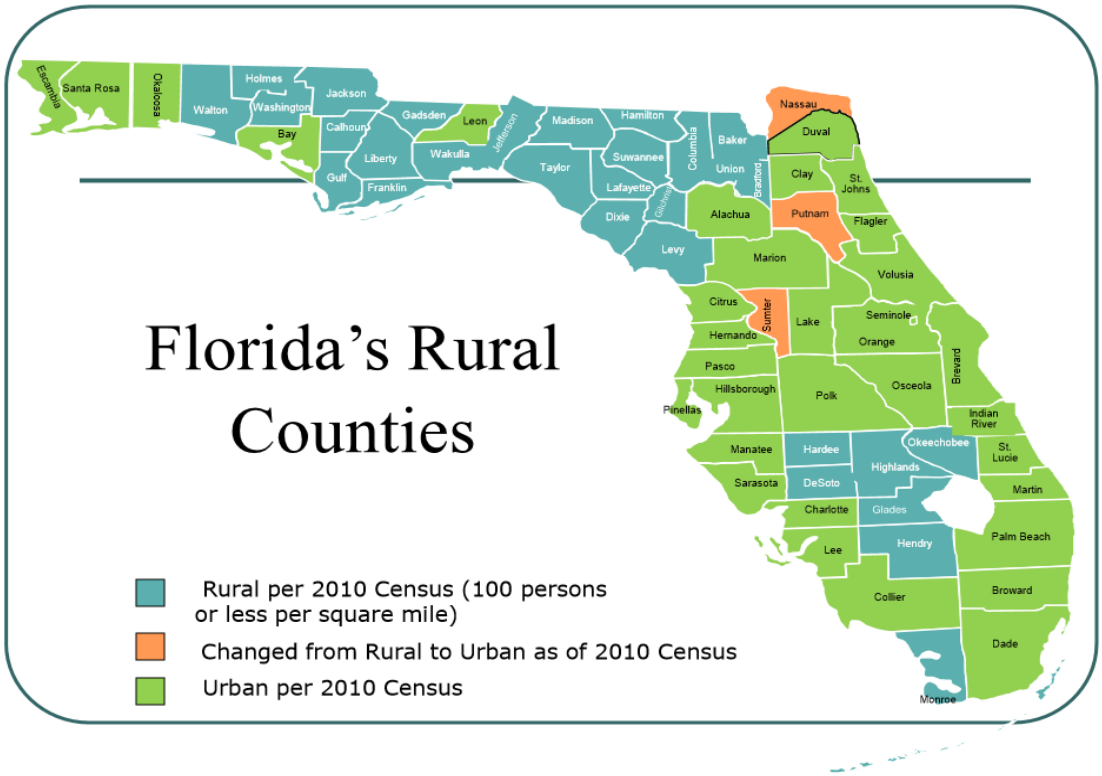
Rural Counties and Population Density

The Department of Health maintains a list of rural counties that is based on a density of less than 100 persons per square mile.[26] The following list identifies Florida's 30 rural counties and their density according to the 2010 Census.

County	Density	County	Density	County	Density
Baker	46.3	Gulf	28.6	Liberty	10.0
Bradford	97.3	Hamilton	28.7	Madison	27.8
Calhoun	25.8	Hardee	43.5	Monroe	73.3
Columbia	84.7	Hendry	34.0	Okeechobee	51.7
DeSoto	54.7	Highlands	96.1	Suwannee	60.4
Dixie	23.3	Holmes	41.3	Taylor	21.7
Franklin	21.2	Jackson	54.3	Union	64.6
Gadsden	89.9	Jefferson	24.7	Wakulla	50.7
Gilchrist	48.5	Lafayette	16.3	Walton	52.0
Glades	16.7	Levy	36.5	Washington	42.9

[26] http://www.floridahealth.gov/programs-and-services/community-health/rural-health/_documents/rual-counties-2000-2010.pdf (last visited Feb. 2, 2016).

The following map depicts these rural counties geographically.[27]



III. Effect of Proposed Changes:

The bill modifies the eligibility criteria for a rural hospital to construct a new or a replacement facility without first obtaining a CON. The population density threshold is raised from less than 30 to less than 100 persons per square mile, which coincides with the population density in the definition of a rural hospital. The bill removes the county population criteria of between 15,000 and 18,000 persons and the requirement that the new or replacement facility be located within 10 miles of the site of the currently licensed rural hospital. The requirement that the new or replacement facility must be in the current primary service area remains unchanged.

The current exemption applies to 11 counties: Calhoun, Dixie*, Franklin, Glades*, Gulf, Hamilton*, Jefferson*, Lafayette*, Liberty*, Madison, and Taylor counties.

The increase in population density adds the following 19 counties to the exemption: Baker, Bradford, Columbia, DeSoto, Gadsden, Gilchrist*, Hardee, Hendry, Highlands, Holmes, Jackson, Levy, Monroe, Okeechobee, Suwannee, Union, Wakulla*, Walton, and Washington.

[27] http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/health-professional-shortage-designations/Rural%20Counties%20Map%202016.pdf (last visited Feb. 2, 2016).

Although Highlands county meets the density requirement under the bill, there are currently three licensed hospitals in Highlands county and none are designated rural hospitals.[28]

* These counties do not currently have a licensed hospital.

The bill is effective July 1, 2016.

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:

A replacement hospital over one mile from the original location costs the maximum CON fee of $50,000. This bill provides the opportunity for a hospital in a rural county to avoid that cost as well as additional costs related to the CON process.

C. Government Sector Impact:

Indeterminate.[29]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[28] *Supra* note 25.
[29] *Id.*

VIII. Statutes Affected:

This bill substantially amends section 395.6025 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 Grimsley

21-00333-16 2016236__

A bill to be entitled

An act relating to certificates of need for rural hospitals; amending s. 395.6025, F.S.; revising the criteria for exempting a rural hospital or the not-for-profit operator of rural hospitals from the requirement to obtain a certificate of need for the construction of a new or replacement facility within the primary service area; providing an effective date.

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

Section 1. Section 395.6025, Florida Statutes, is amended to read:

395.6025 Rural hospital replacement facilities.—Notwithstanding the provisions of s. 408.036, a hospital defined as a statutory rural hospital in accordance with s. 395.602, or a not-for-profit operator of rural hospitals, is not required to obtain a certificate of need for the construction of a new hospital located in a county with a population ~~of at least 15,000 but no more than 18,000 and a~~ density of less than 100 ~~30~~ persons per square mile, or a replacement facility, provided that the replacement, or new, facility is located within ~~10 miles of the site of the currently licensed rural hospital and within~~ the current primary service area. As used in this section, 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 Policy Analysis at the

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

21-00333-16 2016236__

Agency for Health Care Administration.

Section 2. This act shall take effect July 1, 2016.

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: September 21, 2015

I respectfully request that **Senate Bill #132**, relating to Direct Primary Care, **Senate Bill #152**, relating to Ordering of Medication, **Senate Bill #236**, relating to Certificates of Need for Rural Hospitals, and **Senate Bill #238**, relating to Medical Assistant Certification be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

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 Committee on Health Policy

BILL:	SB 858
INTRODUCER:	Senator Legg
SUBJECT:	Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor Interns
DATE:	February 5, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 858 requires that a clinical social work, marriage and family, or mental health counselling intern practice under the supervision of a licensed clinical social worker, marriage and family therapist, or mental health counselor, as applicable, at all times. It clarifies that an intern may only practice if the supervising or another licensed mental health professional is onsite.

The bill limits the duration of a registered internship to five years, with a grandfathering provision for licenses issued before April 1, 2017. The internship may only be renewed if the registration is issued after April 1, 2017, and the intern has passed the theory and practice examination required for full licensure. The bill prohibits a person who has held a provisional license from applying for an intern registration in the same profession.

II. Present Situation:

The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling is located within the Department of Health (DOH), and implements and enforces rules that regulate the practice of clinical social work, marriage and family therapy, and mental health counseling pursuant to ch. 491, F.S. The board is composed of nine members appointed by the Governor and confirmed by the Senate.[1] Presently, the board regulates 9,246 licensed clinical social workers, 1,866 marriage and family therapists, and 10,018 mental health counselors. [2]

[1] Section 491.004(1), F.S.

[2] Florida Dep't of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan Fiscal Year 2014-2015*, p. 13, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf (last visited Feb. 4, 2016).

Clinical Social Work

The practice of clinical social work uses scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior to prevent and treat undesired behavior and enhance mental health. It 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. Clinical social work incorporates psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[3]

Marriage and Family Therapy

The practice of marriage and family therapy uses scientific and applied marriage and family therapies, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems. The practice 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 technique. The practice of marriage and family therapy include methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders or dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. Marriage and family therapy incorporates marriage and family therapy, psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[4]

Mental Health Counseling

Mental health counseling uses scientific and applied behavioral science theories, methods, and techniques for the purpose of describing, preventing, and treating undesired behaviors and enhancing mental health and human development. The practice 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 that are used to evaluate, assess, diagnose, and treat emotional and mental dysfunctions or disorders (whether cognitive, affective, or behavioral), behavioral disorders, interpersonal relationships, sexual dysfunctions, alcoholism, and substance abuse. Mental health counseling incorporates psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[5]

[3] Section 491.003(7), F.S.
[4] Section 491.003(8), F.S.
[5] Section 491.003(9), F.S.

Interns

To be licensed as a clinical social worker, marriage and family therapist, or mental health counselor, an applicant must meet educational requirements, complete a two-year supervised postgraduate or postmaster's clinical practice, and pass a theory and practice examination.[6] During the time in which an applicant is completing the required supervised clinical experience or internship, he or she must register with the DOH as an intern.[7] The supervised clinical experience may be met by providing at least 1,500 hours of face-to-face psychotherapy with clients, which may not be accrued in less than 100 weeks.[8]

An applicant seeking registration as an intern must:[9]

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

A registered intern may renew his or her registration every biennium, with no limit to the number of times it may be renewed. An intern may perform work on or off the premises of the supervising mental health professional provided the off-premises work is not the independent private practice without a licensed mental health professional on the premises when the intern is providing services.[10]

Currently, there are 3,949 clinical social work interns; 1,039 marriage and family therapy interns; and 4,966 registered mental health counselor interns.[11] More than 700 interns have continued to renew their intern registration for more than 10 years, and 150 of them have been renewing their registrations since the inception of this law in 1998. The renewal fee for an intern is $80 for the biennium period and no continuing education is required. Comparatively, the requirements for renewal of a licensed mental health professional's license is payment of a $130 per biennium renewal fee and completion of 30 hours continuing education.[12]

Provisional Licenses

A provisional license allows an individual applying for licensure by examination or licensure by endorsement,[13] who has satisfied the clinical experience requirements, to practice under supervision while meeting additional coursework or examination requirements for licensure.[14] Individuals must meet minimum coursework requirements and possess the respective graduate

[6] Section 491.005, F.S.
[7] Section 491.0045, F.S.
[8] Rule 64B4-2.001, F.A.C
[9] Section 491.0045(2), F.S.
[10] Section 491.005(1)(c), F.S.
[11] *Supra* note 2.
[12] Florida Dep't of Health, *Senate Bill 858 Analysis* (November 17, 2015) (on file with the Senate Committee on Health Policy). The registration renewal fee is $80 for a two-year period.
[13] The procedure for licensure by endorsement is provided in s. 491.006, F.S.
[14] Section 491.0046(1), F.S., and Rule 64B4-3.0075, F.A.C.

degree.[15] A provisional license is valid for 24 months, after which it may not be renewed or reissued.[16]

There are 53 provisionally licensed clinical social workers, 25 provisionally licensed marriage and family therapists, and 152 provisionally licensed mental health counselors.[17] The board has accepted applications for intern registrations from practitioners whose provisional licenses have expired. Currently, there is no prohibition against a provisional licensee applying for an intern registration.[18]

III. Effect of Proposed Changes:

The bill amends ss. 491.0045 and 491.005, F.S., to require that a clinical social work, marriage and family, or mental health counselling intern practice under the supervision of a licensed clinical social worker, marriage and family therapist, or mental health counselor, as applicable, at all times. It clarifies that an intern may practice only if the supervising or another licensed mental health professional is onsite.

The bill limits the duration of a registered internship to five years (60 months) from the date the intern registration is issued. An intern registration issued on or before April 1, 2017, will expire on March 31, 2022, and may not be renewed or reissued. Registrations issued after April 1, 2017, expire 60 months after the date of issuance; and may only be renewed if the candidate has passed the theory and practice examination required for full licensure. The bill prohibits a person who has held a provisional license from applying for an intern registration in the same profession.

The bill deletes obsolete language, makes technical grammatical and conforming changes, and reenacts prohibitions on practicing clinical social work, marriage and family therapy, or mental health counseling unless licensed to practice that profession or the person is a registered intern.

The bill is effective July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[15] Section 491.0046(2), F.S.
[16] Section 491.0046(4), F.S.
[17] *Supra* note 12.
[18] Id.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will provide greater public protection by ensuring that these interns have met minimum qualifications for practice and are adequately supervised.

C. Government Sector Impact:

According to the DOH, it will experience a decrease in revenue associated with the elimination of the biennial renewal fee for interns. However, with the internship time limit restricted to five years, it is anticipated that interns will then apply for full licensure, which will offset the decrease in intern renewal revenue. DOH will also be required to update its licensure system to accommodate the five year intern license, which current resources will be adequate to absorb.[19]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 491.0045 and 491.005.

This bill reenacts section 491.012 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.

[19] *Supra* note 12.

By Senator Legg

17-00689A-16 2016858__

A bill to be entitled

An act relating to clinical social worker, marriage and family therapist, and mental health counselor interns; amending s. 491.0045, F.S.; revising clinical social worker, marriage and family therapist, and mental health counselor intern registration requirements; revising requirements for supervision of registered interns; deleting specified education and experience requirements; establishing validity periods and providing for expiration of intern registrations; establishing requirements for a subsequent intern registration and for an applicant who has held a provisional license; amending s. 491.005, F.S.; requiring a licensed mental health professional to be on the premises when a registered intern provides services in clinical social work, marriage and family therapy, or mental health counseling; deleting a clinical experience requirement for such registered interns; deleting a provision requiring that certain registered interns meet educational requirements for licensure; reenacting s. 491.012(1)(i),(j), and (k), F.S., relating to penalties, to incorporate the amendment made to s. 491.0045, F.S., in a reference thereto; providing an effective date.

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

Section 1. Section 491.0045, Florida Statutes, is amended to read:

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

17-00689A-16 2016858__

491.0045 Intern registration; requirements.—

(1) ~~Effective January 1, 1998,~~ An individual who has not satisfied ~~intends to practice in Florida to satisfy~~ the postgraduate or post-master's level experience requirements, as specified in s. 491.005(1)(c), (3)(c), or (4)(c), must register as an intern in the profession for which he or she is seeking licensure before ~~prior to~~ commencing the post-master's experience requirement. ~~or~~ An individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience, outside the academic arena for any profession, must register as an intern in the profession for which he or she is seeking licensure before ~~prior to~~ commencing the practicum, internship, or field experience.

(2) The department shall register as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern each applicant who the board certifies has:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $200, as set by board rule;

(b)1. Completed the education requirements as specified in s. 491.005(1)(c), (3)(c), or (4)(c) for the profession for which he or she is applying for licensure, if needed; and

2. Submitted an acceptable supervision plan, as determined by the board, for meeting the practicum, internship, or field work required for licensure that was not satisfied in his or her graduate program.

(c) Identified a qualified supervisor.

(3) An individual registered under this section must remain

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under supervision while practicing under registered intern status ~~until he or she is in receipt of a license or a letter from the department stating that he or she is licensed to practice the profession for which he or she applied~~.

~~(4) An individual who has applied for intern registration on or before December 31, 2001, and has satisfied the education requirements of s. 491.005 that are in effect through December 31, 2000, will have met the educational requirements for licensure for the profession for which he or she has applied.~~

(4)~~(5) Individuals who have commenced the experience requirement as specified in s. 491.005(1)(c), (3)(c), or (4)(c) but failed to register as required by subsection (1) shall register with the department before January 1, 2000.~~ Individuals who fail to comply with this section may ~~subsection shall~~ not be granted a license under this chapter, and any time spent by the individual completing the experience requirement as specified in s. 491.005(1)(c), (3)(c), or (4)(c) before ~~prior to~~ registering as an intern does ~~shall~~ not count toward completion of the ~~such~~ requirement.

(5) An intern registration issued on or before April 1, 2017, expires March 31, 2022, and may not be renewed or reissued. An intern registration issued after April 1, 2017, expires 60 months after the date of issuance. No subsequent intern registration may be issued unless the candidate has passed the theory and practice examination described in s. 491.005 (1)(d), (3)(d), and (4)(d).

(6) An individual who has held a provisional license issued by the board may not apply for an intern registration in the same profession.

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Section 2. Paragraphs (a) and (c) of subsection (1), paragraphs (a) and (c) of subsection (3), paragraphs (a) and (c) of subsection (4), and subsections (5) and (6) of section 491.005, Florida Statutes, are amended to read:

491.005 Licensure by examination.—

(1) CLINICAL SOCIAL WORK.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost to the department for purchase of the examination from the American Association of State Social Worker's Boards or a similar national organization, the department shall issue a license as a clinical social worker to an applicant who the board certifies:

(a) Has submitted an ~~made~~ application ~~therefor~~ and paid the appropriate fee.

(c) Has had at least ~~not less than~~ 2 years of clinical social work experience, which took place subsequent to completion of a graduate degree in social work at an institution meeting the accreditation requirements of this section, under the supervision of a licensed clinical social worker or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy clinical experience requirements must register pursuant to s. 491.0045 before ~~prior to~~ commencing practice. If the applicant's graduate program was not a program which emphasized direct clinical patient or client health care services as described in subparagraph (b)2., the supervised experience requirement must take place after the applicant has completed a minimum of 15 semester hours or 22 quarter hours of the coursework required. A doctoral internship may be applied toward

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the clinical social work experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting. ~~The experience requirement may be met by work performed on or off the premises of the supervising clinical social worker or the equivalent, provided the off-premises work is not the independent private practice rendering of clinical social work that does not have a licensed mental health professional, as determined by the board, on the premises at the same time the intern is providing services.~~

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual cost to the department for the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or similar national organization, the department shall issue a license as a marriage and family therapist to an applicant who the board certifies:

(a) Has submitted an ~~made~~ application ~~therefor~~ and paid the appropriate fee.

(c) Has had at least ~~not less than~~ 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before ~~prior to~~ commencing practice. If a graduate has a master's degree with a major

emphasis in marriage and family therapy or a closely related field that did not include all the coursework required under sub-subparagraphs (b)1.a.-c., credit for the post-master's level clinical experience shall not commence until the applicant has completed a minimum of 10 of the courses required under sub-subparagraphs (b)1.a.-c., as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 3 years of required experience, the applicant shall provide direct individual, group, or family therapy and counseling, to include the following categories of cases: unmarried dyads, married couples, separating and divorcing couples, and family groups including children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting. ~~The clinical experience requirement may be met by work performed on or off the premises of the supervising marriage and family therapist or the equivalent, provided the off-premises work is not the independent private practice rendering of marriage and family therapy services that does not have a licensed mental health professional, as determined by the board, on the premises at the same time the intern is providing services.~~

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost to the department for purchase of the examination from the Professional Examination Service for the National Academy of Certified

Clinical Mental Health Counselors or a similar national organization, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an ~~made~~ application ~~therefor~~ and paid the appropriate fee.

(c) Has had at least ~~not less than~~ 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before ~~prior to~~ commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling that did not include all the coursework required under sub-subparagraphs (b)1.a.-b., credit for the post-master's level clinical experience shall not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a.-b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting. ~~The clinical experience requirement may be met by work performed on or off the premises of the supervising mental health counselor or the equivalent, provided the off-premises work is not the independent private practice rendering of services that does not have a licensed mental health professional, as~~

~~determined by the board, on the premises at the same time the intern is providing services.~~

~~(5) INTERNSHIP.—An individual who is registered as an intern and has satisfied all of the educational requirements for the profession for which the applicant seeks licensure shall be certified as having met the educational requirements for licensure under this section.~~

(5) ~~(6)~~ RULES.—The board may adopt rules necessary to implement any education or experience requirement of this section for licensure as a clinical social worker, marriage and family therapist, or mental health counselor.

Section 3. For the purpose of incorporating the amendment made by this act to section 491.0045, Florida Statutes, in a reference thereto, paragraphs (i), (j), and (k) of subsection (1) of section 491.012, Florida Statutes, are reenacted to read:

491.012 Violations; penalty; injunction.—

(1) It is unlawful and a violation of this chapter for any person to:

(i) Practice clinical social work in this state for compensation, unless the person holds a valid, active license to practice clinical social work issued pursuant to this chapter or is an intern registered pursuant to s. 491.0045.

(j) Practice marriage and family therapy in this state for compensation, unless the person holds a valid, active license to practice marriage and family therapy issued pursuant to this chapter or is an intern registered pursuant to s. 491.0045.

(k) Practice mental health counseling in this state for compensation, unless the person holds a valid, active license to practice mental health counseling issued pursuant to this

chapter or is an intern registered pursuant to s. 491.0045.

Section 4. This act shall take effect July 1, 2016.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Education Pre-K - 12, Chair
Ethics and Elections, Vice Chair
Appropriations Subcommittee on Education
Fiscal Policy
Government Oversight and Accountability
Higher Education

SENATOR JOHN LEGG
17th District

Legg.John.web@FLSenate.gov

December 7, 2015

The Honorable Aaron Bean
Committee on Health Policy, Chair
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

RE: SB 858 - Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor Interns

Dear Chair Bean:

SB 858: Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor Interns has been referred to your committee. I respectfully request that it be placed on the Committee on Health Policy Agenda, at your convenience. Your leadership and consideration are appreciated.

Sincerely,

John Legg
State Senator, District 17

cc: Sandra Stovall, Staff Director
Celia Georgiades, Administrative Assistant

REPLY TO:
❒ 262 Crystal Grove Boulevard, Lutz, Florida 33548 (813) 909-9919
❒ 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5017

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Education Pre-K - 12, Chair
Ethics and Elections, Vice Chair
Appropriations Subcommittee on Education
Fiscal Policy
Government Oversight and Accountability
Higher Education

SENATOR JOHN LEGG
17th District

Legg.John.web@FLSenate.gov

February 8, 2016

The Honorable Aaron Bean
Committee on Health Policy, Chair
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

RE: SB 858 - Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor Interns

Dear Chair Bean:

SB 858: Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor Interns is on the Committee on Health Policy agenda, February 9, 2016. I will be at the Committee on Government Oversight and Accountability meeting, and I will be unable to attend.

Please recognize my Legislative Assistant, Jim Browne, to present SB 858 on my behalf. Should you have any questions, please feel free to contact me. Your consideration is greatly appreciated.

Sincerely,

John Legg
State Senator, District 17

cc: Sandra Stovall, Staff Director
Celia Georgiades, Administrative Assistant

REPLY TO:
❒ 262 Crystal Grove Boulevard, Lutz, Florida 33548 (813) 909-9919
❒ 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5017

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

09 February 2016
Meeting Date

858
Bill Number (if applicable)

Topic Mental Health Interns

Amendment Barcode (if applicable)

Name Hassiem A. Kambui, Ph.D.

Job Title Assistant Professor of Counseling

Address Florida A&M University 501 Orr Drive
Street

Phone 850.561.2440

Tallahassee FL 32304
City *State* *Zip*

Email hassiem.kambui@famu.edu

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Mental Health Counselor Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

The Florida Senate

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 Committee on Health Policy

BILL:	CS/SB 946
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Authorized Practices of Advanced Registered Nurse Practitioners and Licensed Physician Assistants
DATE:	February 10, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 946 authorizes advanced registered nurse practitioners (ARNPs) to order any medication, including controlled substances, for administration to patients in certain facilities under an established protocol with an allopathic or osteopathic physician, or dentist. The bill authorizes a physician to delegate to a physician assistant (PA) and the PA to prescribe controlled substances to a patient in a nursing home. The bill also conforms ch. 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act, to reflect the authorization for ARNPs and licensed PAs to order controlled substances for administration to patients in certain facilities under certain circumstances when authorized by a supervising physician, or dentist.

II. Present Situation:

Under current Florida law a supervising physician my delegate to a PA the authority to order controlled substances for the practitioner's patients in hospitals, ambulatory surgery centers, and mobile surgical facilities.[1] However, under current Florida law there is no equivalent delegation of authority for the supervising physician of an ARNP.

[1] *See* ss. 458.347(4) and 459.022(4), F.S.

Also, unlike all other states, Florida does not allow ARNPs to prescribe controlled substances and is one of two states that does not allow PAs to prescribe controlled substances.[2] The states have varying permissions with respect to the Schedules[3] from which an ARNP or PA may prescribe as well as the additional functions, such as dispensing, administering, or handling samples, that an ARNP or PA may perform.

According to a recent study commissioned by the Safety Net Hospital Alliance of Florida,[4] Florida's total current supply of primary care physicians falls short of the number needed to provide a national average level of care by approximately 6 percent. Under a traditional definition of primary care specialties (i.e., general and family practice, general internal medicine, general pediatrics and geriatric medicine) supply falls short of demand by approximately 3 percent. [Based on simulation models, the report concludes that] over the next several years, this shortfall will grow slightly as more people obtain insurance coverage as mandated by the federal Affordable Care Act. However, if current trends continue, this shortfall should disappear within a decade. While supply may be adequate at the state level to provide a national average level of care, there is substantial geographic variation in adequacy of care.

Regulation of Physician Assistants in Florida

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., similarly sets forth the provisions for the regulation of the practice of osteopathic medicine by the Board of Osteopathic Medicine (BOOM). PAs are regulated by both boards. Licensure of PAs is overseen jointly by the boards through the Council on Physician Assistants.[5] During the 2014-2015 state fiscal year, there were 6,744 in-state, actively licensed PAs in Florida.[6]

Physician Assistants are trained and required by statute to work under the supervision and control of allopathic or osteopathic physicians.[7] 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 direct[8] and indirect[9] supervision. A supervising physician's decision to permit a PA to perform a task or procedure under direct or indirect supervision must

[2] DEA Diversion Control, U.S. Department of Justice, *Mid-Level Practitioners Authorization by State* (last updated November 10, 2015) *available at* http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf (last visited Feb. 1, 2016). Kentucky does not allow PAs to prescribe controlled substances.
[3] Controlled substances are assigned to Schedules I - V based on their accepted medical use and potential for abuse.
[4] IHS Global Inc., *Florida Statewide and Regional Physician Workforce Analysis: Estimating Current and Forecasting Future Supply and Demand*, (January 28, 2016) *available at* https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/GME/docs/FINAL_Florida_Statewide_and_Regional_Physician_Workforce_Analysis.pdf, (last visited Feb. 1, 2016).
[5] The council consists of three physicians who are members of the Board of Medicine; one physician who is a member of the Board of Osteopathic Medicine; and a physician assistant appointed by the State Surgeon General. (s. 458.348(9), F.S. and s. 459.022(9), F.S.)
[6] Florida Dep't of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan Fiscal Year 2014-2015*, p. 11, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf, (last visited Feb. 1, 2016).
[7] Sections 458.347(4), and 459.022(4), F.S.
[8] "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.).
[9] "Indirect supervision" requires the physician to be within reasonable physical proximity. (Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.

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.[10] Each physician, or group of physicians supervising a licensed PA, must be qualified in the medical areas in which the PA is to work and is individually or collectively responsible and liable for the performance and the acts and omissions of the PA.[11]

Current law allows a supervisory physician to delegate authority to prescribe or dispense any medication used in the physician's practice, except controlled substances, general anesthetics, and radiographic contrast materials.[12] However, the law allows a supervisory physician to delegate authority to a PA to order any medication, which would include controlled substances, general anesthetics, and radiographic contrast materials, for a patient of the physician during the patient's stay in a facility licensed under ch. 395, F.S.[13]

Regulation of Advanced Registered Nurse Practitioners in Florida

Chapter 464, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health (DOH) and are regulated by the Board of Nursing (BON).[14] During the 2014-2015 state fiscal year, there were 18,276 in-state, actively licensed ARNPs in Florida.[15]

An ARNP is a licensed nurse who is certified in advanced or specialized nursing.[16] Florida recognizes three types of ARNPs: nurse practitioners (NP), certified registered nurse anesthetists (CRNA), and certified nurse midwives (CNM).[17] To be certified as an ARNP, a nurse must hold a current license as a registered nurse[18] and submit proof to the BON that the ARNP applicant meets one of the following requirements:[19]

- Satisfactory completion of a formal postbasic educational program of specialized or advanced nursing practice;

[10] Rules 64B8-30.012(2) and 64B15-6.010(2), F.A.C.
[11] Sections 458.347(3) and (15) and 459.022(3) and (15), F.S.
[12] Sections 458.347(4)(e) and (f)1., and 459.022(4)(e)., F.S.
[13] *See* s. 395.002(16), F.S. The facilities licensed under chapter 395 are hospitals, ambulatory surgical centers, and mobile surgical facilities.
[14] The BON is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. Seven of the 13 members must be nurses who reside in Florida and have been engaged in the practice of professional nursing for at least 4 years. Of those seven members, one must be an advanced registered nurse practitioner, one a nurse educator at an approved nursing program, and one a nurse executive. Three members of the BON must be licensed practical nurses who reside in the state and have engaged in the practice of practical nursing for at least 4 years. The remaining three members must be Florida residents who have never been licensed as nurses and are in no way connected to the practice of nursing, any health care facility, agency, or insurer. Additionally, one member must be 60 years of age or older. *See* s. 464.004(2), F.S.
[15] *Supra* note 5. Certified Nurse Specialists account for 26 of the in-state actively licensed ARNPs.
[16] "Advanced specialized nursing practice" is defined as the performance of advanced-level nursing acts approved by the BON which, by virtue of postbasic specialized education, training and experience, are appropriately performed by an ARNP. (*See* s. 464.003(2), F.S.)
[17] Section 464.003(3), F.S. Florida certifies clinical nurse specialists as a category distinct from ARNPs. (*See* ss. 464.003(7) and 464.0115, F.S.).
[18] Practice of professional nursing. (*See* s. 464.003(20), F.S.)
[19] Section 464.012(1), F.S.

- Certification by an appropriate specialty board;[20] or
- Completion of a master's degree program in the appropriate clinical specialty with preparation in specialty-specific skills.

Advanced or specialized nursing acts may only be performed under the protocol of a supervising physician or dentist. Within the established framework of the protocol, an ARNP may:[21]

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions; and
- Order diagnostic tests and physical and occupational therapy.

The statute further describes additional acts that may be performed within an ARNP's specialty certification (CRNA, CNM, and NP).[22]

An ARNP must meet financial responsibility requirements, as determined by rule of the BON, and the practitioner profiling requirements.[23] The BON requires professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the same amounts payable to the ARNP.[24]

Florida does not allow ARNPs to prescribe controlled substances.[25] However, s. 464.012(4)(a), F.S., provides express authority for a CRNA to order certain controlled substances "to the extent authorized by the established protocol approved by the medical staff of the facility in which the anesthetic service is performed."

Educational Preparation

Physician Assistants[26]

Physician Assistant education is modeled on physician education. PA programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant. All PA programs must meet the same set of national standards for accreditation. PA program applicants must complete at least 2 years of college courses in basic science and behavioral science as a prerequisite to PA training. The average length of PA education programs is about 26 months. Students begin their course of study with a year of basic medical science classes (anatomy, pathophysiology, pharmacology, physical diagnosis, etc.) Then the PA students enter the clinical phase of training, which includes classroom instruction and clinical rotations in medical and

[20] Specialty boards expressly recognized by the BON: Council on Certification of Nurse Anesthetists, or Council on Recertification of Nurse Anesthetists; American College of Nurse Midwives; American Nurses Association (American Nurses Credentialing Center); National Certification Corporation for OB/GYN, Neonatal Nursing Specialties; National Board of Pediatric Nurse Practitioners and Associates; National Board for Certification of Hospice and Palliative Nurses; American Academy of Nurse Practitioners; Oncology Nursing Certification Corporation; American Association of Critical-Care Nurses Adult Acute Care Nurse Practitioner Certification. (Rule 64B9-4.002(2), F.A.C.)
[21] Section 464.012(3), F.S.
[22] Section 464.012(4), F.S.
[23] Sections 456.0391 and 456.041, F.S.
[24] Rule 64B9-4.002(5), F.A.C.
[25] Sections 893.02(21) and 893.05(1), F.S.
[26] *See* American Academy of Physician Assistants, *PAs as Prescribers of Controlled Medications – Issue Brief* (June 2014) *available at* https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2549 (last viewed Feb. 1, 2016).

surgical specialties. PA students, on average, complete 48.5 weeks of supervised clinical practice by the time they graduate.

All PA educational programs include pharmacology courses, and nationally, the average amount of required formal classroom instruction in pharmacology is 75 hours. This does not include instruction in pharmacology that students receive during clinical medicine coursework and clinical clerkships. Based on national data, the mean amount of total instruction in clinical medicine is 358.9 hours. And the average length of required clinical clerkships is 48.5 weeks. A significant percentage of time is focused on patient management, including pharmacotherapeutics. Coursework in pharmacology addresses, but is not limited to, pharmacokinetics, drug interactions, adverse effects, contraindications, indications, and dosage.

Advanced Registered Nurse Practitioners[27]

Applicants for Florida licensure who graduated on or after October 1, 1998, must have completed requirements for a master's degree or post-master's degree.[28] Applicants who graduated before that date, may be or may have been eligible through a certificate program.[29]

The curriculum of a program leading to an advanced degree must include, among other things:

- Theory and directed clinical experience in physical and biopsychosocial assessment.
- Interviewing and communication skills relevant to obtaining and maintaining a health history;
- Pharmacotherapeutics, including selecting, prescribing, initiating, and modifying medications in the management of health and illness;
- Selecting, initiating and modifying diets and therapies in the management of health and illness;
- Performance of specialized diagnostic tests that are essential to the area of advanced practice;
- Differential diagnosis pertinent to the specialty area;
- Interpretation of laboratory findings;
- Management of selected diseases and illnesses;
- Professional socialization and role realignment;
- Legal implications of the advanced nursing practice and nurse practitioner role;
- Health delivery systems, including assessment of community resources and referrals to appropriate professionals or agencies; and
- Providing emergency treatments.

The program must provide a minimum of 500 hours (12.5 weeks) of preceptorship/supervised clinical experience[30] in the performance of the specialized diagnostic procures that are essential to practice in that specialty area.

[27] Rule 64B9-4.003, F.A.C.
[28] Florida Board of Nursing, *ARNP Licensure Requirements* http://floridasnursing.gov/licensing/advanced-registered-nurse-practitioner/, (last visited Feb.1, 2016).
[29] *Id.*, and s. 464.012(1), F.S.
[30] Preceptorship/supervised clinical experience must be under the supervision of a qualified preceptor, who is defined as a practicing certified ARNP, a licensed medical doctor, osteopathic physician, or a dentist. *See* Rule 64B9-4.001(13), F.A.C.

Drug Enforcement Agency Registration

The Drug Enforcement Agency (DEA) registration grants practitioners federal authority to handle controlled substances. However, the DEA registered practitioner may only engage in those activities that are authorized under state law for the jurisdiction in which the practice is located.[31]

According to requirements of the DEA, a prescription for a controlled substance may only be issued by a physician, dentist, podiatrist, veterinarian, mid-level practitioner,[32] or other registered practitioner who is:

- Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice;
- Registered with DEA or exempted from registration (that is, Public Health Service, Federal Bureau of Prisons, or military practitioners); or
- An agent or employee of a hospital or other institution acting in the normal course of business or employment under the registration of the hospital or other institution which is registered in lieu of the individual practitioner being registered provided that additional requirements are met.[33] These requirements include:
  - The dispensing, administering, or prescribing is in the usual course of professional practice;
  - The practitioner is authorized to do so by the state in which he or she practices;
  - The hospital or other institution has verified that the practitioner is permitted to administer, dispense, or prescribe controlled substances within the state;
  - The practitioner acts only within the scope of employment in the hospital or other institution;
  - The hospital or other institution authorizes the practitioner to administer, dispense, or prescribe under its registration and assigns a specific internal code number for each practitioner; and
  - The hospital or other institution maintains a current list of internal codes and the corresponding practitioner.[34]

III. Effect of Proposed Changes:

CS/SB 946 amends s. 464.012, F.S., to authorize an ARNP to order controlled substances for administration to patients in hospitals, ambulatory surgery centers, mobile surgical facilities, and nursing homes under an established protocol with a supervising allopathic or osteopathic physician, or dentist, which is filed with the DOH. The bill amends s. 893.05, F.S., to allow ARNPs and PAs to order controlled substances for administration to patients in hospitals, ambulatory surgery centers, mobile surgical facilities and nursing homes within the framework of an established protocol or as delegated under a supervisory relationship with a physician.

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[31] U.S. Department of Justice, Drug Enforcement Administration, *Practitioner's Manual*, (August 2006), p. 7, *available at* http://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf, (last visited Feb. 1, 2016).
[32] Examples of mid-level practitioners include, but are not limited to: nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, and physician assistants.
[33] *Supra* note 30, at 18.
[34] *Supra* note 30, at 12.

CS/SB amends ss. 458.347 and 458.022, F.S., to authorize a physician to delegate his or her authority to prescribe medications, including controlled substances, to PAs while treating the physician's patients in a nursing home licensed under part II, of ch. 400, F.S., and for the PA to order these medications.

The bill also makes technical changes to s. 893.05, F.S., and reenacts several statutory sections to conform to changes made by the bill.

The effective date of the bill is July 1, 2016.

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:

PAs and ARNPs who are authorized by the supervising physician or under a protocol to prescribe medicinal and controlled substances in certain facilities may be able to care for more patients, and patients receive needed medications more timely, due to reduced coordination with the supervising physician each time a controlled substance is recommended for a patient. Any such impacts are indeterminate.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. None. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.347, 459.022, 464.012, 893.05, 401.445, 766.103, and 893.0551.

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 9, 2016:
Authorizes a physician to delegate his or her authority to prescribe medications, including controlled substances, to PAs and for the PA to so order, while treating the physician's patients in a nursing home licensed under part II, of ch. 400, F.S.

B. Amendments:

None.

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

318100

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/08/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Before line 21
insert:
Section 1. Paragraph (g) of subsection (4) of section 458.347, Florida Statutes, is amended to read:
458.347 Physician assistants.—
(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—
(g) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the

318100

supervisory physician's patient during his or her care in a facility licensed under chapter 395 or chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 or chapter 400 may order any medication under the direction of the supervisory physician.

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

And the title is amended as follows:

Delete line 4

and insert:

assistants; amending s. 458.347, F.S.; authorizing a supervisory physician to delegate to a licensed physician assistant the authority to order medications for a patient during his or her care at a facility licensed under ch. 400, F.S.; amending s. 464.012, F.S.; authorizing an

172548

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/09/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Before line 21
insert:
Section 1. Paragraph (g) of subsection (4) of section 458.347, Florida Statutes, is amended to read:
458.347 Physician assistants.—
(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—
(g) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the

172548

supervisory physician's patient during his or her care in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 or part II of chapter 400 may order any medication under the direction of the supervisory physician.

Section 2. Paragraph (f) of subsection (4) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(f) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the supervisory physician's patient during his or her care in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 or part II of chapter 400 may order any medication under the direction of the supervisory physician.

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

And the title is amended as follows:

Delete line 4

and insert:

assistants; amending ss. 458.347 and 459.022, F.S.; authorizing a supervisory physician to delegate to a

172548

licensed physician assistant the authority to order medications for a patient during his or her care at a licensed nursing home facility; amending s. 464.012, F.S.; authorizing an

By Senator Grimsley

21-01380-16 2016946__

A bill to be entitled

An act relating to authorized practices of advanced registered nurse practitioners and licensed physician assistants; amending s. 464.012, F.S.; authorizing an advanced registered nurse practitioner to order medication for administration to patients in specified facilities; amending s. 893.05, F.S.; authorizing a licensed practitioner to authorize a licensed physician assistant or advanced registered nurse practitioner to order controlled substances for administration to patients in specified facilities under certain circumstances; reenacting ss. 401.445(1) and 766.103(3), F.S., to incorporate the amendment made to s. 464.012, F.S., in references thereto; reenacting s. 893.0551(3)(d), F.S., to incorporate the amendment made to s. 893.05, F.S., in a reference thereto; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 464.012, Florida Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees.—

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the

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

21-01380-16 2016946__

protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Monitor and alter drug therapies and order any medication for administration to a patient in a facility licensed under chapter 395 or part II of chapter 400.

Section 2. Subsection (1) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1)(a) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the controlled substance ~~same~~ to be administered by a licensed nurse or an intern practitioner under his or her direction and supervision only.

(b) Pursuant to s. 458.347(4)(g), s. 459.022(4)(f), or s. 464.012(3), as applicable, a practitioner who supervises a licensed physician assistant or advanced registered nurse practitioner may authorize the licensed physician assistant or advanced registered nurse practitioner to order controlled substances for administration to a patient in a facility

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

licensed under chapter 395 or part II of chapter 400.

(c) A veterinarian may ~~so~~ prescribe, administer, dispense, mix, or prepare a controlled substance for use on animals only, and may cause the controlled substance ~~it~~ to be administered by an assistant or orderly only under the veterinarian's direction and supervision ~~only~~.

(d) A certified optometrist licensed under chapter 463 may not administer or prescribe a controlled substance listed in Schedule I or Schedule II of s. 893.03.

Section 3. Subsection (1) of s. 401.445 and subsection (3) of s. 766.103, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.012, Florida Statutes, in references thereto.

Section 4. Paragraph (d) of subsection (3) of s. 893.0551, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 893.05, Florida Statutes, in a reference thereto.

Section 5. This act shall take effect July 1, 2016.

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 13, 2016

I respectfully request that **Senate Bill #946**, relating to Authorized Practices of Advanced Registered Nurse Practitioners and Licensed Physician Assistants; **Senate Bill #964**, relating to Prescription Drug Monitoring Program; **Senate Bill #1306** relating to Public Records and Meetings/Nurse Licensure Compact and **Senate Bill #1316,** relating to Nurse Licensure Compact be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

946
Bill Number (if applicable)

Topic Scope of practice of NP & PA

Amendment Barcode (if applicable)

Name Stan Whitaker

Job Title

Address 6294 NW Turnpike Rd
Street

Phone 850-545-8501

Bristol FL 32321
City State Zip

Email Stanwh.fl

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fl. Association of Nurse Practitioners

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/2016
Meeting Date

946
Bill Number (if applicable)

Topic Authorized Practices of ARNP's & PA's

Amendment Barcode (if applicable)

Name Chris Floyd

Job Title Consultant

Address 101 E. College Ave. *Street*

Phone 813-624-5117

Tallahassee *City* FL *State* 33606 *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Assoc. of Nurse Practitioners

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9
Meeting Date

Grimsley

946
Bill Number (if applicable)

Topic ARNP & PA

Amendment Barcode (if applicable)

Name Phillis Oetens

Job Title V.P. Govt Baptist Health

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing _____

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

946
Bill Number (if applicable)

Topic Authorized Practice of ARNPs & LPAs

Amendment Barcode (if applicable)

Name Laura Cantwell

Job Title ASD

Address 400 Canton Pkwy, Site 100
Street

St. Pete FL 33710
City *State* *Zip*

Phone 850 570-2110

Email lcantwell@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

946
Bill Number (if applicable)

Topic ARNP/PA administration

Amendment Barcode (if applicable)

Name Ron Watson

Job Title Lobbyist

Address 3738 Murdon Way
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850 567-1202

Email Watson.strategies@comcast.net

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

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

Representing Florida CHAIN

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

946
Bill Number (if applicable)

Topic Ordering of Medications

Amendment Barcode (if applicable)

Name Corinne Mixon

Job Title Lobbyist

Address 119 E. Park
Street

Phone 766 5725

Tallahassee 32301
City *State* *Zip*

Email corinne.mixon@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Academy of Physician Assistants

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/9/16
Meeting Date

SB 946
Bill Number (if applicable)

Topic SB 946 (ARNP scope of practice)

Amendment Barcode (if applicable)

Name Ellie Piloseno

Job Title

Address 106 N. Bronough St.
Street

Phone 850-222-5052

Tallahassee FL 32301
City *State* *Zip*

Email epiloseno@floridataxwatch.org

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida TaxWatch

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/9/16
Meeting Date

SB 946
Bill Number (if applicable)

Topic Scope of Practice

Amendment Barcode (if applicable)

Name Brittney Hunt

Job Title Policy Director

Address 136 S. Bronough St.
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone (850) 521-1200

Email bhunt@flchamber.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/9/16
Meeting Date

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

946
Bill Number (if applicable)

Topic ARNP Prescribing

Amendment Barcode (if applicable)

Name Alisa LaPolt

Job Title Lobbyist

Address
Street

Phone 850-443-1319

Tallahassee
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Nurses Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-9-16
Meeting Date

946
Bill Number (if applicable)

Topic ARNPs ordering

Amendment Barcode (if applicable)

Name Lori Killinger

Job Title Attorney/lobbyist

Address 315 S. Calhoun St. Ste 830
Street

Phone 8502225702

Tallahassee FL 32308
City *State* *Zip*

Email lkillinger@flw-law.com

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

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

Representing Florida Association of Nurse Anesthetists

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

9 Feb '16
Meeting Date

946
Bill Number (if applicable)

Topic Advanced Practice

Amendment Barcode (if applicable)

Name Martha De Castro

Job Title VP

Address 306 E. College
Street

Phone 222 9870

TLH
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fla Hospital Assn

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

The Florida Senate

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 Committee on Health Policy

BILL:	CS/SB 1142
INTRODUCER:	Banking and Insurance Committee and Senator Hays
SUBJECT:	Treatments for Stable Patients
DATE:	February 4, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Lloyd	Stovall	HP	**Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1142 amends the Insurance Code to allow an insured individual living with a complex or chronic medical condition or rare disease to continue to receive their brand drugs at a preferred cost for the calendar year. Currently, health insurers and pharmacy benefit managers often change their prescription drug formularies during the year as they respond to new drugs becoming available or changes in prices by drug manufacturers. As a result, certain prescription drugs may become more costly or unavailable to consumers during a plan year when they are unable to switch to a different health insurance plan.

The bill prohibits any pharmacy benefit manager (PBM) and any individual or group health insurance policy or HMO contract from limiting or excluding coverage for a drug for an insured with a complex or chronic medical condition or a rare disease if:

- The drug was previously approved for coverage by the insurer for a medical condition or disease; and
- The prescribing provider continues to prescribe the drug for the medical condition or disease; and the drug is appropriately prescribed and considered safe and effective for treating the insured's medical condition.

For any drug used to treat a complex or chronic medical condition or a rare disease that has been previously approved for coverage, the bill prohibits a health insurer, HMO or PBM from engaging any of the following activities, except during open enrollment periods:

- Placing limitations on the maximum coverage of prescription drug benefits;

- Increasing the out-of-pocket costs paid by the insured for the drug; and
- Moving the drug to a disadvantaged tier.

The Division of State Group Insurance indicates that the bill will have an indeterminate negative fiscal impact.

II. Present Situation:

Regulation of Insurers and Health Maintenance Organizations in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[1] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[2] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[3] The OIR does not regulate or license pharmacy benefit managers.

Florida' State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with section 125, Internal Revenue Code. To administer the state group health insurance program, the DMS contracts with third party administrators for self-insured health plans, insured HMOs, and a PBM for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

The state employees' self-insured prescription drug program has three cost-share categories for members: generic drugs, preferred brand name drugs (those brand name drugs on the preferred drug list), and non-preferred brand name drugs (those brand name drugs not on the preferred drug list). Contractually the PBM for the state employees' self-insured prescription drug program updates the preferred drug list quarterly as brand drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.

Generic drugs are the least expensive and have the lowest member cost share, preferred brand name drugs have the middle cost share, and non-preferred brand name drugs are the most expensive and have the highest member cost share. Generally, prescriptions written for a brand name drug, preferred or non-preferred, will be substituted with a generic drug when available. If the prescribing provider states on the prescription that the brand name drug is "medically necessary" over the generic equivalent, the member will pay only the brand name (preferred or non-preferred) cost share. If the member requests the brand name drug over the generic equivalent then the member will pay the brand name (preferred or non-preferred) cost share plus the difference between the cost of the generic drug and the brand name drug.

[1] Section 20.121(3)(a)1., F.S.
[2] Section 641.21(1), F.S.
[3] Section 641.495, F.S.

The program has no formulary management or other prescription drug management protocols, covers all federal legend drugs (open formulary) for covered medical conditions, and employs very limited utilization review and clinical review for traditional or specialty prescription drugs. Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions such as cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling (e.g., refrigeration during shipping) and administration (such as injection or infusion).

The federal out-of-pocket limit applies to members of the state group self-insured health plans and insured HMOs, all of which include prescription drug coverage. Copayments (and coinsurance for high deductible plans) for each drug tier are the same for all members, without preference to health status, as follows:

Drug Tier	Retail – Up to 30-Day Supply	Retail and Mail – Up to 90-Day Supply and Specialty Medications
Generic	$7	$14
Preferred Brand	$30	$60
Non-Preferred Brand	$50	$100

The program typically makes benefits changes on a plan year basis, which is January 1 through December 31.

Federal Patient Protection and Affordable Care Act

Health Insurance Reforms

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[4] The PPACA provides fundamental changes to the U.S. health care system by requiring health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required essential health benefits, rating and underwriting standards, review of rate increases, and internal and external appeals of adverse benefit determinations.[5] Section 1302 of the PPACA requires health plans that are required to provide coverage of essential health benefits (EHB), meet cost-sharing limits, and actuarial value requirements. The law directs that EHBs cover at least 10 specified categories, which includes prescription drugs.[6]

[4] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. Pub. Law No. 111-148.
[5] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg *et seq*.).
[6] See https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited Feb. 4, 2016) for Florida's benchmark plan.

Prescription Drug Coverage

Currently, for purposes of a health plan complying with the essential health benefits, insurers and HMOs must include in their formulary drug list the greater of one drug for each U.S. Pharmacopeia (USP) category and class; or the same number of drugs in each USP category and class as the state's essential health benefit (EHB) benchmark plan. For plan years beginning on or after January 1, 2017, plans must also use a Pharmacy and Therapeutics Committee (P&T) process that meets certain requirements. The P&T committee must design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines.[7]

Formulary Drug List

The regulations require a health plan must publish an up-to-date and complete list of all covered drugs on its formulary drug list, including any tiered structure and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the marketplace, HHS, and the public. Additionally, insurers and HMOs must also make this information available in a standard-readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.

Drug Exceptions Process

Under current HHS regulations, plans providing EHBs must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not included on the plan's formulary drug list. Such procedures must include a process to request an expedited review based on exigent circumstances. Under this expedited process, the issuer must make its coverage determination no later than 24 hours after it receives the request. This requirement, commonly referred to as the "exceptions process," applies to drugs that are not included on the plan's formulary drug list. For plan years beginning in 2016, these processes must also include certain processes and timeframes for the standard review process, and have an external review process if the internal review request is denied. The costs of the non-formulary drug provided through the exceptions process count towards the annual limitation on cost sharing and actuarial value of the plan.[8]

Proposed HHS Notice of Benefit and Payment Parameters for 2017

According to the OIR, the tentative CMS deadline for insurers and HMOs for the submission of 2017 rates and forms to CMS and the OIR is May 11, 2016.[9]

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[7] 45 CFR s. 156.122.

[8] 45 C.F.R. s. 156.122(c). The drug exception process is distinct from the coverage appeals process, which applies if an enrollee receives an adverse benefit determination for a drug that is included on the plan's formulary drug list. The coverage appeals process has separate requirements for its external review process and allows for a secondary level of internal review before the final internal review determination for group plans. [45 C.F.R. s. 147.136]

[9] Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS), *Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces* (December 23, 2015), p. 9, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-Letter-to-Issuers-12-23-2015_508.pdf (last visited Feb.4, 2016).

Prescription Drug Cost Containment

Private-sector entities that offer prescription drug insurance coverage, such as employers, labor unions, and managed care companies, often hire pharmacy benefit managers (PBMs) to manage these insurance benefits. The PBMs engage in many activities to manage their clients' prescription drug insurance coverage. The PBMs assemble networks of retail pharmacies so that a plan sponsor's members can fill prescriptions easily and in multiple locations by just paying a copayment amount. The PBMs consult with plan sponsors to decide which drugs a plan sponsor will provide insurance coverage to treat each medical condition. The PBM manages this list of preferred drug products (formulary) for each of its plan sponsor clients. Consumers with insurance coverage are provided incentives, such as low copayments, to use formulary drugs.

Due to increasing health care expenditures, economic and financial uncertainties, as well as the development of new, more expensive technologies, insurers continue to look for cost containment methods. Further, greater payer demand for expenditure reductions will increase the pressure for therapeutic substitution in responding patients. However, research notes that the biologic therapy medications of some patients are being switched for nonclinical reasons, despite the lack of data to support this practice and an abundance of data demonstrating clinically meaningful differences among biologics.[10]

Non-Medical Switching of Prescription Drugs

Non-medical switching of prescription drugs occurs when there may be multiple options available within a treatment class and a less expensive or patient-preferred medicine is substituted, often for cost containment reasons. Non-medical switching may be as simple as the substitution of a brand name drug for its generic equivalent. A generic drug are copies of brand-name drugs and are the same in dosage form, safety, strength, route of administration, performance characteristics, and intended use.[11] Generic drugs must pass the same safety standards as a brand-name drug.

The second method of substitution involved products that have been deemed to have therapeutic equivalence with an originally prescribed medicine or therapy. These drugs will have a different chemical composition and use a different active ingredient than the originally prescribed drug.[12]

One study reviewing the reason for adjusting anti-tumor necrosis (TNF) agents involving patients primarily with rheumatoid arthritis, psoriasis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, or ulcerative colitis found that non-medical switching of anti-TNF agents was associated with an increase in side effects and lack of efficacy that also led to an increase in health care utilization.[13]

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[10] http://www.medscape.com/viewarticle/768031_5 (last visited Jan. 29, 2016).
[11] Federal Food and Drug Administration, *Understanding Generic Drugs* (last updated February 5, 2016) *available at* http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/default.htm (last visited Feb. 4, 2016).
[12] Rachel Chu, et al, *Patient Safety and Comfort - The Challenges of Switching Medicines* (2010) *available at* http://www.patients-rights.org/uploadimages/Patient_Safety_and_Comfort_The_Challenges_of_Switching.pdf (last visited Feb. 4, 2016).
[13] D.T. Rubin, et al, *Analysis of outcomes after non-medical switching of anti-tumor necrosis factor agents,* European Crohn's and Colitis Organisation (2015) *available at* https://www.ecco-ibd.eu/index.php/publications/congress-abstract-

Patients with rheumatic or immune disease who were identified as having switched anti-TNF agents for cost-influenced reasons showed a 62 percent increased likelihood of the need for additional treatment related to side effects of their new drug compared to 20 percent for patients who remained on the previous treatment.[14] For patients that were switched, there was a difference in the mean number of visits of 13 compared to 5.8 visits in the group that remained on stable treatment for the first 90 days.[15]

In 2007, a small national survey of nursing home administrators was conducted about the Medicare Part D prescription drug benefit and policies related to the potential clinical and cost implications of managing a pharmacy benefit for the long-term care population. More than 76 percent of the respondents said it was common for a resident's new drug to be less effective after a switch for formulary reasons.[16] Additionally, in 37 percent of switching situations, the side effects from the new drug created the need for a completely new medication to treat the side effect.[17] Nonmedical switches also increased administrative time and raised the overall risk of more costly outcomes.[18]

III. Effect of Proposed Changes:

Sections 1 and 2 create s. 627.42392 and subsection (44) of s. 641.31, F.S., and **Section 3** amends s. 627.6699, F.S.

The bill defines the term, "complex or chronic medical condition," as a physical, behavioral or development condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated. The term, "rare disease," is defined to have the same meaning as provided in 42 U.S.C. s. 287a-1, a disease or condition that affects less than 200,000 persons in the United States.

The bill prohibits any pharmacy benefit manager (PBM) and any individual or group health insurance policy or HMO contract providing major medical coverage from limiting or excluding coverage for a drug for an insured with a complex or chronic medical condition or a rare disease if:

- The drug was previously approved for coverage by the insurer for a medical condition or disease of the insured,

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s/abstracts-2015/item/p354-analysis-of-outcomes-after-non-medical-switching-of-anti-tumor-necrosis-factor-agents.html?category_id=430 (last visited Feb. 4, 2016).

[14] Gibofsky A, et al., *Non-medical switch of anti-TNF agents may result in increased side effects, lack of efficacy,*(Paper #SAT0139), Presented at: European League Against Rheumatism Annual European Congress of Rheumatology; June 10-13, 2015; Rome), http://www.healio.com/rheumatology/psoriatic-arthritis/news/online/%7B4d3c5bb3-c81b-4f16-bf9c-6614e281f1d6%7D/non-medical-switch-of-anti-tnf-agents-may-result-in-increased-side-effects-lack-of-efficacy (last visited Feb. 4, 2016).

[15] Id.

[16] Bryan R. Cote, M.A., et al, *Impact of Therapeutic Switching in Long Term Care,* American Journal of Managed Care, (November 15, 2008) http://www.ajmc.com/journals/issue/2008/2008-11-vol14-n11sp/nov08-3703psp23-sp28/ (last visited Feb. 4, 2016).

[17] Id.

[18] Id.

- The prescribing provider continues to prescribe the drug for the medical condition or disease, and
- The drug is appropriately prescribed and considered safe and effective for treatment of the insured's medical condition or rare disease.

In addition, for any drug prescribed to an insured with a complex or chronic medical condition or a rare disease, the bill prohibits a health insurer, HMO or PBM from engaging any of the following actions, except during open enrollment periods:

- Placing limitations on the maximum coverage of prescription drug benefits,
- Increasing the out-of-pocket costs paid by the insured for the drug, and
- Moving the drug to a disadvantaged tier.

These provisions would not apply to a grandfathered health plan or to excepted benefits.

Section 4 of the bill is effective January 1, 2018.

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:

CS/SB 1142 allows insured individuals living with complex, chronic medical condition or rare diseases to continue to receive their brand drugs at a preferred cost for the calendar year. According to advocates of the bill, the bill will allow an insured individual who has been previously approved for a specific medication that is effective for stabilizing the patient to continue using the medication as long as he or she remains covered by the health plan.

C. Government Sector Impact:

Division of State Group Insurance

The bill will have an indeterminate negative fiscal impact.[19] The DMS indicates that the bill would allow an insured individual living with a complex or chronic medical condition or rare disease to continue to receive all their brand drugs at a "preferred" cost share throughout a calendar year, even when the PBM negotiates better pricing and rebates for interchangeable clinically appropriate brand drugs.

VI. Technical Deficiencies:

The provisions of the bill amend the Insurance Code and apply to insurers, HMOs, and pharmacy benefit managers. However, pharmacy benefit managers are not regulated under the Insurance Code.

The definition of the term, "complex or chronic conditions" may be difficult to interpret and implement. It is unclear which specific conditions would meet the definition.

VII. Related Issues:

According to the Office of Insurance Regulation, this bill partially addresses a consumer issue where an individual selects a plan based on the plan providing certain prescription drug benefits and the plan then changes its prescription drug benefits during the plan year. Under these types of situations, a consumer may face unexpectedly higher costs with an inability to switch to a different health insurance plan until the next open enrollment period. While an individual with a complex or chronic medical condition or rare disease may be more likely than the average person to select a health insurance plan based on the particular drug benefits of the plan, this issue is not limited to those with a complex or chronic medical condition or rare disease. As a result, the bill may be considered discriminatory as it seeks only to protect those with a complex or chronic medical condition or rare disease rather than all medical conditions.[20]

Pursuant to federal regulations, a group health plan is not required to provide coverage for any particular benefits to any group of similarly situated individuals. However, benefits provided under a plan must be uniformly available to all similarly situated individuals. Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances).[21]

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[19] Department of Management Services, *2016 Agency Legislative Bill Analysis* (Jan. 4, 2016) (on file with Senate Committee on Banking and Insurance).

[20] Office of Insurance Regulation, *2016 Agency Legislative Bill Analysis* (Dec. 29, 2015) (on file with Senate Committee on Banking and Insurance).

[21] 45 C.F.R. s. 146.121. For example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 641.31 and 627.6699.

This bill creates section 627.42392 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 Banking and Insurance on February 1, 2016:
The CS provides technical, conforming changes and revises the effective date of the bill from January 1, 2017, to January 1, 2018.

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 the Committee on Banking and Insurance; and Senator Hays

597-02875-16 20161142c1

A bill to be entitled

An act relating to treatments for stable patients; creating s. 627.42392, F.S.; defining terms; requiring a pharmacy benefits manager or a specified individual or group insurance policy to continue to cover a drug for specified insureds under certain circumstances; prohibiting certain actions by a pharmacy benefits manager or an individual or group policy with respect to a drug for a certain insured except under certain circumstances; providing applicability; amending s. 627.6699, F.S.; expanding a list of conditions that certain health benefit plans must comply with; amending s. 641.31, F.S.; defining terms; requiring a pharmacy benefits manager or a specified health maintenance contract to continue to cover a drug for specified subscribers under certain circumstances; prohibiting certain actions by a pharmacy benefits manager or a health maintenance contract with respect to a drug for a certain subscriber except under certain circumstances; providing applicability; providing an effective date.

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

Section 1. Section 627.42392, Florida Statutes, is created to read:

627.42392 Continuity of care for medically stable patients.—

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

(a) "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal

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

597-02875-16 20161142c1

if left untreated or undertreated.

(b) "Rare disease" has the same meaning as in the Public Health Service Act, 42 U.S.C. s. 287a-1.

(2) A pharmacy benefits manager or an individual or group insurance policy that is delivered, issued for delivery, renewed, amended, or continued in this state and that provides medical, major medical, or similar comprehensive coverage must continue to cover a drug for an insured with a complex or chronic medical condition or a rare disease if:

(a) The drug was previously covered by the insurer for a medical condition or disease of the insured; and

(b) The prescribing provider continues to prescribe the drug for the medical condition or disease, provided that the drug is appropriately prescribed and neither of the following has occurred:

1. The United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

2. The manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by s. 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. s. 356c.

(3) With respect to a drug for an insured with a complex or chronic medical condition or a rare disease which meets the conditions of paragraphs (2)(a) and (2)(b), except during open enrollment periods, a pharmacy benefits manager or an individual or group insurance policy may not:

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

(a) Set forth, by contract, limitations on maximum coverage of prescription drug benefits;

(b) Subject the insured to increased out-of-pocket costs; or

(c) Move a drug for an insured to a more restrictive tier, if an individual or group insurance policy or a pharmacy benefits manager uses a formulary with tiers.

(4) This section does not apply to a grandfathered health plan as defined in s. 627.402, or to benefits set forth in s. 627.6561(5)(b), (c), (d), and (e).

Section 2. Paragraph (e) of subsection (5) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(e) All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or

issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer.

4. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late

enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

8. A small employer carrier must provide continuity of care for medically stable patients as required by s. 627.42392.

Section 3. Subsection (44) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(44)(a) As used in this subsection, the term:

1. "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

2. "Rare disease" has the same meaning as in the Public Health Service Act, 42 U.S.C. s. 287a-1.

(b) A pharmacy benefits manager or a health maintenance contract that is delivered, issued for delivery, renewed, amended, or continued in this state and that provides medical, major medical, or similar comprehensive coverage must continue to cover a drug for a subscriber with a complex or chronic

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

medical condition or a rare disease if:

1. The drug was previously covered by the health maintenance organization for a medical condition or disease of the subscriber; and

2. The prescribing provider continues to prescribe the drug for the medical condition or disease, provided that the drug is appropriately prescribed and neither of the following has occurred:

a. The United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

b. The manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by s. 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. s. 356c.

(c) With respect to a drug for a subscriber with a complex or chronic medical condition or a rare disease which meets the conditions of subparagraphs (b)1. and (b)2., except during open enrollment periods, a pharmacy benefits manager or a health maintenance contract may not:

1. Set forth, by contract, limitations on maximum coverage of prescription drug benefits;

2. Subject the subscriber to increased out-of-pocket costs; or

3. Move a drug for a subscriber to a more restrictive tier, if a health maintenance contract or a pharmacy benefits manager uses a formulary with tiers.

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

(d) This section does not apply to a grandfathered health plan as defined in s. 627.402.

Section 4. This act shall take effect January 1, 2018.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR ALAN HAYS
11th District

COMMITTEES:
Appropriations Subcommittee on General Government, *Chair*
Governmental Oversight and Accountability, *Vice Chair*
Appropriations
Environmental Preservation and Conservation
Ethics and Elections
Fiscal Policy

JOINT COMMITTEE:
Joint Select Committee on Collective Bargaining, *Alternating Chair*

MEMORANDUM

To: Senator Aaron Bean, Chair
Committee on Health Policy
CC: Sandra Stovall, Staff Director
Celia Georgiades, Committee Administrative Assistant

From: Senator D. Alan Hays

Subject: Request to agenda SB 1142- Treatment for Stable Patients

Date: February 1, 2016

The above referenced bill passed through Banking and Insurance this morning. In the interest of keeping the bill moving forward, I am asking that you please consider adding it to your next agenda "if received." If you have any questions regarding this legislation, I welcome the opportunity to meet with you one-on-one to discuss it in further detail. Thank you so much for your consideration of this request.

Sincerely,

D. Alan Hays, DMD
State Senator, District 11

REPLY TO:
- 871 South Central Avenue, Umatilla, Florida 32784-9290 (352) 742-6441
- 320 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5011
- 1104 Main Street, The Villages, Florida 32159 (352) 360-6739 FAX: (352) 360-6748
- 685 West Montrose Street, Suite 210, Clermont, Florida 34711 (352) 241-9344 FAX: (888) 263-3677

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on General Government, *Chair*
Governmental Oversight and Accountability, *Vice Chair*
Appropriations
Environmental Preservation and Conservation
Ethics and Elections
Fiscal Policy

JOINT COMMITTEE:
Joint Select Committee on Collective Bargaining, *Alternating Chair*

SENATOR ALAN HAYS
11th District

February 5, 2016

Senator Aaron Bean, Chairman
Health Policy Committee
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

RE: SB 1142- Treatment of Stable Patients

Dear Chairman Bean,

Please allow my assistant, Ms. Amy Nicotra to present the above referenced bill in your committee on Tuesday 2/9/16. I have two bills up in two other committees and I do not believe I will be able to arrive in time to present to your committee too.

Thank you for your favorable consideration of this request.

Sincerely,

D. Alan Hays, DMD
State Senator District 11

CC: Sandra Stovall, Staff Director
Celia Georgiades, Administrative Assistant

REPLY TO:
❒ 871 South Central Avenue, Umatilla, Florida 32784-9290 (352) 742-6441
❒ 320 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5011
❒ 1104 Main Street, The Villages, Florida 32159 (352) 360-6739 FAX: (352) 360-6748
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Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1142
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 1000 Riverside Ave
Street

Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians
Florida Gastroenterologic Society

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

412-K
10:00AM

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-9-2016
Meeting Date

SB 1142
Bill Number (if applicable)

Topic TREATMENTS FOR STABLE PATIENTS

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLUESTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

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

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

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1142
Bill Number (if applicable)

Topic Treatments of Stable Patients

Amendment Barcode (if applicable)

Name FELY CURVA, Ph.D.

Job Title Partner, Curva Associates LLC

Address 1212 Piedmont Dr.
Street

Phone (850) 508-2256

Tallahassee FL 32312
City *State* *Zip*

Email curva@mindspring.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Budd Bell Clearinghouse on Human Services

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2-9-16
Meeting Date

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

SB 1142
Bill Number (if applicable)

Topic Treatments for Stable Patients

Amendment Barcode (if applicable)

Name Michael Ruppal

Job Title Executive Director, The AIDS Institute.

Address 17 Davis Blvd Suite 403
Street

Tampa FL 33606
City *State* *Zip*

Phone 813-258-5929

Email mruppal@theaidsinstitute.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing The AIDS Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Feb. 9, 15 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 1142

Meeting Date *Bill Number (if applicable)*

Topic Patient Stability Act *Amendment Barcode (if applicable)*

Name Toni Large

Job Title

Address 519 E. Park Ave Phone (850) 556-1461

Street

Tallahassee, FL 32301 Email toni@sulaw.net

City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information Waive Speaking: ☒ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Florida Society of Rheumatology

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

SB 1142
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name ~~Jeff~~ RALPH NOBO M.D.

Job Title PRESIDENT of FMA

Address 222 W MAIN ST
Street

Phone 850 224-6496

BARTOW FL 33830
City *State* *Zip*

Email rnobo@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1142
Bill Number (if applicable)

Topic Stable Patients

Amendment Barcode (if applicable)

Name Doug Bell

Job Title

Address 101 N. Monroe St
Street

Tall
City *State* *Zip*

Phone 681-3291

Email douglas.bell@bipc.com

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

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

Representing Florida Chapter American Academy of Pediatrics

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-9-16
Meeting Date

1142
Bill Number (if applicable)

Topic ~~AI~~ Treatments for Stable Patients

Amendment Barcode (if applicable)

Name Marnie George

Job Title Sr. Advisor - Buchanan Ingersoll & Rooney

Address 110 N. Monroe St. Suite 1090
Street

Phone 850-510-8866

Tallahassee FL 32303
City *State* *Zip*

Email marnie.george@bipc.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL. Chapter, Am. College of Cardiology

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1240
INTRODUCER:	Health Policy Committee and Senator Sobel
SUBJECT:	Children's Medical Services Eligibility and Enrollment
DATE:	February 11, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1240 revises the definitions of "children with special health care needs" and "clinical eligibility" for the Children's Medical Services (CMS) program. The bill revises the eligibility criteria to children who have a chronic condition rather than the condition being chronic and serious.

The bill directs the Department of Health (DOH) to determine clinical eligibility through an assessment tool or review of documentation provided by a health care practitioner. The CMS program is required to provide ch. 120, F.S., appeal notices to the parents or guardian of children who are found ineligible for the program and of their right to request another clinical eligibility determination. The DOH is authorized to adopt rules to implement the provisions of this bill and until such rules are adopted, the DOH shall continue to determine clinical eligibility under its existing rule.

The Children's Medical Services Managed Care Plan (plan) is exempted from the regional specialty plan enrollment limits under the Medicaid Managed Care Assistance (MMA) program.

The DOH estimates an annual fiscal impact of over $22.9 million.

The bill provides an effective date of upon becoming law.

II. Present Situation:

Children's Medical Services

Children's Medical Services is a group of programs that serves children with special health care needs under the supervision of the DOH. Within CMS, individual services or programs are designed to address specific conditions or family needs such as the newborn screening program, early intervention screenings, or its managed medical assistance plan. CMS is created under ch. 391, F.S., which is divided into three parts: Part I (General Provisions), Part II (Children's Medical Services Councils and Panels), and Part III (Developmental Evaluation and Intervention Programs).

Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services. The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Over 3.7 million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over $23.4 billion.[1]

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) Program as part IV of ch. 409, F.S.[2] The SMMC has two components: the Long Term Care Managed Care (LTC) program and the Managed Medical Assistance (MMA) program. The SMMC is an integrated, comprehensive, managed care program for Medicaid enrollees that manages the delivery of primary and acute care in 11 regions.

Managed Medical Assistance Program (MMA)

For the MMA component, health care services were bid competitively using 11 regions. Thirteen non-specialty managed care plans contract with AHCA across the different regions.

Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans.

Specialty plans are also held to an enrollment cap in each region. The aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of that region.

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[1] Office of Economic and Demographic Research, *Social Services Estimating Conference* (August 4, 2015) *available at* http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Dec. 11, 2015).
[2] *See* Chapter Laws, 2011-134 and 2011-135.

Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services.

Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements, including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

Statewide implementation of SMMC started May 1, 2014, and was completed by August 1, 2014.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:
- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[3]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:
- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

The MMA program is authorized by a section 1115 demonstration waiver by the federal CMS. It was approved in 2005 and is currently operating as an expansion of the managed care pilot program and was renewed on July 31, 2014, for a second 3-year period through June 30, 2017.[4]

CMS MMA Plan

The CMS MMA plan serves children with special health care needs who meet both financial and clinical eligibility. The CMS plan determines clinical eligibility using an assessment instrument.

Children are referred to the CMS Plan in several ways:
- Medicaid counselors;
- Screening questions on the application; and
- Medical professionals.[5]

---

[3] Section 409.972, F.S.

[4] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014) *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf (last visited Feb. 8, 2016).

[5] OPPAGA Research Memorandum, *Children's Medical Services Screening Tool and Enrollment Trends* (March 4, 2015) (on file with the Senate Committee on Health Policy).

When a child is referred to CMS, a care coordinator contacts the family or caregiver by telephone to determine the child's clinical eligibility for CMS. Care coordinators use a computer based tool to enter the information in the CMS system.[6] Care coordinators re-screen children annually or more often, as determined by a primary care physician.[7]

In 2012, the Legislature amended ch. 391, F.S., to include "serious" in the definition of a child with special health care needs.[8] The DOH implemented a new assessment tool to comply with the change in statutory definition that a child's condition needed to be both serious and chronic to be eligible for the CMS specialty plan.[9] The most recent version of the assessment instrument incorporated questions from the Child and Adolescent Health Measurement Initiative's (CAHMI).

The CAHMI Screener is a national based screener based out of The Bloomberg School of Public Health at Johns Hopkins University in Baltimore, Maryland. The model stresses family and consumer empowerment and involvement.[10] The screener is used to identify children and teens with special health care needs through a survey model that is completed by parents and/or teens and assesses preventive and developmental services including:

- Standardized developmental and behavioral screening;
- Avoidable hospitalizations;
- Whether a child has a medical home, including measures specific to children with special health care needs;
- Whether care is culturally competent; and
- Other topic areas.[11]

The most common CMS diagnoses were asthma, attention deficit disorder, and congenital anomalies for 2009-2010 through 2013-2014 fiscal years.[12] The CMS specialty plan also covers a range of conditions from birth such as heart defects and permanent disabilities.[13]

Title XXI Program

The Florida Kidcare Program (Kidcare) was created in 1998 by the Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the FPL and meet other eligibility criteria. The state statutory authority for Kidcare is found under part II of ch. 409, F.S.,

[6] Id.
[7] Id.
[8] Chapter 2012-184, s. 75, Laws of Fla.
[9] Florida Dep't of Health, *Senate Bill 1240 Analysis*, p. 2 (January 4, 2016) (on file with the Senate Committee on Health Policy).
[10] The Child and Adolescent Health Measurement Initiative, *Who We Are* http://www.cahmi.org/about-us/ (last visited Feb. 8, 2016).
[11] OPPAGA Research Memorandum, *Children's Medical Services Screening Tool and Enrollment Trends* (March 4, 2015) (on file with the Senate Committee on Health Policy).
[12] OPPAGA Research Memorandum, *Children's Medical Services Screening Tool and Enrollment Trends,* p. 6 (March 4, 2015) (on file with Senate Committee on Health Policy).
[13] Id.

specifically in ss. 409.810 through 409.821, F.S. Children with special health care needs may also enroll in the CMS plan who are Title XXI eligible.

The CHIP-funded components of Florida Kidcare serve distinct populations:

- Medicaid for Children: Children from birth until age 1 for family incomes between 185 percent and 200 percent of the FPL.
- Medikids: Children from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL. Those enrollees above 200 percent FPL may enroll at a non-subsidized rate established by the AHCA.
- Healthy Kids: Children from age 5 through age 18 for family incomes between 133 and 200 percent of the FPL. Those above 200 percent FPL may enroll at a non-subsidized rate established by the FHKC.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs.

Kidcare is funded by Medicaid funds under Title XIX of the Social Security Act, state funds from General Revenue and the Tobacco Settlement Trust Fund, and family contributions.[14] The CHIP has an enhanced federal matching rate that is more favorable than Medicaid. For the period of October 2014 through June 2015, the federal match rate is 71.80 percent.[15]

Title XXI is a non-entitlement program, so families contribute monthly premiums. Family contributions are based on family size, household income, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in Kidcare at a non-subsidized rate (full-pay) in Healthy Kids or the Medikids program components. The non-subsidized rates are established by the individual program and are based on the actual costs of the program, both premiums and an administrative fee. The income limit for premium assistance is 200 percent of the FPL.

Total enrollment for the CMS plan, both Medicaid and CHIP for January 2016 is provided below:

Children's Medical Services Plan Enrollment[16,17]			
	Title XIX Medicaid MMA	**Title XXI CHIP**	**Total**
January 2016	53,592	9,504	63,096

[14] Florida Kidcare Coordinating Council, *2014 Annual Report and Recommendations*, p. 14, *available at* http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last reviewed Feb. 8, 2016).
[15] Office of Economic and Demographic Research, *Expenditure Social Services Estimating Conference - Florida Kidcare Program Final Report* (February 12, 2015) *available at* http://edr.state.fl.us/Content/conferences/kidcare/kidcaredetail.pdf (last viewed Feb. 8, 2016).
[16] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report* (January 2016) *available at* http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 8, 2016).
[17] Florida Healthy Kids Corporation, *Enrollment January 2016* https://www.healthykids.org/resources/enrollment/ (last visited Feb. 8, 2016).

Revised Screening Tool

The CMS plan implemented the revised screening tool with new enrollees and began the re-evaluation of existing enrollees in May 2015.[18] The CMS plan enrollees who were found no longer clinically eligible, but still financially eligible for an MMA plan were transitioned to another MMA plan. The child's new MMA plan was required to honor any ongoing treatment that was authorized or scheduled prior to the child's enrollment into the new health plan for up to 60 days after the child enrolled in the plan.[19]

In June 2015, an administrative petition was filed against the DOH seeking a ruling that the CMS Network Clinical Eligibility Screening Guide was an unadopted rule whose existence violated s. 120.54(1)(a), F.S.[20] On September 22, the administrative law judge agreed and found the Screening Guide constituted an unadopted rule because it had not been adopted through a formal rulemaking process and ordered the DOH to immediately cease using the screening tool as a method of determining eligibility.[21]

The DOH subsequently began the formal rulemaking process and noticed its first proposed rule and rule workshops for October 16, 2015. An interim, time-limited eligibility process was also developed between the DOH and the AHCA to allow for enrollment to continue into the CMS plan during rule development.[22] The interim process permitted a child's physician to attest to the child's diagnosis as meeting one of the qualifying diagnoses as serious and chronic for enrollment.[23] Serious and chronic under the SMMC contract is defined as one or a combination of some the following conditions:

- Acute or chronic lymphoid leukemia;
- Acute or chronic myeloid leukemia;
- Congenital or acquired quadriplegia;
- Congenital diplegia or hemiplegia;
- Spina bifida;
- Malignant neoplasm of the esophagus, stomach, small intestine, pancreas, ovary, kidney, brain, unspecified part of the nervous system, or lung; or
- HIV.[24]

After several workshops, rulemaking concluded in December and the final rule went into effect January 11, 2016.[25] The final rule creates two pathways to CMS clinical eligibility. A child's clinical eligibility may be established through completion of the CMS Clinical Eligibility Screening Form with an authorized representative of the DOH. A child with a diagnosis of one or more health conditions listed on the CMS Eligibility Attestation form may also be determined

[18] E-Mail correspondence from Bryan Wendel, Department of Health (July 17, 2015) (on file with the Senate Committee on Health Policy).
[19] Id.
[20] A.R., et al v. Dept. of Health, Case No. 15-3737RU (Fla. DOAH 2015).
[21] *See* Final Order, A.R., et al v. Dept. of Health, Case No. 15-3737RU (Fla. DOAH 2015).
[22] Agency for Health Care Administration, *Florida Medicaid - Interim Process to Qualify Children for Enrollment in the Children's Medical Services Plan* (November 2015) (on file with the Senate Committee on Health Policy).
[23] Id.
[24] Id.
[25] Rule 64C-2.002, F.A.C. (2016).

clinically eligibility for the plan through attestation by a physician.[26] The physician-determined automatic eligibility conditions are specific and inclusive to over 2,418 diagnoses.[27] Both the screening tool and the attestation form are adopted by reference in the administrative rule.

Specialty Plan Enrollment Cap

The CMS plan's enrollment is counted as part of the 10 percent enrollment cap placed on aggregate specialty plan enrollment. The chart provided below shows the breakdown of specialty plan enrollment compared to MMA enrollment for January 2016.[28]

Specialty Plan Enrollment						
Region	**MMA Enrollment**	**10% of MMA Enrollment**	**Other Specialty Plans**	**CMS Specialty Plan**	**Child Welfare Plan**	**Total Specialty Plan Enrollment**
1	102,355	10,235	216	1,368	1,054	2,638
2	112,592	11,259	2,555	3,983	1,004	7,542
3	259,389	25,940	530	5,486	3,245	9,261
4	307,647	30,765	6,558	4,489	4,059	15,106
5	182,994	18,299	4,753	3,662	2,066	10,481
6	419,797	42,980	7,875	7,209	4,206	29,771
7	409,097	40,910	8,717	7,034	3,334	19,085
8	210,760	21,076	448	3,246	1,827	5,518
9	272,695	27,270	5,452	4,939	2,592	12,983
10	267,695	26,770	5,309	6,406	3,006	14,721
11	548,272	54,827	10,700	5,770	2,750	19,220

III. Effect of Proposed Changes:

Section 1 amends s. 391.021, F.S., to revise the definition of children with special health care needs to allow the physical, developmental, behavioral, or emotional condition to be chronic, rather than both chronic and serious. A definition for *clinical eligibility* is added to mean the process used to determine if a child has a special health care need.

Section 2 amends s. 391.029, F.S., to remove repetitive language that is included in the definitions and is based on a child with special health care needs.

The DOH must determine a child's eligibility for the CMS program through either the use of an assessment instrument or the review of documentation provided by a health care practitioner provided to the DOH.

The DOH shall adopt rules to implement this section. Until such rules are adopted, the DOH shall continue to determine clinical eligibility in accordance with its existing Rule 64C-2.002 of the Florida Administrative Code.

[26] Id.
[27] *Supra* note 9, at 2.
[28] *Supra* note 16.

Section 3 amends s. 391.081, F.S., to require the DOH to notify the parent or guardian of a child who has been determined clinically ineligible for the program of the right to appeal such determination or to request another clinical eligibility redetermination on behalf of his or her child, in accordance with the requirements of ch. 120, F.S.

Section 4 amends 409.974, F.S., to exempt the CMS plan from the aggregate enrollment limits that are applicable to the MMA specialty plans.

Section 5 provides the bill is effective 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:

Changing the eligibility requirements for the CMS plan may increase the number of eligible children, leading to an increased enrollment. Children that may be enrolled in private sector plans who may not have been previously eligible for the CMS plan may seek enrollment in the plan as a result of this change.

C. Government Sector Impact:

Using the 2009-2010 National Survey of Children with Special Health Care Needs, the DOH reports that Florida has an estimated 606,215 children with special health care needs.[29] This translates to potentially an additional 303,107 children who would be eligible for the program and enrolled through either Medicaid or CHIP with the changes in CS/SB 1240.[30] Historically, the CMS Plan has served between 75,000 and 80,000

[29] *Supra* note 9, at 4.
[30] Id.

children when clinical eligibility for the plan was identical to that provided in CS/SB 1240.[31]

The CMS Plan enrollment for December 2015 was 63,614 and the DOH supported that enrollment level with 258 care coordinators.[32] In order to meet the potential increased enrollment, the DOH estimates a need for an additional 66 FTEs to provide care coordination services for the increased caseload. The estimated annual total cost for the additional FTEs would be $6,210,864[33].

In addition to the care coordinators for the program, the DOH estimates that 169 new nurses would be needed to collect and complete the information needed to determine clinical eligibility on the additional screenings. The estimated annual cost for the additional nurses is $15,903,576.

Since the CMS plan pays fee for service rates and is not capitated, the service utilization expenditures of the expanded population are indeterminate.[34]

CS/SB 1240 applies ch. 120, F.S., appeal rights for all children determined clinically ineligible for the program. Historically according to the DOH, there have been 7,000 new referrals.[35] To handle the expected volume of appeals, the DOH requests two additional attorneys at an estimated annual cost of $182,784.

The program's technology and rules need to be updated to reflect the changes to the clinical eligibility process.

Department of Health Estimated Fiscal Impact - Annual		
Issue	**Cost Assumptions**	**Annualized Amount**
66 FTEs for Care Coordination	1 FTE for every 250 new enrollees @ $94,104	$ $6,210,864
169 FTEs for Eligibility Screenings	1 FTE for 2,000 screenings @$94,104	$15,903,576
2 FTEs for Appeals Hearings	2 FTEs @ $91,392	$182,784
		$22,297,224

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[31] Department of Health, *Senate Bill 1240 Analysis* (February 8, 2016) (on file with the Senate Committee on Health Policy).
[32] Id.
[33] Id.
[34] Supra note 9, at 4.
[35] Id.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 391.021, 391.029, 391.081, and 409.974.

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 9, 2016:
The committee substitute:

- Modifies the definition of children with special health needs to remove the requirement that a condition be serious as it is applies to the CMS program;
- Amends the definition of clinical eligibility to mean the process used to determine if a child has a special health care need;
- Provides that the DOH shall determine a child's clinical eligibility for the CMS program through the use of an assessment tool or through a review of documentation from a health care practitioner to the DOH;
- Authorizes the DOH to implement rules and to continue to determine clinical eligibility under the existing rule until updated rules can be adopted; and
- Requires the DOH to notify a parent or guardian of a child who has been denied eligibility of their rights to request another clinical eligibility determination.

B. Amendments:

None.

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

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/09/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (2) of section 391.021, Florida Statutes, is amended, present subsections (3) through (8) of that section are redesignated as subsections (4) through (9), respectively, and a new subsection (3) is added to that section, to read:

391.021 Definitions.—When used in this act, the term:

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(2) "Children with special health care needs" means those children younger than 21 years of age who have chronic ~~and serious~~ physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children.

(3) "Clinical eligibility" means the process used to determine if a child has a special health care need.

Section 2. Section 391.029, Florida Statutes, is amended to read:

391.029 Program eligibility.—

~~(1) Eligibility for the Children's Medical Services program is based on the diagnosis of one or more chronic and serious medical conditions and the family's need for specialized services.~~

(1)~~(2)~~ The following individuals are eligible to receive services through the Children's Medical Services program:

(a) A high-risk pregnant female who is enrolled in Medicaid.

(b) Children with ~~serious~~ special health care needs from birth to 21 years of age who are enrolled in Medicaid.

(c) Children with ~~serious~~ special health care needs from birth to 19 years of age who are enrolled in a program under Title XXI of the Social Security Act.

(2)~~(3)~~ Subject to the availability of funds, the following individuals may receive services through the program:

(a) Children with ~~serious~~ special health care needs from birth to 21 years of age who do not qualify for Medicaid or Title XXI of the Social Security Act but who are unable to

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access, due to lack of providers or lack of financial resources, specialized services that are medically necessary or essential family support services. Families shall participate financially in the cost of care based on a sliding fee scale established by the department.

(b) Children with special health care needs from birth to 21 years of age, as provided in Title V of the Social Security Act.

(c) An infant who receives an award of compensation under s. 766.31(1). The Florida Birth-Related Neurological Injury Compensation Association shall reimburse the Children's Medical Services Network the state's share of funding, which must thereafter be used to obtain matching federal funds under Title XXI of the Social Security Act.

(3) ~~(4)~~ Any child who has been provided with surgical or medical care or treatment under this act prior to being adopted and has ~~serious and chronic~~ special health care needs shall continue to be eligible to be provided with such care or treatment after his or her adoption, regardless of the financial ability of the persons adopting the child.

(4) The department shall determine a child's clinical eligibility for the Children's Medical Services program. A child's clinical eligibility must be determined through the use of an assessment instrument or through the review of documentation provided by a health care practitioner to the department.

(5) The department shall adopt rules to implement this section. Until such rules are adopted, the department shall continue to determine clinical eligibility in accordance with

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rule 64C-2.002, Florida Administrative Code.

Section 3. Section 391.081, Florida Statutes, is amended to read:

391.081 Grievance reporting and resolution requirements.—The department shall adopt and implement a system to provide assistance to eligible individuals and health care providers to resolve complaints and grievances. To the greatest extent possible, the department shall use existing grievance reporting and resolution processes. The department shall ensure that the system developed for the Children's Medical Services program does not duplicate existing grievance reporting and resolution processes. The department must notify a parent or guardian of a child who has been determined clinically ineligible for the Children's Medical Services program of the parent's or guardian's option to request another clinical eligibility determination and of the right to appeal the determination on behalf of his or her child, in accordance with the requirements of chapter 120.

Section 4. Subsection (3) of section 409.974, Florida Statutes, is amended to read:

409.974 Eligible plans.—

(3) SPECIALTY PLANS.—Participation by specialty plans shall be subject to the procurement requirements of this section. The aggregate number of enrollees in ~~enrollment of~~ all specialty plans in a region, not including enrollees in the Children's Medical Services Network, may not exceed 10 percent of the total number of enrollees in ~~of~~ that region. Enrollment in the Children's Medical Services Network is not subject to the enrollment limit requirement of this subsection.

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Section 5. 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 everything before the enacting clause and insert:

A bill to be entitled

An act relating to Children's Medical Services eligibility and enrollment; amending s. 391.021, F.S.; revising the definition of the term "children with special health care needs"; defining the term "clinical eligibility"; amending s. 391.029, F.S.; revising eligibility requirements for the Children's Medical Services program; requiring the Department of Health to determine clinical eligibility for the Children's Medical Services program by the use of an assessment instrument or through the review of documentation provided by a health care practitioner; requiring the department to adopt rules; providing for the continued applicability of an existing rule until new rules are adopted; amending s. 391.081, F.S.; requiring the department to provide notice to a parent or guardian of a child who has been determined clinically ineligible for the Children's Medical Services program of the parent's or guardian's option to request another clinical eligibility determination and appeal rights under ch. 120, F.S.; amending s. 409.974, F.S.; providing an exemption from regional specialty plan enrollment limits for the Children's

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Medical Services Network; providing an effective date.

By Senator Sobel

33-01250-16 20161240__

A bill to be entitled

An act relating to Children's Medical Services eligibility and enrollment; amending s. 391.021, F.S.; revising the definition of the term "children with special health care needs"; defining the term "clinical eligibility"; amending s. 391.029, F.S.; revising eligibility requirements for the Children's Medical Services program; requiring the Department of Health to use an assessment instrument to determine clinical eligibility for the Children's Medical Services program; specifying minimum requirements for an assessment instrument; amending s. 391.081, F.S.; requiring the department to provide notice to a parent or guardian of a child who has been determined clinically ineligible for the Children's Medical Services program of the parent's or guardian's appeal rights under ch. 120, F.S.; amending s. 409.974, F.S.; providing an exemption from regional specialty plan enrollment limits for the Children's Medical Services Network; providing an effective date.

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

Section 1. Subsection (2) of section 391.021, Florida Statutes, is amended, present subsections (3) through (8) of that section are redesignated as subsections (4) through (9), respectively, and a new subsection (3) is added to that section, to read:

391.021 Definitions.—When used in this act, the term:

(2) "Children with special health care needs" means those children younger than 21 years of age who have a chronic or ~~and~~ serious physical, developmental, behavioral, or emotional

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

33-01250-16 20161240__

condition ~~conditions~~ and who require health care and related services of a type or amount beyond that which is generally required by children.

(3) "Clinical eligibility" means a determination based on an assessment instrument and a clinical evaluation that a child has special health care needs as defined in this chapter and is eligible to receive services through the Children's Medical Services program.

Section 2. Section 391.029, Florida Statutes, is amended to read:

391.029 Program eligibility.—

~~(1) Eligibility for the Children's Medical Services program is based on the diagnosis of one or more chronic and serious medical conditions and the family's need for specialized services.~~

(1)~~(2)~~ The following individuals are eligible to receive services through the Children's Medical Services program:

(a) A high-risk pregnant female who is enrolled in Medicaid.

(b) Children with ~~serious~~ special health care needs from birth to 21 years of age who are enrolled in Medicaid.

(c) Children with ~~serious~~ special health care needs from birth to 19 years of age who are enrolled in a program under Title XXI of the Social Security Act.

(2)~~(3)~~ Subject to the availability of funds, the following individuals may receive services through the program:

(a) Children with ~~serious~~ special health care needs from birth to 21 years of age who do not qualify for Medicaid or Title XXI of the Social Security Act but who are unable to

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

access, due to lack of providers or lack of financial resources, specialized services that are medically necessary or essential family support services. Families shall participate financially in the cost of care based on a sliding fee scale established by the department.

(b) Children with special health care needs from birth to 21 years of age, as provided in Title V of the Social Security Act.

(c) An infant who receives an award of compensation under s. 766.31(1). The Florida Birth-Related Neurological Injury Compensation Association shall reimburse the Children's Medical Services Network the state's share of funding, which must thereafter be used to obtain matching federal funds under Title XXI of the Social Security Act.

(3) ~~(4)~~ Any child who has been provided with surgical or medical care or treatment under this act prior to being adopted and has a chronic or serious ~~and chronic~~ special health care need ~~needs~~ shall continue to be eligible to be provided with such care or treatment after his or her adoption, regardless of the financial ability of the persons adopting the child.

(4) The department must use an assessment instrument to determine a child's clinical eligibility for the Children's Medical Services program. At a minimum, the instrument must identify chronic or serious physical, developmental, behavioral, or emotional conditions in the child which require health care and related services of a type or to an extent greater than that generally required by children or which, when used as part of a clinical evaluation of the child by a licensed health care professional, indicate the child meets the definition of a child

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

with special health care needs under s. 391.021.

Section 3. Section 391.081, Florida Statutes, is amended to read:

391.081 Grievance reporting and resolution requirements.—The department shall adopt and implement a system to provide assistance to eligible individuals and health care providers to resolve complaints and grievances. To the greatest extent possible, the department shall use existing grievance reporting and resolution processes. The department shall ensure that the system developed for the Children's Medical Services program does not duplicate existing grievance reporting and resolution processes. The department must notify a parent or guardian of a child who has been determined clinically ineligible for the Children's Medical Services program of the parent's or guardian's right to appeal such determination on behalf of his or her child, in accordance with the requirements of chapter 120.

Section 4. Subsection (3) of section 409.974, Florida Statutes, is amended to read:

409.974 Eligible plans.—

(3) SPECIALTY PLANS.—Participation by specialty plans shall be subject to the procurement requirements of this section. The aggregate number of enrollees in ~~enrollment of~~ all specialty plans in a region, not including enrollees in the Children's Medical Services Network, may not exceed 10 percent of the total number of enrollees in ~~of~~ that region. Enrollment in the Children's Medical Services Network is not subject to the enrollment limit requirement of this subsection.

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

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Health Policy, *Vice Chair*
Agriculture
Education Pre-K-12
Appropriations Subcommittee on Health and Human Services

SENATOR ELEANOR SOBEL
33rd District

January 15, 2016

Senator Aaron Bean, Chair
Committee on Health Policy
302 Senate Office Building
404 South Monroe Street
Tallahassee, Florida 32399

Dear Chair Bean,

This letter is to request that **SB 1240,** relating to **Children's Medical Services Eligibility and Enrollment**, be placed on the agenda of the next scheduled meeting of the Committee on Health Policy.

This bill will revise eligibility requirements for the Children's Medical Services program, require the Department of Health to use an assessment instrument to determine clinical eligibility for the Children's Medical Services program, and require the department to provide notice to a parent or guardian of a child who has been determined clinically ineligible for the Children's Medical Services program of the parent's or guardian's appeal rights under ch. 120, F.S., etc.

Thank you for your consideration of this request.

With Best Regards,

Eleanor Sobel
State Senator, 33rd District

REPLY TO:
❒ The "Old" Library, First Floor, 2600 Hollywood Blvd., Hollywood, Florida 33020 (954) 924-3693 FAX: (954) 924-3695
❒ 410 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1240
Bill Number (if applicable)

Topic CMS

Amendment Barcode (if applicable)

Name Karen Woodall

Job Title Director

Address 579 E. Call St.
Street

Phone 850-321-9386

Tallahassee, FL 32301
City *State* *Zip*

Email fcfep@yahoo.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Center for Fiscal & Economic Policy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

SB 1240
Bill Number (if applicable)

Topic CMS

Amendment Barcode (if applicable)

Name Abbie Woodard

Job Title parent / Speech-Language Pathologist

Address 833 Sir Richard Rd
Street

Phone 850-576-8029

Tallahassee FL 32310
City *State* *Zip*

Email Abbie.woodard@yahoo.com

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

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

Representing self

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

SB 1240
Bill Number (if applicable)

Topic CMS

Amendment Barcode (if applicable)

Name Casey Stoutamire

Job Title Lobbyist

Address 118 E Jefferson St.
Street

Phone 850-224-1089

Tallahassee FL 32301
City *State* *Zip*

Email cstoutamire@floridadental.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1240
Bill Number (if applicable)

Topic CMS

Amendment Barcode (if applicable)

Name Ron Watson

Job Title Lobbyist

Address 3738 Mundon Way
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850 567-1202

Email watson.strategies@comcast.net

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida CHAIN

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

02/09/2016
Meeting Date

S-1240
Bill Number (if applicable)

N/A
Amendment Barcode (if applicable)

Topic Children's Medical Services

Name Phyllis J. Sloyer

Job Title Health Care Consultant

Address 258 Seawolf Ct
Street

Tallahassee FL 32312
City *State* *Zip*

Phone 850.766.5714

Email seawolfct@aol.com

Speaking: ☑ For ☐ Against ☑ Information

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

Representing Self

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

SB 1240
Bill Number (if applicable)

Topic Children's Medical Services

Amendment Barcode (if applicable)

Name Amy Liem

Job Title

Address 2425 Torreya Dr.
Street

Phone 850-385-7900

Tallahassee FL 32303
City *State* *Zip*

Email amy@floridalegal.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Legal Services

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

09 FEB 16
Meeting Date

1240
Bill Number (if applicable)

Topic CMS ELIGIBILITY & ENROLLMENT

Amendment Barcode (if applicable)

Name MICHAEL MCQUONE (MICK-CUE-ONE)

Job Title ASSOCIATE DIRECTOR FOR HEALTH

Address 201 W. PARK AVE
Street

Phone 850-284-9130

TALLAHASSEE, FLORIDA 32301
City *State* *Zip*

Email mmcquone@flaccb.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FLORIDA CONFERENCE OF CATHOLIC BISHOPS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/15
Meeting Date

SB 1240
Bill Number (if applicable)

Topic SB 1240

Amendment Barcode (if applicable)

Name Dr. Paul Robinson

Job Title Pediatrician

Address 1301 Hodges Dr.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-431-3230

Email Robinsondp@Mac.com

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

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

Representing Florida Chapter of the AAP

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1240
Bill Number (if applicable)

888676
Amendment Barcode (if applicable)

Topic CMS

Name Karen Woodall

Job Title Executive Director

Address 579 E. Call St.
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone 850-321-9386

Email fcfep@yahoo.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Center for Fiscal & Economic Policy

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1306
INTRODUCER:	Senator Grimsley
SUBJECT:	Public Records and Meetings/Nurse Licensure Compact
DATE:	February 4, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			GO	
3.			RC	

I. Summary:

SB 1306 creates an exemption from the public record requirements for a nurse's personal identifying information obtained from the coordinated licensure information system (CLIS) under the Nurse Licensure Compact (NLC or compact), as defined in s. 464.0095, F.S.,[1] and held by the Department of Health (department) or the Board of Nursing (board).

The bill also creates an exemption from the public meeting requirements for a meeting or a portion of the meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under the compact for specified circumstances. The recordings, minutes, and records generated from those meetings are also confidential and exempt from s. 119.071(1), F.S., and s. 24(a), Art. I of the State Constitution.

The bill takes effect on the same date that an undesignated Senate Bill or similar legislation takes effect. Senate Bill 1316, the substantive bill for the compact, is effective on December 31, 2018, or upon enactment of the NLC into law by 26 states whichever occurs first.

The bill provides for the repeal of the exemption on October 2, 2021, unless reviewed and reenacted by the Legislature. It also provides statements of public necessity for the public records and public meetings exemptions as required by the State Constitution.

Because the bill creates a new public records exemption, a two-thirds vote of the members present and voting in each house of the Legislature is required for final passage.

[1] Section 464.0095, F.S., is created in SB 1316 and establishes the state's participation in the Nurse Licensure Compact and the coordinated licensure information system.

II. Present Situation:

The Florida Constitution provides that the public has the right to access government records and meetings. The public may inspect or copy any record made or received in connection with the official business of any public body, officer, or employee received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.[2] The public also has a right to be afforded notice and access to meetings of any collegial public body of the executive branch of state government or of any local government.[3] The Legislature's meetings must also be open and noticed to the public, unless there is an exception provided for by the Constitution.[4]

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. Chapter 119, F.S., the "Public Records Act" constitutes the main body of public records laws, and states that:

> It is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is the duty of each agency.[5]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] A violation of the Public Records Act may result in civil or criminal liability.[7]

Section 286.011, F.S., the "Sunshine Law,"[8] requires all meetings of any board or commission or local agency or authority at which official acts are to be taken to be noticed and open to the public.[9]

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[2] FLA. CONST. art. 1, s. 24(a).
[3] FLA. CONST. art. 1, s. 24(b).
[4] FLA. CONST. art. 1, s. 24 (b).
[5] Chapter 119, F.S.
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of their physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purpose of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency." The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). The Legislature's records are public pursuant to s. 11.0431, F.S.
[7] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are penalties for violations of those laws.
[8] *Board of Public Instruction of Broward County v. Doran*, 224 So. 2d 693, 695 (Fla. 1969).
[9] Section 286.011(1)-(2), F.S. The Sunshine Law does not apply to the Legislature; rather, open meetings requirements for the Legislature are set out in the Florida Constitution, Article III, s. 4(e) of the Florida Constitution provides the legislative committee meetings must be open and noticed to the public. In addition, prearranged gatherings, between more than two members of the Legislature, or between the Governor, the President of the Senate, or the Speaker of the House of Representatives, the purpose of which is to agree upon or to take formal legislative action, must be reasonable open to the public.

The Legislature may, by two-thirds votes of the House and the Senate[10] create an exemption to public records or open meetings requirements.[11] An exemption must explicitly state the public necessity of the exemption[12] and must be tailored to accomplish the stated purpose of the law.[13] A statutory exemption which does not meet these two criteria may be found unconstitutional, and efforts may not be made by the court to preserve the exemption.[14]

Open Government Sunset Review Act

In addition to the constitutional requirements relating to the enactment of a public records exemption, the Legislature may subject the new or broadened exemption to the Open Government Sunset Review Act (OGSR).

The OGSR prescribes a legislative review process for newly created or substantially amended public records.[15] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[16] In practice, many exemptions are continued by repealing the sunset date rather than reenacting the exemption.

Under the OGSR the purpose and necessity of reenacting the exemption are reviewed. The Legislature must consider the following questions during its review of an exemption:[17]

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?

[10] FLA. CONST. art. I, s. 24(c).
[11] FLA. CONST. art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates as *confidential* and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).
[12] FLA. CONST. art. I, s. 24(c).
[13] FLA. CONST. art. I, s. 24(c).
[14] *Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So.2d 567 (Fla. 1999). In *Halifax Hospital*, the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. In *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004), the court found that the intent of a statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional.
[15] Section 119.15, F.S. According to s. 119.15(4)(b), F.S., a substantially amended exemption is one that is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to s. 119.15(2), F.S. The OGSR process is currently being followed; however, the Legislature is not required to continue to do so. The Florida Supreme Court has found that one legislature cannot bind a future legislature. *Scott v. Williams*, 107 So. 3d 379 (Fla. 2013).
[16] Section 119.15(3), F.S.
[17] Section 119.15(6)(a), F.S.

- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

If the Legislature expands an exemption, then a public necessity statement and a two-thirds vote for passage are required.[18] If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are not required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless otherwise provided for by law.[19]

Nurse Licensure Compact

The Nurse Licensure Compact bill, SB 1316, authorizes Florida to enter the revised Nurse Licensure Compact (NLC or compact), a multi-state agreement that establishes a mutual recognition system for the licensure of registered nurses and licensed practical or vocational nurses. A nurse who is issued a multi-state license from a state that is a party to the NLC would be permitted to practice in any state that is also a party to the compact. A nurse with a multistate license privilege must comply with the practice laws of the state in which he or she is practicing or where the patient is located. A party state may continue to issue a single-state license, authorizing practice only in that state.

The NLC permits a state to take adverse action against the multistate licensure privilege of any nurse practicing in that state. The home state has the exclusive authority to take adverse action against the home state license, including revocation and suspension. The NLC requires all participating states to report to the CLIS, all adverse actions taken against a nurse's license or multistate licensure practice privilege, any current significant investigative information, and denials of information.

All party states may access the CLIS to see licensure and disciplinary information for nurses licensed in the party states. The CLIS includes nurse's personal identifying information, licensure classification information and statuses, public emergency and final disciplinary action information, and status information about multistate licensure privileges from all party states. A party state may designate the information it contributes to the CLIS as confidential, prohibiting its disclosure to nonparty states. State licensing boards must report disciplinary information, significant investigative information, and denials of applications to the CLIS promptly.

The NLC establishes the Interstate Commission of Nurse Licensure Compact Administrators (commission) to oversee the operation of the NLC. The head of each state's licensing board of his or her designee must serve as the state's delegate to the commission. The NLC grants the commission authority to promulgate uniform rules relating to the implementation and administration of NLC. The commission may also take action against a party state if a party state fails to meet its obligations under the NLC, including termination of membership after exhausting all other means of compliance.

[18] FLA. CONST. art. I, s. 24(c).
[19] Section 119.15(7), F.S.

All commission meetings are open to the public and must be publicly noticed. Both commission meetings and hearings for proposed rules must be noticed at least 60 days prior to each meeting on the commission's website and on the website of each party state's licensing board or published in the publication in which each state would otherwise post proposed rules. The compact also provides for public comment opportunities through both oral and written testimony. Closed meetings are permitted if the commission is discussing:

- A party state's noncompliance with its obligations under the compact;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigating compliance with the NLC; or
- Matters specifically exempted from disclosure by federal or state law.

The commission must keep comprehensive minutes of matters discussed in its meetings and provide a full and accurate summary of actions taken, and the reasons. Minutes of a closed meeting will be sealed; however, such minutes may be released pursuant to a majority vote of the commission or an order of a court of competent jurisdiction.

The compact is effective on December 31, 2018, or upon enactment of the NLC into law by 26 states whichever occurs first.[20]

III. Effect of Proposed Changes:

Section 1 creates section 464.0096, F.S., to make a nurse's personal identifying information obtained from the coordinated licensure information system, as defined in s. 464.0095, F.S., and held by the department or board confidential and exempt from public disclosure under s. 119.07(1), F.S. and s. 24(a), Art. I of the State Constitution, unless the state that originally reported the information to the coordinated licensure information system authorizes the disclosure of such information by law. Under such circumstances, the information may only be disclosed to the extent permitted by the reporting state's law.

The bill also creates an exemption from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution for a meeting or any portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators during which any of the following is discussed:

- Failure of a party state to comply with its obligations under the compact;

[20] Twenty-five states have enacted the original Nurse Licensure Compact.

- Employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices;
- Current, threatened, or reasonably anticipated litigation;
- Negotiation of contracts for the purchase or sale of goods, services or real estate;
- Accusations against any person of a crime or formal censure of any person;
- Disclosure of trade secrets as defined in s. 688.002, F.S., or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of active investigatory records[21] compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with NLC; or
- Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state; and
- Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest and the privacy of individuals, and proprietary information.

Recordings, minutes, and records generated during an exempt meeting are confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2 provides, as required by the State Constitution, a statement of public necessity which states that protection of the specified information is required under the Nurse Licensure Compact which the state must adopt in order to become a party state to the compact. Without the public records exemption, the state would be unable to effectively and efficiently implement and administer the compact.

Additionally, the bill provides a statement of public necessity, as required by the State Constitution, for protecting any meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators (commission) where any of the issues that are outlined above are discussed.

Without the public meeting exemption, the state will be prohibited from becoming a party to the compact. Thus, the state will be unable to effectively and efficiently administer the compact.

The bill includes a statement of public necessity by the Legislature that the recordings, minutes, and records generated during an exempt meeting of the commission is exempt pursuant to s. 464.0096, F.S., and exempt from s. 119.07(1), F.S. and s. 24(a), Art. I of the State Constitution. Release of such information would negate the public meeting exemption.

[21] For the purposes of this subparagraph, "active" has the same meaning as provided in s. 119.011(3)(d), F.S.

Section 3 provides that the act shall take effect on the same date as an undesignated Senate Bill or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The commission requires its meetings be open to the public and that such meetings, including rulemaking hearings, be publicly noticed 60 days prior to each meeting. Proposed rules must be posted to the commission's website and to the party state's licensing board websites or the publication in which each party state would otherwise publish proposed rules. The public must also be provided a reasonable opportunity for public comment, orally or in writing, for proposed rules.

However, the compact permits the commission to meet in closed, nonpublic meetings under circumstances listed in Section 1 of the bill.

Closure of a public meetings for some of these reasons may be inconsistent with Florida law.

The commission is required to keep minutes of these closed sessions that fully describe all matters discussed and provide an accurate summary of actions taken. All minutes and documents of a closed meeting shall remain under seal according to the compact's provisions, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

Vote Requirement

Article I, Section 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public records or public meeting exemption. This bill creates a public records exemption for information held by the Agency for Health Care Administration or its designee in the Clearinghouse for Compassionate and Palliative Care Plans; thus it requires a two-thirds vote.

Public Necessity Statement

Article I, Section 24(c) of the State Constitution requires a public necessity statement for a newly created or expanded public records or public meeting exemption. This bill creates a new public records exemption and includes a public necessity statement that supports the exemption. The exemption is no broader than necessary to accomplish the stated purpose.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The department reports no impact for SB 1306.

VI. Technical Deficiencies:

SB 1306 does not include the specific linked bill. The bill should reference SB 1316.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 464.0096 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.

226384

LEGISLATIVE ACTION

Senate . House

. .

. .

. .

. .

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment

Delete line 140

and insert:

SB 1316 or similar legislation takes effect, if such legislation

By Senator Grimsley

21-01887-16 20161306__

A bill to be entitled

An act relating to public records and meetings; creating s. 464.0096, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Nursing pursuant to the Nurse Licensure Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meeting requirements for certain meetings of the Interstate Commission of Nurse Licensure Compact Administrators; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such a meeting; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 464.0096, Florida Statutes, is created to read:

464.0096 Nurse Licensure Compact; public records and meetings exemptions.—

(1) A nurse's personal identifying information obtained from the coordinated licensure information system, as defined in s. 464.0095, and held by the department or the board is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated licensure information system authorizes the disclosure of such information by law. Under such circumstances, the information may only be

21-01887-16 20161306__

disclosed to the extent permitted by the reporting state's law.

(2)(a) A meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under s. 464.0095 during which any of the following is discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution:

1. Failure of a party state to comply with its obligations under the Nurse Licensure Compact.

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation.

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Trade secrets as defined in s. 688.002 or commercial or financial information required by the commission's bylaws or rules to be kept privileged or confidential.

7. Information of a personal nature which the commission determines by majority vote would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public.

8. Active investigatory records compiled for law enforcement purposes. For the purposes of this subparagraph, the term "active" has the same meaning as provided in s. 119.011(3)(d).

9. Information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the Nurse Licensure Compact.

10. Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state.

11. Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest and the privacy of individuals, and proprietary information.

(b) Recordings, minutes, and records generated during an exempt meeting are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a nurse's personal identifying information obtained from the coordinated licensure information system, as defined in s. 464.0095, Florida Statutes, and held by the Department of Health or the Board of Nursing be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Nurse Licensure Compact, which the state must adopt in order to become a party state to the compact. Without the public records exemption, this state will be unable to effectively and efficiently implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting or portion of a meeting of the Interstate

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

Commission of Nurse Licensure Compact Administrators established under s. 464.0095, Florida Statutes, at which any of the following is discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution:

1. Failure of a party state to comply with its obligations under the Nurse Licensure Compact.

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation.

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Trade secrets as defined in s. 688.002, Florida Statutes, or commercial or financial information required by the commission's bylaws or rules to be kept privileged or confidential.

7. Information of a personal nature which the commission determines by majority vote would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public.

8. Active investigatory records compiled for law enforcement purposes.

9. Information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the Nurse Licensure Compact.

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

10. Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state.

11. Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest, the privacy of individuals, and proprietary information.

(b) The Nurse Licensure Compact requires any meeting or portion of a meeting in which the substance of paragraph (a) is discussed to be closed to the public. Without the public meeting exemption, this state will be prohibited from becoming a party state to the compact. Thus, this state will be unable to effectively and efficiently administer the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 464.0096, Florida Statutes, be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meeting exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that SB ____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 13, 2016

I respectfully request that **Senate Bill #946**, relating to Authorized Practices of Advanced Registered Nurse Practitioners and Licensed Physician Assistants; **Senate Bill #964**, relating to Prescription Drug Monitoring Program; **Senate Bill #1306** relating to Public Records and Meetings/Nurse Licensure Compact and **Senate Bill #1316,** relating to Nurse Licensure Compact be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

09 FEB 2016
Meeting Date

1306
Bill Number (if applicable)

Topic PUBLIC RECORDS / MEETINGS

Amendment Barcode (if applicable)

Name PAUL JESS

Job Title

Address 218 S. MONROE ST
Street

TALLAHASSEE FL 32301
City *State* *Zip*

Phone

Email

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FLORIDA JUSTICE ASSOCIATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

9 Feb '16
Meeting Date

1306
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Martha De Castro

Job Title VP

Address 306 E. College
Street

Phone 222 9800

TLH 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fla Hospital Assn

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

SB 1306 SB 1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Rebecca Fitsch

Job Title State Advocacy Associate

Address 111 E Wacker, Ste 2900
Street

Phone 312-505-3035

Chgo IL 60601
City *State* *Zip*

Email rfitsch@ncsbn.org

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

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

Representing National Council of State Boards of Nursing

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-9-16
Meeting Date

1306 & 1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Rick Masters

Job Title Special Counsel, Nurse Licensure Compact Administrators

Address 1012 S. 4th St. *Street*

Phone (502) 262-5881

Louisville *City* Ky. *State* 40203 *Zip*

Email rmasters@csg.org

Speaking: ☑ For ☐ Against ☑ Information

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

Representing Nurse License Compact Administrators & Council of State Govts.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1316
INTRODUCER:	Senator Grimsley
SUBJECT:	Nurse Licensure Compact
DATE:	February 5, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 1316 authorizes Florida to enter the revised Nurse Licensure Compact (NLC), a multi-state agreement that establishes a mutual recognition system for the licensure of registered nurses and licensed practical or vocational nurses. The bill enacts the NLC into law, which is a prerequisite for joining the compact.

A nurse who is issued a multi-state license from a state that is a party to the NLC is permitted to practice in any state that is also a party to the compact. However, the nurse must comply with the practice laws of the state in which he or she is practicing or where the patient is located. A party state may continue to issue a single-state license, authorizing practice only in that state.

The bill has an indeterminate fiscal impact on the Department of Health (department).

The bill is effective on December 31, 2018, or upon enactment of the NLC into law by 26 states, whichever occurs first.

II. Present Situation:

The Nurse Practice Act, ch. 464, F.S., governs the licensure and regulation of nurses in Florida. The department is the licensing agency and the Board of Nursing (board) is the regulatory authority. The board is comprised of 13 members appointed by the Governor and confirmed by the Senate.[1]

To be licensed as a nurse by examination, an individual must:

- Submit an application with the appropriate fee;
- Satisfactorily complete a criminal background screening;

[1] Section 464.004(1), F.S.

- Demonstrate English competency;
- Successfully complete an approved nursing educational program; and
- Pass a licensure exam.[2]

A nurse from out of state who wishes to work temporarily in the state of Florida may obtain licensure via examination or endorsement. Licensure by endorsement requirements can be found in s. 464.009, F.S., and include:

- Holding a valid license to practice professional or practical nursing in another state or territory of the United States;
- Having successfully completed the State Board Test Pool Examination (SBTPE) or NCLEX; or
- Having actively practiced nursing in another state or jurisdiction, or territory of the United States for two of the preceding 3 years without having his or her license acted against by the licensing authority of any jurisdiction; and
- Conducting an electronic fingerprinting through the Florida Department of Law Enforcement for any Florida and national criminal history records for consideration by the state board office through Livescan;[3]
- Clearing prior criminal convictions through the board office. Any applicants who has ever been found guilty of, or pled guilty or no contest/nolo contendere to any charge other than a minor traffic offense must list each offense on the application.[4]

Health care boards or the department are not permitted to issue a license, certificate, or registration to any candidate if the applicant:

- Has been convicted of, or entered a plea of nolo contendere to, regardless of adjudication, a felony, under ch. 409, F.S., (relating to social and economic assistance), ch. 817, F.S., (relating to fraudulent practices), ch. 893, F.S., (relating to drug abuse prevention and control), or similar felony offense(s) in another state or jurisdiction;
- 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 (relating to controlled substances) or 42 U.S.C. ss 1395-1396 (relating to public health, welfare, Medicare, and Medicaid issues);
- Has been terminated for cause from the Medicaid program pursuant to s. 409.913, F.S., unless the candidate has been in good standing for the most recent 5 years;
- Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or 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 application; and

[2] Section 464.008, F.S., For its licensure examination, the department uses the National Council Licensure Examination (NCLEX), developed by the National Council of State Boards of Nursing.
[3] Section 446.009, F.S. For spouses of active duty military personnel who relocate to Florida pursuant to official military orders, the spouse is deemed to meet the requirements of licensure by endorsement if he or she is licensed by a state that is a member of the Nurse Licensure Compact, and will be issued a license upon submission of an application for licensure with the appropriate fee and satisfactory completion of the required criminal background screening.
[4] Florida Board of Nursing, *Licensed Practical Nurse & Registered Nurse by Endorsement* (page modified November 20, 2015) *available at* http://floridasnursing.gov/licensing/licensed-practical-nurse-registered-nurse-by-endorsement/ (last visited Feb. 2, 2016).

- Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.[5]

Licenses are renewed biennially.[6] Each renewal period, an RN or LPN must document completion of one contact hour of continuing education for each calendar month of the licensure cycle.[7] As part of the total continuing education hours required, all licensees must complete a 2-hour course on the prevention of medical errors and a 2-hour course in Florida laws and rules.[8] Effective August 1, 2017, all licensees must also complete a 2-hour course in recognizing impairment in the workplace.[9]

Interstate Compacts

An interstate compact is an agreement between two or more states to address common problems or issues, create an independent, multistate government authority, or establish uniform guidelines, standards or procedures for the compact's member states.[10] Article I, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. The case has provided that not all interstate agreements are subject to congressional approval, but only those that encroach on the federal government's power.[11] Florida is a party to at least 25 interstate compacts, including the Interstate Compact on Educational Opportunity for Military Children, Compact on Adoption and Medical Assistance, and the Compact on the Placement of Children.[12]

The Nurse Licensure Compact

The National Council of State Boards of Nursing (council) administers the Nurse Licensure Compact (NLC). The council is a non-profit organization that coordinates the efforts of the member states. The council includes the boards of nursing in the 50 states, the District of Columbia and four U.S. Territories.

The NLC allows licensed practical and registered nurses the ability to practice in all member states by maintaining a single license in their primary state of residence.[13] A second compact covers Advanced Practice Registered Nurses, such as nurse anesthetists, nurse practitioners, nurse midwives, and clinical nurse specialists. The compacts were revised and adopted by the

[5] Id.
[6] Section 464.013, F.S.
[7] Rule 64B9-5.002, F.A.C. A course in HIV/AIDS is required in the first biennium only and a domestic violence course is required every third biennium.
[8] Rule 64b9-5.011, F.A.C.
[9] *Supra* note 5 and Rule 64B9-5.014, F.A.C.
[10] Council of State Governments, *Capitol Research: Interstate Compacts*, http://knowledgecenter.csg.org/kc/content/interstate-compacts-background-and-history (last visited Feb. 2, 2016).
[11] *See Virginia v. Tennessee*, 148 U.S. 503 (1893) and *New Hampshire v. Maine*, 426 U.S. 363 (1976).
[12] OPPAGA, *2015 Nurse Licensure Compact Revisions Address Some Barriers and Disadvantages in 2006 OPPAGA Report* (November 20, 2015) (on file in the Senate Committee on Health Policy).
[13] The compact model rules defined "primary state of residence" to mean the state of a person's declared, fixed permanent and principal home for legal purposes.

Delegate Assembly in May 2015.[14] Currently, 25 states have enacted the original NLC legislation.[15] Presently, 1.4 million of the nation's nurses hold a multistate license.[16]

To join the NLC, a state must pass the NLC model legislation, the state board of nursing must implement the compact, and the state licensing agency must pay an annual fee of $6,000.[17] States that adopted the NLC prior to the 2015 revisions must adopt the revised NLC to become members of the new compact.[18]

The council also manages NURSYS™, the national database for verification of nurse licensure, discipline, and practice privileges for registered nurses licensed by participating boards of nursing, including all states in the compact. Fifty-three states participate in the NURSYS™ database, including Florida.

There are three publicly available components to the verification system:

- e-Notify which provides real-time licensure and publicly available discipline data to institutions about nurses employed by that institution and for nurses to manage their licenses statuses and renewals;
- Licensure QuickConfirm that allows employers and recruiters to receive licensure and discipline information in one location; and
- Nurse Licensure Verification service which enables nurses to verify their licenses from a participating board when applying for endorsement for $30 per license type, per each board.[19]

2015 Revised Nurse Licensure Compact

Under the NLC, an applicant for a license to practice as an RN or LPN/LVN has to apply in his or her home state for a multistate license.[20] The home state is the applicant's primary state of residence.[21] The NLC has 11 Articles covering areas such as general jurisdiction, application process, governance, and rule-making. The key highlights in the 2015 revised NLC include:

- A nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time the service is provided. The practice of nursing in a

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[14] National Council of State Boards of Nursing, *Nurse Licensure Compact*, https://www.ncsbn.org/nurse-licensure-compact.htm (last visited Jan. 29. 2016).
[15] Id. The 25 states are: Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.
[16] Florida Dep't of Health, *House Bill 1061 Analysis* (January 11, 2016) (on file with the Senate Committee on Health Policy).
[17] *Supra* note 16.
[18] *Supra* note 15.
[19] National Council of State Boards of Nursing, *License Verification (Nursys.com)* https://www.ncsbn.org/license-verification.htm (last visited Feb. 2, 2016).
[20] A multistate license is a license to practice as an RN or LPN/LVN issued by a home state licensing board that authorizes the license holder to practice in all party states under a multistate licensure privilege.
[21] Pursuant to the model rules developed under the prior NLC, a nurse's home state may be evidenced by a drivers' license with a home address, voter registration card with a home address, federal income tax return, military documentation of state of legal residence, or a W2 from the U.S. government or any bureau, division, or agency thereof. *See* Nurse Licensure Compact Administrators, *Nurse Licensure Compact Model Rules and Regulations*, (Rev. Nov. 13, 2012, Aug. 4, 2008, Sept. 16, 2004), *available at* https://www.ncsbn.org/NLC_Model_Rules.pdf (last visited Feb. 2, 2016).

party state under a multistate license subjects a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the patient is located at the time the service is provided.

- All party states are required, in accordance with existing state due process law, to take adverse action against a nurse's multistate license privilege, such as revocation, suspension, probation, or cease and desist actions. If a party state takes such action, the party state is required to notify the administrator of the coordinated licensure information system.
- A party state may continue to issue a single-state license, which does not grant a nurse the privilege to practice in any other party state.
- All party states must participate in the coordinated licensure system, which includes information on the licensure and disciplinary history of each nurse.
- The head of each state licensing board or his or her designee is required to be a member of the Interstate Commission of Nurse Licensure Compact Administrators (commission).
- The commission meets at least once a year and is required to have public meetings. The NLC provides for certain meetings or portions of meetings to be closed to the public. Minutes, records, and recordings of closed meetings must be kept by the commission.
- The NLC provides rulemaking authority to the commission. Rules and amendments to the rules passed by the commission are binding on the party states as of the effective date specified in each rule or amendment.
- The NLC becomes effective and binding on the earlier of the date of legislative enactment by at least 26 states or December 31, 2018.
- To withdraw from the NLC, a state must enact a statute repealing the NLC, which may not take effect until 6 months after the enactment of the repealing legislation.
- The NLC may be amended by the party states; however, an amendment will not be effective until it is enacted into the laws of all the party states.
- The NLC is to be liberally construed to effectuate its purposes. The NLC contains a severability clause that provides that any provision that is found to be unconstitutional pursuant to a state constitution or the U.S. Constitution is severed and the other provisions of the compact remain valid. If the entire compact is found to be unconstitutional in a party state, the NLC remains in full force and effect for all other party states.

OPPAGA Review of the NLC

2006 OPPAGA Report

In 2006, the Office of Program Policy Analysis and Government Accountability (OPPAGA) released a report evaluating the possibility of Florida adopting the original NLC.[22] The OPPAGA concluded that adopting the NLC would allow the state to alleviate short-term nursing shortages but would not resolve the state's long-term nursing shortage. The report identified several benefits that would be realized by adopting the NLC. Those benefits included:

- Access to NURSYS®, the coordinated licensure information system, would provide improved access to information regarding disciplinary action taken against a nurse's license and notification of a nurse under investigation for patient safety issues, including information that is only available to party states.

[22] OPPAGA, *Nurse Licensure Compact Would Produce Some Benefits But Not Resolve the Nursing Shortage*, Report No. 06-02 (Jan. 2006) *available at* http://www.oppaga.state.fl.us/Summary.aspx?reportNum=06-02 (last visited Feb. 2, 2016).

- As a party state, Florida would be able to influence interstate nursing policies as a member of the Nurse Licensure Compact Administrators.

Conversely, the report also identified several disadvantages to joining the compact at that time:
- Potentially, there could be an increase in disciplinary cases, both domestic and multistate, which could have a negative fiscal impact on the department;
- Florida's continuing education requirements would not apply to a nurse working in Florida but whose home state is not Florida;
- A nurse whose home state was not Florida may not be subject to a criminal background screening because some party states did not a require criminal background screening for licensure;
- Public access to licensure and disciplinary action may be impaired; and
- The department and board will incur some initial start-up costs in implementing the NLC.

Additionally, OPPAGA identified barriers to implementing the original NLC legislation:
- The provisions of the original NLC language may conflict with Florida's public records and open meetings laws. The original NLC required states receiving information to honor the confidentiality restrictions of the state providing the information, and did not address notice requirements for open meetings;
- The original NLC provided general and broad authorization for the compact administrators to develop rules that were required to be adopted by party states, which raised concern about an unlawful delegation of legislative authority;
- The department and the board would need to educate nurses and employers on the NLC and its requirements for the NLC to operate as intended; and
- A compact nurse is not required to notify the board when he or she enters the state to practice nursing, making it difficult for the workforce data to be captured. Additionally, the board would not be on notice that a nurse under investigation in another state has entered Florida to work.

The report made several recommendations, including seeking approval to use alternative compact language to address the barriers identified in the report. Other recommendations including authorizing the board to require employers to report employment data, providing a later effective date to allow for education of the public regarding the NLC, and requiring the board to report information to the legislature on the effect of the NLC 2 years after its implementation.

2015 OPPAGA Memorandum

In 2015, the OPPAGA reviewed the revised NLC to determine if it adequately addresses concerns identified in the 2006 report.[23] The OPPAGA found that the revised NLC resolved some of the barriers and disadvantages listed above, and specifically it found:
- The revised NLC partially addresses the concerns regarding constitutional issues related to public meetings but did not address public records concerns:

[23] OPPAGA, *2015 Nurse Licensure Compact Revisions Address Some Barriers and Disadvantages in 2006 OPPAGA Report,* A Presentation to the House Select Committee on Affordable Healthcare Access (December 1, 2015) *available at* http://www.oppaga.state.fl.us/Presentations.aspx (last visited Feb 2, 2016).

  - Under the revised NLC, there are provisions requiring the commission to publicly notice meetings on its website, as well as the websites of party states. However, the commission is allowed to have closed door meetings to address certain issues. Such meetings may be deemed inconsistent with Florida's open meetings law.
  - A party state may still designate information it provides as confidential and restrict the sharing of such information. However, once the information is in the possession of the board, it may be considered a public record under Florida law, available through the board.
- The revised NLC addresses the issue of delegation of legislative authority, by limiting the scope of the rules the commission may adopt to only those rules that would facilitate and coordinate the implementation and administration of the NLC. The OPPAGA suggests that the legislature include an expiration date, an automatic repeal provision, or a required review of the NLC to provide the legislature with an opportunity to review the rules adopted by the commission;
- The revised NLC does not become effective until it has been enacted by 26 states or December 31, 2018, whichever is earlier. This provides the state with the time needed to educate nurses and employers about the NLC.
- The revised NLC does not require employers of compact nurses who are practicing in a state under a multistate licensure privilege to report such employment to the state's board of nursing;
- Public access to nurse disciplinary information has improved due to the increased state participation in NURSYS®, the coordinated licensure information system;
- The revised NLC requires a criminal background screening for licensees. However, this requirement only applies to new multistate licensure applicants, and a nurse who currently holds a multistate license will not have to undergo a criminal background screening unless required by his or her home state; and
- The NLC does not address continuing education requirements. Although most states require some continuing education, not all states do. Florida authorities would be unable to enforce continuing education requirements for those practicing in the state under the multistate licensing privilege.

The OPPAGA advises that the revised NLC does not affect the benefits it identified in its 2006 report. In addition to those benefits, it noted that as a member of the NLC, the processing time and resources required to process a licensure by endorsement would be reduced or eliminated. Florida would also be able to access investigative information earlier and would be able to open its own investigation if the nurse is practicing in this state.

Florida Nursing Workforce

The Florida Center for Nursing was established by the Legislature in 2001, to address the issues of supply and demand for nursing, including the recruitment, retention, and utilization of nurse workforce resources.[24] The bill requires the Florida Center for Nursing to include the impact of the state's participation in the NLC in its supply and demand calculations and projections for the need for nurse workforce resources. The Florida Center for Nursing is authorized to request any information held by the board regarding nurses licensed in this state, holding a multistate license,

[24] Chapter 2001-277, L.O.F. and s. 464.0195, F.S.

or any information reported by employers of such nurses, other than personally identifiable information.

The Florida Center for Nursing prepares long-range forecasts of nurse supply and demand every 2 years to assist with the state's planning. The last published report was posted in October 2010 for the forecasting period of 2010-2025. The nursing supply shortage was projected to worsen beginning in 2014 with the combination of health care reform, an aging population requiring more health care services, and as older nurses retired from the workforce.[25]The 2010 model projected a shortage of 50,000 RNs by 2025.[26] The shortage of LPNs was projected to be 13,250 by 2025.[27]

The Long-Term Employment projections program of the Department of Economic Opportunity identifies Registered Nurses as an occupation where employment is expected to grow from 168,885 individuals to 196,503 or 16.4 percent in the next 8 years.[28] Nurse Practitioners, while a smaller occupational group, have a higher expected growth rate of 30.9 percent over the 8 year span growing from 7,199 individuals to 9,421.[29] Nursing and residential care facilities rank fifth overall in the Florida's fastest growing industries, with a minimum of 10,000 jobs.

Nursing, as an occupation is the 8th fastest growing occupation with a 30.9 percent growth rate and a median hourly wage in 2015 of $44.22 for nurse practitioners.[30] Registered nurses are expected to gain the 5th most jobs in the state over the next 8 years, more than 52,000. These jobs have a median hourly rate in 2015 of $29.89 and require a minimum education level of an associate's degree.[31]

III. Effect of Proposed Changes:

The bill adopts the revised Nurse Licensure Compact (NLC) into state law.

Section 1 amends s. 456.073, F.S., relating to disciplinary proceedings for boards within the department's jurisdiction. The department shall be required to report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure system pursuant to s. 464.0095, F.S. This reporting is a requirement of the NLC.

Section 2 amends s. 456.076, F.S., relating to treatment programs for impaired practitioners. The bill requires the consultant under the impaired practitioner program to disclose to the department, upon the department's request, whether an applicant for a multistate license under s. 464.0095,

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[25] Florida Center for Nursing, *Technical Report: Forecasting Nurse Supply and Demand in Florida* (Oct. 2010) p. 16, *available at* https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=14&PortalId=0&TabId=151 (last visited Feb. 2, 2016).
[26] Id at 17.
[27] Id at 18.
[28] Department of Economic Opportunity, *Florida Jobs by Occupation - 2015-2013 Projections Statewide,* http://www.floridajobs.org/labor-market-information/data-center/statistical-programs/employment-projections (last visited Feb. 2, 2016).
[29] Id.
[30] Id at *Fastest Growing Occupations* Tab.
[31] Id at *Occupations Gaining the Most New Jobs* Tab.

F.S., is participating in a treatment program and must report to the department when a nurse holding a multistate license under s. 464.0095, F.S., enters a treatment program. A nurse holding a multistate license under s. 464.0095, F.S., must report to the department within two business days after entering a treatment program pursuant to this section.

Section 3 amends s. 464.003, F.S., to modify definitions to recognize that a nurse may hold a multistate license.

Section 4 amends s. 464.004, F.S., to appoint the executive director of the Board of Nursing or his or her designee as the state administrator of the Nurse Licensure Compact as required under the NLC.

Section 5 amends 464.008, F.S., relating to licensure by examination to incorporate the multistate licensure process. The bill authorizes an applicant who resides in this state, meets the licensure requirements, and meets the criteria for multistate licensure to request the issuance of a multistate license from the department.

A nurse who holds a single-state license in this state and applies to the department for a multistate license must meet the eligibility criteria for a multistate license under s. 464.0095, F.S., and must pay an application and licensure fee to change his or her licensure status.

The bill requires the department to conspicuously distinguish a multistate license from a single-state license.

A person who holds an active multistate license in another state pursuant to the NLC is exempt from the licensure requirements in Florida.

Section 6 amends s. 464.009, F.S., relating to licensure by endorsement, to exempt a person who holds an active multistate license in another state from the requirements of licensure by endorsement in Florida.

Section 7 creates the Nurse Licensure Compact (NLC or compact) under s. 464.0095, F.S., and enters Florida into the compact with all other jurisdictions legally joining the NLC. The compact includes 11 Articles and is substantially similar to the model compact language.

Article I provides the general findings and declaration of purpose for the compact. The general findings under Article I include:

- The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
- Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
- The expanded mobility of nurses and the use of advanced communication technologies as part of the nation's health care delivery system require greater coordination among states in the areas of nurse licensure and regulation;
- New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex; The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and

- Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

The general purposes for the compact include:
- Facilitate the states' responsibility to protect the public's health and safety;
- Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;
- Facilitate the exchange of information among party states in the areas of nurse regulation, investigation, and adverse action;
- Promote compliance with the laws governing the practice of nursing in each jurisdiction;
- Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses;
- Decrease redundancies in the consideration and issuance of nurse licenses; and
- Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

Article II creates the definitions applicable to the compact.

"Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege, such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

"Alternative program" means a nondisciplinary monitoring program approved by a licensing program.

"Commission" means the Interstate Commission of Nurse Licensure Administrators established by this compact.

"Compact" means the Nurse Licensure Compact recognized, established, and entered into by the state under this compact.

"Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws which is administered by a nonprofit organization composed of and controlled by licensing boards.

"Current significant investigate information" means:
(a) Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

(b) Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

"Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

"Home state" means the party state that is the nurse's primary state of residence.

"Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

"Multistate license" means a license to practice as a registered nurse (RN) or a licensed practical or vocational nurse (LPN/VN) issued by a home state licensing board which authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

"Multistate licensure privilege" means a legal authorization associated with a multistate licensure permitting the practice of nursing as either an RN or LPN/VN in a remote state.

"Nurse" means an RN or LPN/VN, as those terms are defined in each party state's practice laws.

"Party state" means any state that has adopted this compact.

"Remote state" means a party state other than the home state.

"Single-state license" means a nurse license issued by a party state which authorizes practice only within the issuing state and does not include a multi-state licensure privilege to practice in any other party state.

"State" means a state, territory, or possession of the United States, or the District of Columbia.

"State practice laws" means a party state's laws, rules, and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing disciple. The term does not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

Article III provides for the compact's general provisions and jurisdiction as follows:

- Each party state will recognize a multistate license to practice registered or licensed practical or vocational nursing issued by a home state to a resident in that state as authorizing the RN or LPN/VN to practice in its state.
- The state must ensure that each applicant fulfills the following criteria to obtain or retain a multistate license in the home state:
    - Has met the home state's qualifications for licensure or renewal;
    - Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program or other approved educational program with a comparable prelicensure education program.
    - Demonstrates a proficiency in English, if the applicant is a graduate of a foreign prelicensure program not taught in English;

  - Has successfully passed an NCLEX-RN or NCLEX-PN Examination or recognized predecessor, as applicable;
  - Is eligible for or holds an active, unencumbered license;
  - Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for criminal history check with the FBI and the state's criminal records;
  - Has not been convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, of a felony offense under applicable state or federal law;
  - Has not been convicted or found guilty, or entered into an agreed disposition other than a disposition that results in a nolle prosequi, of a misdemeanor offense related to the practice of nursing, as determined on a case by case basis;
  - Is not currently enrolled in an alternative program;
  - Is subject to self-disclosure requirements regarding current participation in an alternative program; and
  - Has a valid social security number.
- All party states are required, in accordance with existing state due process law, to take adverse action against a nurse's multistate license privilege, such as revocation, suspension, probation, or cease and desist actions. If a party state takes such action, the party state is required to notify the administrator of the coordinated licensure information system (CLIS). The administrator of the CLIS must promptly notify the home state of any such actions by a remote state.
- A nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time the service is provided. The practice of nursing is not limited to patient care but includes all nursing practice as defined by the state practice laws of the party state in which the patient is located.
- The practice of nursing in a party state under a multistate license subjects a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the patient is located at the time the service is provided.
- A person not residing in a party state shall continue to be able to apply for a party state's single-state license. The issuance of a single-state license in a party state does not grant a nurse the privilege to practice in any other party state. The compact does not affect the requirements established by a party state for the issuance of a single-state license.
- A nurse holding a home state multistate license, on the effective date of this compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that the nurse who changes his or her primary state of residence after the effective date meets all of the multistate licensure requirements to obtain a multistate license from a new home state. A nurse who fails to satisfy the multistate licensure requirements due to a disqualifying event occurring after the effective date is ineligible to retain or renew his or her multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with the compact's rules.

Article IV of the compact creates the application process for the multistate license. The application process requires the licensing board in the issuing state to determine, through the CLIS, whether the applicant has ever held, or is the holder of, a license issued by another state, whether there are any encumbrances on any license or multistate licensure privilege, whether any

adverse action has been taken against the license or multistate licensure privilege, and whether the applicant is participating in an alternative program.

A nurse may hold a multistate license, issued by a home state, in only one party state at a time. If a nurse moves and changes his or her primary state, the nurse must apply for licensure in the new home state, and the multistate licensure issued by the prior home state must be deactivated. A new license may be applied for in advance of a primary change in residence. However, a new multistate license may not be issued until the nurse provides satisfactory evidence of change in his or her primary state of residence and has satisfied all applicable requirements to obtain a new multistate license in the new home state. If the nurse has moved to a non-party state, the multistate license issued by the prior home state must convert to a single-state license valid only in the prior home state.

Article V vests additional authority in the party state licensing board relating to the multistate licensure privilege. In addition to the powers already granted to the state's Board of Nursing (board), the board may also:

- Take adverse action against a nurse's multistate licensure privilege to practice within that party state.
    - Only the home state has the power to take adverse action against a nurse's license issued by the home state.
    - For purposes of adverse action, the home state licensing board or state agency shall give the same priority and effect to conduct reported by a remote state as it would if such conduct had occurred within the home state. In doing so, the home state shall apply its own state laws to determine appropriate action.
- Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.
- Complete any pending investigation of a nurse who changes his or her primary state of residence during the course of such investigation. Conclusion of such actions must be promptly reported to the administrator of the CLIS. The administrator of the CLIS shall promptly notify the new home state of any such action.
- Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses or the production of evidence. Enforcement of a subpoena to parties in another state will be enforced by courts in the latter state.
- Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the FBI for criminal background checks, receive FBI results, and use the results to make licensure decisions.
- If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.
- Take adverse action based on the factual findings of the remote state, provided that the licensing board or state agency follows its own procedures for taking such adverse action.
- If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party state shall be deactivated until all encumbrances are removed from the multistate license. All home state disciplinary orders shall impose adverse action against a nurse's multistate license and shall include a statement

that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.
- The compact does not override a party state's decision to use an alternative program in lieu of adverse action and the home state licensing board shall deactivate the multistate licensing privilege for the duration of the nurse's participation in the alternative program.

Article VI creates the CLIS and the process for the exchange of information under the NLC. The system requires all party states to participate and to include information on the licensure and discipline history of each nurse, as submitted by the party states, to assist in the coordination of nurse licensure and enforcement efforts. Those coordination efforts include:
- Formulating necessary procedures by the commission, in consultation with the administrator of the system for the identification, collection and exchange of information under the NLC;
- Promptly reporting by all licensing boards any adverse action, any current significant investigative information, denials of applications, the reason for application denials, and nurse participation in alternative programs, regardless of whether such participation is nonpublic or confidential under state law;
- Transmitting through the system current significant investigative information and participation in nonpublic or confidential alternative programs available only to the party states;
- Notwithstanding any other provision of law, providing that all party state licensing boards contributing information to the system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state;
- Providing that any personal identifying information obtained from the system by a party state licensing board may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information;
- Allowing any information contributed to the system which is subsequently required to be expunged by the laws of the party state contributing the information to also be expunged from the system;
- Requiring the compact administrator of each party state to furnish a uniform data set to each other party state that includes, at a minimum:
  - Identifying information;
  - Licensure data;
  - Information related to alternative program participation; and
  - Other information that may facilitate the administration of the compact; and
- Requiring the compact administrator of a party state to provide all investigative documents and information requested by another party state.

Article VII establishes the Interstate Commission of Nurse Licensure Compact Administrators (commission), its authorities, duties and responsibilities. The party states establish the joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators as an instrumentality of the party states. The following provisions are included in the structure of the commission:

Venue - Judicial proceeding by or against the commission shall be brought solely and exclusively, in a court of competent jurisdiction where the commission's principal office is located.[32] The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

Sovereign Immunity - The compact does not waive sovereign immunity. The administrators, officers, executive director, employees, and representatives of the commission are immune from suit and liability either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability cause by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities.

Sovereign immunity under these provisions does not protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

The commission shall defend any administrator, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from that person's intentional, willful, or wanton misconduct. An individual is not prohibited from retaining his or her own counsel.

The commission shall also indemnify and hold harmless any officer, administrator, executive director, employee or representative of the commission for the amount of any judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from that person's intentional, willful, or wanton misconduct.

Compact Administrator - Each party state is limited to one administrator. The executive director of the state licensing board or his or her designee serves as the administrator of the compact for each party state. Any administrator may be removed or suspended from office as provided by the laws of the administrator's home state. Any vacancy occurring on the commission shall be filled in accordance with the laws of the party state in which the vacancy occurred.

Voting - Each administrator is entitled to one vote with regard to the adoption of the rules and the creation of the bylaws. The administrator shall have the opportunity to participate in the business and affairs of the commission and shall vote in person or by other means as allowed in the bylaws. The bylaws may also provide for the administrator's participation in commission meetings by telephone or other means of communication.

[32]The principal office of the commission is located in Chicago, Illinois.

Meetings - The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the commission's bylaws and rules. All meetings are open to the public, and public notice of the meetings must be given in the same manner as required under Article VIII. Closed meetings are permitted if the commission is discussing:

- Failure of a party state to comply with its obligations under the compact;
- Employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices;
- Current, threatened, or reasonably anticipated litigation;
- Negotiation of contracts for the purchase or sale of goods, services or real estate;
- Accusations against any person of a crime or formal censure of any person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigating compliance with this compact; or
- Matters specifically exempted from disclosure by federal or state statute.

If a meeting is closed to the public under this section, the commission's legal counsel or designee shall certify that the meeting, or portion of the meeting is closed and reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed during the closed session and shall provide a full and accurate summary of the action taken and reasons for those actions, including a description of the views expressed. All documents considered during the session must also be identified in the minutes. All minutes and documents from the closed session must remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

Commission Bylaws -The commission is also required, by a majority vote of the administrators, to prescribe bylaws or rules to govern its conduct, including but not limited to:

- Establishing the commission's fiscal year;
- Providing reasonable standards and procedures:
  - For the establishment and meetings of other committees.
  - Governing any general or specific delegation of any authority or function of the commission.
- Providing reasonable procedures for calling and conducting meetings, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance by interested parties, with exceptions to protect the public's interest, the privacy of individuals, and proprietary information. The commission may only meet in closed session after a majority of members vote to close the meeting in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy vote allowed.
- Establishing the titles, duties, authority, and reasonable procedures for electing commission officers;

- Providing reasonable standards and procedures for establishing the commission's personnel policies and programs;
- Providing a mechanism for winding up the commission's operations and the equitable distribution of any surplus funds that may exist after the compact's termination upon the payment of all obligations;
- Publishing the commission bylaws and rules, its amendments thereto, in a convenient form on the commission's website;
- Maintaining the commission's financial records in accordance with the bylaws; and
- Meeting and taking action consistent with the compact and bylaws.

Adoption of Rules by the Commission - The commission may also:

- Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules shall have the force and effect of binding law in all party states;
- Bring and prosecute legal proceedings and actions in the name of the commission, provided that the standing of any licensing board to sue or be sued under applicable law is not affected;
- Purchase and maintain insurance and bonds;
- Borrow, accept, or contract for services of personnel, including employees of a party state or nonprofit organizations;
- Cooperate with other organizations that administer state compacts related to the regulation of nursing, including sharing administrative staff expenses, office space, or other resources;
- Hire employees, elect or appoint officers, fix compensation, define duties, grant such authority to carry out the compact, and establish personnel policies and programs relating to conflict of interest, qualifications of personnel, and other related personnel matters;
- Accept appropriate donations, grants, and gifts of money, equipment, supplies, materials, and services and dispose of the same while avoiding the appearance of any impropriety or conflict of interest;
- Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, or improve or use any property, whether real, personal, or mixed, provided that, at all times the commission avoids any appearance of impropriety;
- Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property whether real, personal, or mixed;
- Establish a budget and make expenditures;
- Borrow money;
- Appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, consumer representatives, and other interested persons;
- Exchange information and cooperate with law enforcement agencies;
- Adopt and use an official seal; and
- Perform other functions as may be necessary to achieve the compact's purpose consistent with the state regulation of nurse licensure and practice.

Financing of the Commission - The commission:

- Shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities;

- May levy and collect an annual assessment from each party state to cover the cost of operations, activities, and staff in its annual budget, as approved. The annual assessment amount, if approved, shall be determined by the commission based on a formula determined by the commission and adopted by rule that is binding on all party states;
- May not incur obligations of any kind before securing the adequate funds to meet the obligation and the commission may not pledge the credit of any party states, except by and with the authority of such party state; and
- Shall keep accurate accounts all receipts and disbursements which shall be subject to audit and accounting procedures and audited yearly by a certified or licensed public accountant;

Article VIII establishes the commission's authority for rulemaking. The commission exercises its rulemaking authority under this article and any rules adopted thereunder. Rules and amendments become binding as of the date specified in the rule or the amendment and have the same force and effect as any provision of the compact.

Rulemaking - The commission may adopt rules or amendments to its rules at a regular or special meeting; however, before adoption of a final rule, the commission must file a notice of proposed rulemaking at least 60 days prior to the commission meeting where the rule will be considered and voted upon. Notice of the proposed rule shall be posted on the commission's website and on the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

The proposed rule notice must include:
- The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;
- The text of the proposed rule or amendment and the reason for the proposed rule;
- A request for comments on the proposed rule from any interested person; and
- The manner in which an interested party may submit notice to the commission of his or her intention to attend the public hearing and his or her written comments.

Before adoption of the proposed rule, the commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public. The commission shall also grant an opportunity for a public hearing before it adopts a rule or amendment and publish the place, time, and date of that hearing.

Hearings must allow each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings must be recorded and a copy made available upon request. Rules may be grouped together for the convenience of the commission; a separate hearing is not required for each rule. If no interested person appears at the public hearing, the commission may proceed with the adoption of the proposed rule.

Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing is not held, the commission shall consider all comments received. Action on the proposed rule will be by majority vote of the commission and the commission shall determine the effective date, if any, based on the rulemaking record and the full text of the rule.

Emergency Rulemaking - If a determination is made that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures in this compact and article are applied retroactively to this rule as soon as reasonably possible within 90 days after the effective date of the emergency rule. An emergency rule is one that must be adopted immediately to:

- Meet an imminent threat to public health, safety, or welfare;
- Prevent a loss of commission or party state funds; or
- Meet a deadline for the adoption of an administrative rule that is required by federal law or rule.

The commission may direct revisions to previously adopted rules or amendments to correct typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of these revisions shall be posted on the commission's website. These revisions are subject to challenge for 30 days after posting. Challenges may only be based on the grounds that the revisions results in a material change in the rule. The challenge must be made in writing before the end of the notice period. If there is no challenge, the rule takes effect without the commission's approval.

Article IX establishes the oversight, dispute resolution, and enforcement provisions of the compact. Oversight of the compact will be established by:

- Each party state enforcing the compact and taking all actions necessary and appropriate to effectuate the compact's purposes and intent;
- The commission being entitled to receive service of process in any proceeding that may affect the powers, responsibility, or actions of the commission and having standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such a proceeding to the commission renders a judgment or order void as to the commission, this compact, or its adopted rules;

When the commission determines that a party state has defaulted under the compact:

- The commission shall provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default, or any other action to be taken by the commission or provide remedial training and specific technical assistance regarding the default.
- If a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated upon an affirmative vote of a majority of administrators and all rights, privileges, and benefits conferred by this compact may be terminated on the effective date of the termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.
- Termination of compact membership shall be imposed only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to suspend or terminate to the governor of the defaulting state, the executive officer of the state's licensing board, and to all party states.
- A state whose compact membership is terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

- The commission shall not bear any costs related to a state that is found to be in default or whose membership is terminated unless agreed upon in writing between the commission and the defaulting state.
- The defaulting state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district in which the commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

The commission is also permitted to use a dispute resolution process in the following manner:

- Upon request by a party state, the commission shall attempt to resolve disputes related to the compact that arise between party states and party and nonparty states;
- The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes, as appropriate; and
- In the event the commission cannot resolve disputes among party states arising under this compact:
    - The party states may submit issues in the dispute to an arbitration panel, which will be comprised of individuals appointed by the compact administrator in each of the affected party states and an individual mutually agreed upon by the compact administrators of all party states involved in the dispute.
    - The decision of a majority of the arbitrators is final and binding.

The commission is charged with, in the reasonable exercise of its discretion, enforcement of the compact and its rules. By majority vote, the commission may initiate legal action in the United States District of Columbia or the federal court in which the commission has its principal office against a party state that is in default to enforce compliance with the compact and the adopted bylaws and rules. Relief sought may include both injunctive relief and damages. If judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

The remedies provided in this Article are not exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

Article X establishes the effective date, withdrawal and amendment provisions for the compact as follows:

- The compact becomes effective and binding on the date of legislative enactment of this compact by no fewer than 26 states or on December 31, 2018, whichever occurs first;
- All party states which were also parties to the prior Nurse Licensure Compact ("prior compact,") are deemed to have withdrawn from the prior compact within 6 months after the effective date of this compact;
- Each party start to this compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the prior compact until such party state is withdrawn from the prior compact;
- Any party state may withdraw from this compact by enacting a statute repealing the compact; however, a party state's withdrawal does not take effect until 6 months after the enactment of the repealing statute;

- A party state's withdrawal or termination does not affect the continuing requirement of the withdrawing or terminating state's licensing board to report adverse actions and significant investigations occurring before the effective date of such withdrawal or termination;
- This compact does not invalidate or prevent any nurse licensure agreement or other cooperative agreement between a party state and a nonparty state that is made in accordance with the other provisions of this compact;
- This compact may be amended by the party states; however, an amendment does not become effective and binding upon the party states unless and until it is enacted into the laws of all party states; and
- Representatives of nonparty states to this compact shall be invited to participate in the activities of the commission on a nonvoting basis, before the adoption of the compact by all party states.

Article XI addresses the construction and severability of the compact. The compact may be liberally construed so as to effectuate its purposes. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if its applicability to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability to any government, agency, person, or circumstance is not affected.

If this compact is declared to be contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable provisions.

Section 8 amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners (ARNP) to recognize that an applicant may hold a multistate license.

Section 9 amends s. 464.015, F.S., relating to titles and abbreviations, to recognize the alternative multistate license available under s. 464.0095, F.S., and to make grammatical changes.

Section 10 amends s. 464.018, F.S., relating to disciplinary actions, to recognize the alternative multistate license available under s. 464.0095, F.S., to align the grounds for denial of a license or disciplinary action with the reasons provided under the compact. Grammatical changes throughout the section are also made to modify "licensee" to "nurse."

The compact modified existing statutes to provide that an individual who entered a plea of guilty to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or the ability to practice nursing becomes grounds for discipline. The bill expands the listed adjudications that constitute grounds for disciplinary action to add "convicted of" and "entering a plea of guilty or nolo contendere" to what had previously said "found guilty of the following offenses":

The grounds for denial of a license or disciplinary action are also made applicable to multistate license applicants or multistate licensees.

The bill authorizes the board to take adverse action against a nurse's multistate license privilege and impose any of the penalties under s. 456.072, F.S., when the nurse is found guilty of violating subsection (1) or s. 456.072(1), F.S.

Section 11 amends s. 464.0195, F.S., relating to the Florida Center for Nursing and its goals. The bill directs the Florida Nursing Center to analyze the current nursing supply and demand in the state and make future projections, including an assessment of the impact of the state's participation in the NLC. The Florida Nursing Center may request information from the board about nurses licensed in the state or holding multistate licenses and other information reported to the board by employers of such nurses, other than personal identifying information.

Section 12 provides an effective date of December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by 26 states, whichever occurs first.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The commission requires most of its meetings to be open to the public and that such meetings, including rulemaking hearings, be publicly noticed 60 days prior to each meeting. Proposed rules must be posted to the commission's website and to the party state's licensing board websites or the publication in which each party state would otherwise publish proposed rules. The public must also be provided a reasonable opportunity for public comment, orally or in writing, for proposed rules.

However, the compact permits the commission to meet in closed, nonpublic meetings if the commission must discuss any of the following circumstances:

- Failure of a party state to comply with its obligations under the compact;
- Employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices;
- Current, threatened, or reasonably anticipated litigation;
- Negotiation of contracts for the purchase or sale of goods, services or real estate;
- Accusations against any person of a crime or formal censure any person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information or a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or
- Matters specifically exempted from disclosure by federal or state statute.

Closure of a public meetings for some of these reasons may be inconsistent with Florida law.

The commission is required to keep minutes of these closed sessions that fully describe all matters discussed and provide an accurate summary of actions taken. All minutes and documents of a closed meeting shall remain under seal according to the compact's provisions, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The compact authorizes administrators to develop rules that party states must adopt, which is potentially an unlawful delegation of legislative authority. The revised compact limits the rulemaking by the commission to rules that facilitate and coordinate the implementation and administration of the Nurse Licensure Compact.

If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative authority to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[33,34] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely addresses this issue in the context of interstate compacts.

The most recent case Florida courts have had to address this issue was in *Department of Children and Family Services v. L.G.*, involving the Interstate Compact for the Placement of Children (ICPC).[35] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms

[33] *Freimuth v. State*, 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel Orange State Oil Co.,* 155 Fla. 772 (1945).

[34] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State*, 723 So.2d 199 (Fla. 1998).

[35] 801 So.2d 1047 (Fla. 1st DCA 2001).

and provisions of this compact."[36] The court states that "the precise legal effect of the ICPC compact administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[37] However, in a footnote, the court provided:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[38]

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. This case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[39]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[36] Id at 1052.
[37] Id.
[38] *Id.*
[39] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no biding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).

B. Private Sector Impact:

A Florida nurse converting his or her single-state license would be subject to a fee to convert to a multistate license.

Health care employers, such as hospitals, nursing homes, assisted living facilities and others, may benefit from the availability of additional nurses in the workforce as nurses from other party states move to Florida for employment. According to one report, Florida's currently needs 12,493 nurses and another 9,947 for 2016.[40] Hospitals are facing an average turnover rate of 18.3 percent in 2015 for registered nurses in hospitals providing additional recruitment opportunities.[41]

C. Government Sector Impact:

The Department of Health, Medical Quality Assurance reports an expected increase in revenues associated with the multistate application initial and renewal fees. The increase of applications in Florida is unknown; therefore, the fiscal impact for this component is indeterminate at this time.[42] There are currently 1.4 million nurses with a multistate license.

The department\MQA anticipates an increase in workload and recurring expenses for:
- Additional regulations for new licensure;
- Investigation of complaints and investigations related to that new licensure; and
- Processing of initial and renewal applications and related fees.[43]

The department/MQA is unable to determine the cost of these expenses at this time, but most of these expenses can be absorbed within existing department resources.

The annual membership cost with the Nurse Licensure Compact is approximately $6,000 which the department\MQA indicates can be absorbed within current budget authority.[44]

The department\MQA also will incur non-recurring costs to update the Nursing application and the Licensing and Information Database System, both of which the department indicates can be absorbed within existing resources.[45]

VI. Technical Deficiencies:

None.

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[40] Kathleen McGrory, *Florida Facing a "Nursing Shortage Tsunami" Due to Increased Population, More Insured Patients*, TAMPA BAY TIMES, Feb. 1, 2016, *available at* http://www.tampabay.com/news/health/florida-facing-a-nursing-shortage-tsunami-due-to-increased-population-more/2263588.
[41] Id.
[42] *Supra* note 16, at 6.
[43] Id at 6-7.
[44] Id.
[45] Id.

VII. Related Issues:

Florida's continuing education requirements for nurses (24 hours of continuing education over 2 years) would not apply to compact nurses. Florida's Board of Nursing could not require or enforce these continuing education requirements on nurses from other states that practiced in Florida under a multistate license privilege. Some compact states do not require continuing education.

Florida requires applicants to submit fingerprints for state and federal criminal records checks. The grandfather clause for nurses who are currently holding or renewing a multistate license privilege would exempt nurses from the criminal background screening whose home state does not require criminal background screening.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.073, 456.076, 464.003, 464.004, 464.008, 464.009, 464.012, 464.015, 464.018, and 464.0195.

This bill creates section 464.0095 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 Grimsley

21-00477-16 20161316__

A bill to be entitled

An act relating to the Nurse Licensure Compact; amending s. 456.073, F.S.; requiring the Department of Health to report certain investigative information to the coordinated licensure information system; amending s. 456.076, F.S.; requiring an impaired practitioner consultant to disclose certain information to the department upon request; requiring a nurse holding a multistate license to report participation in a treatment program to the department; amending s. 464.003, F.S.; revising definitions to conform to changes made by the compact; amending s. 464.004, F.S.; requiring the executive director of the Board of Nursing or his or her designee to serve as state administrator of the Nurse Licensure Compact; amending s. 464.008, F.S.; providing eligibility criteria for a multistate license; requiring that multistate licenses be distinguished from single-state licenses; exempting certain persons from licensed practical nurse and registered nurse licensure requirements; amending s. 464.009, F.S.; exempting certain persons from requirements for licensure by endorsement; creating s. 464.0095, F.S.; creating the Nurse Licensure Compact; providing findings and purpose; providing definitions; providing for the recognition of nursing licenses in party states; requiring party states to perform criminal history checks of licensure applicants; providing requirements for obtaining and retaining a multistate license; authorizing party states to take adverse action against a nurse’s multistate licensure privilege; requiring notification to the home licensing state of an adverse action against a

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licensee; requiring nurses practicing in party states to comply with state practice laws; providing limitations for licensees not residing in a party state; providing the effect of the act on a current licensee; providing application requirements for a multistate license; providing licensure requirements when a licensee moves between party states or to a nonparty state; providing certain authority to state licensing boards of party states; requiring deactivation of a nurse’s multistate licensure privilege under certain circumstances; authorizing participation in an alternative program in lieu of adverse action against a license; requiring all party states to participate in a coordinated licensure information system; providing for the development of the system, reporting procedures, and the exchange of certain information between party states; establishing the Interstate Commission of Nurse Licensure Compact Administrators; providing for the jurisdiction and venue for court proceedings; providing membership and duties; authorizing the commission to adopt rules; providing rulemaking procedures; providing for state enforcement of the compact; providing for the termination of compact membership; providing procedures for the resolution of certain disputes; providing an effective date of the compact; providing a procedure for membership termination; providing compact amendment procedures; authorizing nonparty states to participate in commission activities before

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adoption of the compact; providing construction and severability; amending s. 464.012, F.S.; authorizing a multistate licensee under the compact to be certified as an advanced registered nurse practitioner if certain eligibility criteria are met; amending s. 464.015, F.S.; authorizing registered nurses and licensed practical nurses holding a multistate license under the compact to use certain titles and abbreviations; amending s. 464.018, F.S.; revising the grounds for denial of a nursing license or disciplinary action against a nursing licensee; authorizing certain disciplinary action under the compact for certain prohibited acts; amending s. 464.0195, F.S.; revising the information required to be included in the database on nursing supply and demand; requiring the Florida Center for Nursing to analyze and make future projections of the supply and demand for nurses; authorizing the center to request, and requiring the Board of Nursing to provide, certain information about licensed nurses; providing a contingent effective date.

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

Section 1. Subsection (10) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.—Disciplinary proceedings for each board shall be within the jurisdiction of the department.

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(10) The complaint and all information obtained pursuant to the investigation by the department are confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department, or until the regulated professional or subject of the investigation waives his or her privilege of confidentiality, whichever occurs first. The department shall report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure information system pursuant to s. 464.0095. Upon completion of the investigation and a recommendation by the department to find probable cause, and pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an opportunity to inspect the investigative file or, at the subject's expense, forward to the subject a copy of the investigative file. Notwithstanding s. 456.057, the subject may inspect or receive a copy of any expert witness report or patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any information received under this subsection until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 456.057. The subject may file a written response to the information contained in the investigative file. Such response must be filed within 20 days of mailing by the department, unless an extension of time has been granted by the department. This subsection does not prohibit the department from providing such information to any law enforcement agency or to any other regulatory agency.

Section 2. Subsection (9) of section 456.076, Florida

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Statutes, is amended to read:

456.076 Treatment programs for impaired practitioners.—

(9) 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 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. The consultant must disclose to the department, upon the department's request, whether an applicant for a multistate license under s. 464.0095 is participating in a treatment program and must report to the department when a nurse holding a multistate license under s. 464.0095 enters a treatment program. A nurse holding a multistate license pursuant to s. 464.0095 must report to the department within 2 business days after entering a treatment program pursuant to this section. If a disciplinary proceeding is pending, an impaired licensee may obtain such information from the department under s. 456.073.

Section 3. Subsections (16) and (22) of section 464.003, Florida Statutes, are amended to read:

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

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(16) "Licensed practical nurse" means any person licensed in this state or holding an active multistate license under s. 464.0095 to practice practical nursing.

(22) "Registered nurse" means any person licensed in this state or holding an active multistate license under s. 464.0095 to practice professional nursing.

Section 4. Subsection (5) is added to section 464.004, Florida Statutes, to read:

464.004 Board of Nursing; membership; appointment; terms.—

(5) The executive director of the board appointed pursuant to s. 456.004(2) or his or her designee shall serve as the state administrator of the Nurse Licensure Compact as required under s. 464.0095.

Section 5. Subsection (2) of section 464.008, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

464.008 Licensure by examination.—

(2)(a) Each applicant who passes the examination and provides proof of meeting the educational requirements specified in subsection (1) shall, unless denied pursuant to s. 464.018, be entitled to licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable.

(b) An applicant who resides in this state, meets the licensure requirements of this section, and meets the criteria for multistate licensure under s. 464.0095 may request the issuance of a multistate license from the department.

(c) A nurse who holds a single-state license in this state and applies to the department for a multistate license must meet the eligibility criteria for a multistate license under s.

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464.0095 and must pay an application and licensure fee to change the licensure status.

(d) The department shall conspicuously distinguish a multistate license from a single-state license.

(5) A person holding an active multistate license in another state pursuant to s. 464.0095 is exempt from the licensure requirements of this section.

Section 6. Subsection (7) is added to section 464.009, Florida Statutes, to read:

464.009 Licensure by endorsement.—

(7) A person holding an active multistate license in another state pursuant to s. 464.0095 is exempt from the requirements for licensure by endorsement in this section.

Section 7. Section 464.0095, Florida Statutes, is created to read:

464.0095 Nurse Licensure Compact.—The Nurse Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I

FINDINGS AND DECLARATION OF PURPOSE

(1) The party states find that:

(a) The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws.

(b) Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public.

(c) The expanded mobility of nurses and the use of advanced

communication technologies as part of the nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation.

(d) New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex.

(e) The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states.

(f) Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

(2) The general purposes of this compact are to:

(a) Facilitate the states' responsibility to protect the public's health and safety.

(b) Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation.

(c) Facilitate the exchange of information among party states in the areas of nurse regulation, investigation, and adverse actions.

(d) Promote compliance with the laws governing the practice of nursing in each jurisdiction.

(e) Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.

(f) Decrease redundancies in the consideration and issuance of nurse licenses.

(g) Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

ARTICLE II

DEFINITIONS

As used in this compact, the term:

(1) "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege, such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

(2) "Alternative program" means a nondisciplinary monitoring program approved by a licensing board.

(3) "Commission" means the Interstate Commission of Nurse Licensure Compact Administrators established by this compact.

(4) "Compact" means the Nurse Licensure Compact recognized, established, and entered into by the state under this compact.

(5) "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws which is administered by a nonprofit organization composed of and controlled by licensing boards.

(6) "Current significant investigative information" means:

(a) Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true,

would indicate more than a minor infraction; or

(b) Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

(7) "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

(8) "Home state" means the party state that is the nurse's primary state of residence.

(9) "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

(10) "Multistate license" means a license to practice as a registered nurse (RN) or a licensed practical or vocational nurse (LPN/VN) issued by a home state licensing board which authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

(11) "Multistate licensure privilege" means a legal authorization associated with a multistate license permitting the practice of nursing as either an RN or an LPN/VN in a remote state.

(12) "Nurse" means an RN or LPN/VN, as those terms are defined by each party state's practice laws.

(13) "Party state" means any state that has adopted this compact.

(14) "Remote state" means a party state other than the home state.

(15) "Single-state license" means a nurse license issued by a party state which authorizes practice only within the issuing

state and does not include a multistate licensure privilege to practice in any other party state.

(16) "State" means a state, territory, or possession of the United States, or the District of Columbia.

(17) "State practice laws" means a party state's laws, rules, and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. The term does not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE III

GENERAL PROVISIONS AND JURISDICTION

(1) A multistate license to practice registered or licensed practical or vocational nursing issued by a home state to a resident in that state is recognized by each party state as authorizing a nurse to practice as an RN or as an LPN/VN under a multistate licensure privilege in each party state.

(2) Each party state must implement procedures for considering the criminal history records of applicants for initial multistate licensure or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(3) In order for an applicant to obtain or retain a multistate license in the home state, each party state must require that the applicant fulfills the following criteria:

(a) Has met the home state's qualifications for licensure

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or renewal of licensure, as well as all other applicable state laws.

(b)1. Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program; or

2. Has graduated from a foreign RN or LPN/VN prelicensure education program that has been approved by the authorized accrediting body in the applicable country and has been verified by a licensing board-approved independent credentials review agency to be comparable to a licensing board-approved prelicensure education program.

(c) If the applicant is a graduate of a foreign prelicensure education program not taught in English, or if English is not the applicant's native language, has successfully passed a licensing board-approved English proficiency examination that includes the components of reading, speaking, writing, and listening.

(d) Has successfully passed an NCLEX-RN or NCLEX-PN Examination or recognized predecessor, as applicable.

(e) Is eligible for or holds an active, unencumbered license.

(f) Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(g) Has not been convicted or found guilty, or has entered into an agreed disposition other than a disposition that results

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in nolle prosequi, of a felony offense under applicable state or federal criminal law.

(h) Has not been convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis.

(i) Is not currently enrolled in an alternative program.

(j) Is subject to self-disclosure requirements regarding current participation in an alternative program.

(k) Has a valid social security number.

(4) All party states may, in accordance with existing state due process law, take adverse action against a nurse's multistate licensure privilege, such as revocation, suspension, probation, or any other action that affects the nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

(5) A nurse practicing in a party state shall comply with the state practice laws of the state in which the patient is located at the time service is provided. The practice of nursing is not limited to patient care but includes all nursing practice as defined by the state practice laws of the party state in which the patient is located. The practice of nursing in a party state under a multistate licensure privilege subjects a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the patient is located at the

time service is provided.

(6) A person not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. The single-state license granted to such a person does not grant the privilege to practice nursing in any other party state. This compact does not affect the requirements established by a party state for the issuance of a single-state license.

(7) A nurse holding a home state multistate license, on the effective date of this compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that the nurse who changes his or her primary state of residence after the effective date meets all applicable requirements under subsection (3) to obtain a multistate license from a new home state. A nurse who fails to satisfy the multistate licensure requirements under subsection (3) due to a disqualifying event occurring after the effective date is ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the commission.

ARTICLE IV

APPLICATIONS FOR LICENSURE IN A PARTY STATE

(1) Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any

license or multistate licensure privilege held by the applicant, and whether the applicant is currently participating in an alternative program.

(2) A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

(3) If a nurse changes his or her primary state of residence by moving from one party state to another party state, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state must be deactivated in accordance with applicable rules adopted by the commission.

(a) The nurse may apply for licensure in advance of a change in his or her primary state of residence.

(b) A multistate license may not be issued by the new home state until the nurse provides satisfactory evidence of a change in his or her primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

(4) If a nurse changes his or her primary state of residence by moving from a party state to a nonparty state, the multistate license issued by the prior home state must convert to a single-state license valid only in the former home state.

ARTICLE V

ADDITIONAL AUTHORITY VESTED IN PARTY STATE LICENSING BOARDS

(1) In addition to the other powers conferred by state law, a licensing board or state agency may:

(a) Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

1. Only the home state has the power to take adverse action

against a nurse's license issued by the home state.

2. For purposes of taking adverse action, the home state licensing board or state agency shall give the same priority and effect to conduct reported by a remote state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

(b) Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.

(c) Complete any pending investigation of a nurse who changes his or her primary state of residence during the course of such investigation. The licensing board or state agency may also take appropriate action and shall promptly report the conclusions of such investigation to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such action.

(d) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses or the production of evidence. Subpoenas issued by a licensing board or state agency in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, and mileage and other fees required by the service statutes of the state in which the witnesses or evidence is located.

(e) Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks, and use the results in making licensure decisions.

(f) If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.

(g) Take adverse action based on the factual findings of the remote state, provided that the licensing board or state agency follows its own procedures for taking such adverse action.

(2) If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances are removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

(3) This compact does not override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

ARTICLE VI

COORDINATED LICENSURE INFORMATION SYSTEM AND EXCHANGE INFORMATION

(1) All party states shall participate in a coordinated licensure information system relating to all licensed RNs and LPNs/VNs. This system shall include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(2) The commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this compact.

(3) All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications, the reasons for application denials, and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

(4) Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(5) Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express

permission of the contributing state.

(6) Any personal identifying information obtained from the coordinated licensure information system by a party state licensing board may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(7) Any information contributed to the coordinated licensure information system which is subsequently required to be expunged by the laws of the party state contributing that information is also expunged from the coordinated licensure information system.

(8) The compact administrator of each party state shall furnish a uniform data set to the compact administrator of each other party state, which shall include, at a minimum:

(a) Identifying information.

(b) Licensure data.

(c) Information related to alternative program participation.

(d) Other information that may facilitate the administration of this compact, as determined by commission rules.

(9) The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

ARTICLE VII

ESTABLISHMENT OF THE INTERSTATE COMMISSION OF NURSE LICENSURE COMPACT ADMINISTRATORS

(1) The party states hereby create and establish a joint

public entity known as the Interstate Commission of Nurse Licensure Compact Administrators.

(a) The commission is an instrumentality of the party states.

(b) Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively, in a court of competent jurisdiction where the commission's principal office is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) This compact does not waive sovereign immunity.

(2)(a) Each party state shall have and be limited to one administrator. The executive director of the state licensing board or his or her designee shall be the administrator of this compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring on the commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

(b) Each administrator is entitled to one vote with regard to the adoption of rules and the creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the commission's bylaws or rules.

(d) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under Article VIII of this compact.

(e) The commission may convene in a closed, nonpublic meeting if the commission must discuss:

1. Failure of a party state to comply with its obligations under this compact;

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures;

3. Current, threatened, or reasonably anticipated litigation;

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

5. Accusing any person of a crime or formally censuring any person;

6. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

7. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

8. Disclosure of investigatory records compiled for law enforcement purposes;

9. Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or

10. Matters specifically exempted from disclosure by federal or state statute.

(f) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or designee shall certify that the meeting, or portion of the meeting, is closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(3) The commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including, but not limited to:

(a) Establishing the commission's fiscal year.

(b) Providing reasonable standards and procedures:

1. For the establishment and meetings of other committees.

2. Governing any general or specific delegation of any authority or function of the commission.

(c) Providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information,

including trade secrets. The commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed.

(d) Establishing the titles, duties and authority, and reasonable procedures for the election of the commission's officers.

(e) Providing reasonable standards and procedures for the establishment of the commission's personnel policies and programs. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the commission's personnel policies and programs.

(f) Providing a mechanism for winding up the commission's operations and the equitable disposition of any surplus funds that may exist after the termination of this compact after the payment or reserving of all of its debts and obligations.

(4) The commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the commission's website.

(5) The commission shall maintain its financial records in accordance with the bylaws.

(6) The commission shall meet and take such actions as are consistent with this compact and the bylaws.

(7) The commission may:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and are binding in all

party states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including employees of a party state or nonprofit organizations.

(e) Cooperate with other organizations that administer state compacts related to the regulation of nursing, including sharing administrative or staff expenses, office space, or other resources.

(f) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(g) Accept any and all appropriate donations, grants, and gifts of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that, at all times, the commission avoids any appearance of impropriety or conflict of interest.

(h) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, whether real, personal, or mixed, provided that, at all times, the commission avoids any appearance of impropriety.

(i) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, whether real,

personal, or mixed.

(j) Establish a budget and make expenditures.

(k) Borrow money.

(l) Appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, consumer representatives, and other interested persons.

(m) Provide information to, receive information from, and cooperate with law enforcement agencies.

(n) Adopt and use an official seal.

(o) Perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of nurse licensure and practice.

(8) Relating to the financing of the commission, the commission:

(a) Shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) May also levy and collect an annual assessment from each party state to cover the cost of its operations, activities, and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based on a formula to be determined by the commission, which shall adopt a rule that is binding on all party states.

(c) May not incur obligations of any kind before securing the funds adequate to meet the same; and the commission may not pledge the credit of any of the party states, except by and with the authority of such party state.

(d) Shall keep accurate accounts of all receipts and

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disbursements. The commission's receipts and disbursements are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in, and become part of, the commission's annual report.

(9) Relating to the sovereign immunity, defense, and indemnification of the commission:

(a) The administrators, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. This paragraph does not protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any administrator, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities,

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provided that the actual or alleged act, error, or omission did not result from that person's intentional, willful, or wanton misconduct. This paragraph does not prohibit that person from retaining his or her own counsel.

(c) The commission shall indemnify and hold harmless any administrator, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment and have the same force and effect as provisions of this compact.

(2) Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

(3) Before adoption of a final rule or final rules by the commission, and at least 60 days before the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(a) On the commission's website.

(b) On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

(4) The notice of proposed rulemaking shall include:

(a) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which an interested person may submit notice to the commission of his or her intention to attend the public hearing and any written comments.

(5) Before adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(6) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

(7) The commission shall publish the place, time, and date of the scheduled public hearing.

(a) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

(b) This article does not require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(8) If no interested person appears at the public hearing, the commission may proceed with adoption of the proposed rule.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing is not held, the commission shall consider all written and oral comments received.

(10) The commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(11) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in this compact and in this article are applied retroactively to the rule as soon as reasonably possible within 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or party state funds; or

(c) Meet a deadline for the adoption of an administrative rule that is required by federal law or rule.

(12) The commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the commission's website. The revision is subject to challenge by any person for 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing

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and delivered to the commission before the end of the notice period. If no challenge is made, the revision shall take effect without further action. If the revision is challenged, the revision may not take effect without the commission's approval.

ARTICLE IX

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1) Oversight of this compact shall be accomplished by:

(a) Each party state, which shall enforce this compact and take all actions necessary and appropriate to effectuate this compact's purposes and intent.

(b) The commission, which is entitled to receive service of process in any proceeding that may affect the powers, responsibilities, or actions of the commission and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the commission renders a judgment or order void as to the commission, this compact, or adopted rules.

(2) When the commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this compact or the adopted rules, the commission shall:

(a) Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default, or any other action to be taken by the commission.

(b) Provide remedial training and specific technical assistance regarding the default.

(3) If a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated

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upon an affirmative vote of a majority of the administrators, and all rights, privileges, and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(4) Termination of membership in this compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the governor of the defaulting state, to the executive officer of the defaulting state's licensing board, and each of the party states.

(5) A state whose membership in this compact is terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(6) The commission shall not bear any costs related to a state that is found to be in default or whose membership in this compact is terminated unless agreed upon in writing between the commission and the defaulting state.

(7) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district in which the commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(8) Dispute resolution may be used by the commission in the following manner:

(a) Upon request by a party state, the commission shall attempt to resolve disputes related to the compact that arise among party states and between party and nonparty states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.

(c) In the event the commission cannot resolve disputes among party states arising under this compact:

1. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the compact administrator in each of the affected party states and an individual mutually agreed upon by the compact administrators of all the party states involved in the dispute.

2. The decision of a majority of the arbitrators is final and binding.

(9)(a) The commission shall, in the reasonable exercise of its discretion, enforce the provisions and rules of this compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district in which the commission has its principal offices against a party state that is in default to enforce compliance with this compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies provided in this subsection are not the

exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE X

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(1) This compact becomes effective and binding on the date of legislative enactment of this compact into law by no fewer than 26 states or on December 31, 2018, whichever occurs first. All party states to this compact which were also parties to the prior Nurse Licensure Compact ("prior compact"), superseded by this compact, are deemed to have withdrawn from the prior compact within 6 months after the effective date of this compact.

(2) Each party state to this compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the prior compact until such party state is withdrawn from the prior compact.

(3) Any party state may withdraw from this compact by enacting a statute repealing the compact. A party state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(4) A party state's withdrawal or termination does not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring before the effective date of such withdrawal or termination.

(5) This compact does not invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a nonparty state that is made in accordance with the other provisions of this compact.

(6) This compact may be amended by the party states. An amendment to this compact does not become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

(7) Representatives of nonparty states to this compact shall be invited to participate in the activities of the commission, on a nonvoting basis, before the adoption of this compact by all party states.

ARTICLE XI

CONSTRUCTION AND SEVERABILITY

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact are severable, and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If this compact is declared to be contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

Section 8. Subsection (1) of section 464.012, Florida Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and

submit proof that he or she holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing pursuant to s. 464.0095 and that he or she meets one or more of the following requirements as determined by the board:

(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.

(b) Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(c) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

Section 9. Subsections (1), (2), and (9) of section 464.015, Florida Statutes, are amended to read:

464.015 Titles and abbreviations; restrictions; penalty.—

(1) Only a person ~~persons~~ who holds a license in this state or a multistate license pursuant to s. 464.0095 ~~hold licenses~~ to practice professional nursing ~~in this state~~ or who performs ~~are performing~~ nursing services pursuant to the exception set forth in s. 464.022(8) may ~~shall have the right to~~ use the title "Registered Nurse" and the abbreviation "R.N."

(2) Only a person ~~persons~~ who holds a license in this state or a multistate license pursuant to s. 464.0095 ~~hold licenses~~ to practice as a licensed practical nurse ~~nurses in this state~~ or who performs ~~are performing~~ practical nursing services pursuant to the exception set forth in s. 464.022(8) may ~~shall have the right to~~ use the title "Licensed Practical Nurse" and the abbreviation "L.P.N."

(9) A person may not practice or advertise as, or assume the title of, registered nurse, licensed practical nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or advanced registered nurse practitioner or use the abbreviation "R.N.," "L.P.N.," "C.N.S.," "C.R.N.A.," "C.N.M.," or "A.R.N.P." or take any other action that would lead the public to believe that person was authorized by law to practice ~~certified~~ as such or is performing nursing services pursuant to the exception set forth in s. 464.022(8)~~,~~ unless that person is licensed, ~~or~~ certified, or authorized pursuant to s. 464.0095 to practice as such.

Section 10. Subsections (1) and (2) of section 464.018, Florida Statutes, are amended to read:

464.018 Disciplinary actions.—

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

456.072(2) and 464.0095:

(a) Procuring, attempting to procure, or renewing a license to practice nursing or the authority to practice practical or professional nursing pursuant to s. 464.0095 by bribery, by knowing misrepresentations, or through an error of the department or the board.

(b) Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

(d) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, ~~of~~ any of the following offenses:

1. A forcible felony as defined in chapter 776.

2. A violation of chapter 812, relating to theft, robbery, and related crimes.

3. A violation of chapter 817, relating to fraudulent practices.

4. A violation of chapter 800, relating to lewdness and indecent exposure.

5. A violation of chapter 784, relating to assault, battery, and culpable negligence.

6. A violation of chapter 827, relating to child abuse.

7. A violation of chapter 415, relating to protection from abuse, neglect, and exploitation.

8. A violation of chapter 39, relating to child abuse, abandonment, and neglect.

9. For an applicant for a multistate license or for a multistate licenseholder under s. 464.0095, a felony offense under Florida law or federal criminal law.

(e) Having been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

(f) Making or filing a false report or record, which the nurse ~~licensee~~ knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the nurse's capacity as a licensed nurse.

(g) False, misleading, or deceptive advertising.

(h) Unprofessional conduct, as defined by board rule.

(i) Engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee

that probable cause exists to believe that the nurse ~~licensee~~ is unable to practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a nurse ~~licensee~~ to submit to a mental or physical examination by physicians designated by the department. If the nurse ~~licensee~~ refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the nurse ~~licensee~~ resides or does business. The nurse ~~licensee~~ against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A nurse affected by ~~the provisions of~~ this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

(k) Failing to report to the department any person who the nurse ~~licensee~~ knows is in violation of this part or of the rules of the department or the board; however, if the nurse ~~licensee~~ verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the nurse ~~licensee~~ is required to report such person only to an impaired professionals consultant.

(l) Knowingly violating any provision of this part, a rule of the board or the department, or a lawful order of the board or department previously entered in a disciplinary proceeding or failing to comply with a lawfully issued subpoena of the department.

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(m) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the nurse also provides services.

(n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the nurse ~~licensee~~ is not qualified by training or experience.

(o) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or nurse ~~licensee~~ who is found guilty of violating ~~any provision of~~ subsection (1) ~~of this section~~ or ~~who is found guilty of violating any provision of~~ s. 456.072(1).

(b) The board may take adverse action against a nurse's multistate licensure privilege and impose any of the penalties in s. 456.072(2) when the nurse is found guilty of violating subsection (1) or s. 456.072(1).

Section 11. Paragraph (a) of subsection (2) of section 464.0195, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

464.0195 Florida Center for Nursing; goals.—

(2) The primary goals for the center shall be to:

(a) Develop a strategic statewide plan for nursing manpower in this state by:

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1. Establishing and maintaining a database on nursing supply and demand in the state, to include current supply and demand~~, and future projections~~; ~~and~~

2. Analyzing the current nursing supply and demand in the state and making future projections of such, including assessing the impact of this state's participation in the Nurse Licensure Compact under s. 464.0095; and

3.~~2.~~ Selecting from the plan priorities to be addressed.

(4) The center may request from the board, and the board must provide to the center upon its request, any information held by the board regarding nurses licensed in this state or holding a multistate license pursuant to s. 464.0095 or information reported to the board by employers of such nurses, other than personal identifying information.

Section 12. This act shall take effect December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by 26 states, whichever occurs first.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 13, 2016

I respectfully request that **Senate Bill #946**, relating to Authorized Practices of Advanced Registered Nurse Practitioners and Licensed Physician Assistants; **Senate Bill #964**, relating to Prescription Drug Monitoring Program; **Senate Bill #1306** relating to Public Records and Meetings/Nurse Licensure Compact and **Senate Bill #1316**, relating to Nurse Licensure Compact be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

SB 1316
Bill Number (if applicable)

Topic NURSE COMPACT

Amendment Barcode (if applicable)

Name Bob Reynolds

Job Title

Address P.O. Box 4369
Street

Phone 850-422-0656

TALL FLA. 32315
City State Zip

Email RRRASSOCIATION@EARTHLINK.NET

Speaking: ☒ For ☐ Against ☐ Information

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

Representing FLORIDA RENAL ADMINISTRATORS ASSOCIATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/9/16
Meeting Date

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

1316
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Nurse Licensure Compact

Name Alisa LaPolt

Job Title Lobbyist

Address _____ Phone 443-1319
Street

_____ Email _____
City *State* *Zip*

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

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

Representing Florida Nurses Association

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1316
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Nurse Licensure Compact

Name Melody Arnold

Job Title Government Affairs Manager

Address 307 West Park Ave
Street

TLH FL 32301
City *State* *Zip*

Phone (850)224-3907

Email marnold@fhca.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Health Care Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-9-16
Meeting Date

1306 & 1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Rick Masters

Job Title Special Counsel, Nurse Licensure Compact Administrators

Address 1012 S. 4th St. (*Street*)

Phone (502) 262-5881

Louisville (*City*) Ky. (*State*) 40203 (*Zip*)

Email rmasters@csg.org

Speaking: ☑ For ☐ Against ☑ Information

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

Representing Nurse License Compact Administrators & Council of State Govts.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

SB 1306 SB 1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Rebecca Fitch

Job Title State Advocacy Associate

Address 111 E Wacker, Ste 2900
Street

Chgo IL 60601
City *State* *Zip*

Phone 312-505-3035

Email rfitch@ncsbn.org

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

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

Representing National Council of State Boards of Nursing

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

09 FEB 2016
Meeting Date

1316
Bill Number (if applicable)

Topic NURSE COMPACT LIABILITY

Amendment Barcode (if applicable)

Name PAUL JESS

Job Title

Address 218 S. MONROE ST
Street

TALLAHASSEE FL 32301
City *State* *Zip*

Phone

Email

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FLORIDA JUSTICE ASSOCIATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Martha DeCastro

Job Title VP Nursing

Address 306 E College Ave
Street

Phone 222-9800

TLH
City *State* *Zip*

Email martha@fha.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9
Meeting Date

1316
Bill Number (if applicable)

Topic R.N. Compact

Amendment Barcode (if applicable)

Name Phillis Oeters

Job Title V.P. Govt Relations

Address Baptist Health
Street

Phone

City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Laura Cantwell

Job Title ASD

Address 400 Carillon Pkwy, Suite 100
Street

St. Pete FL 33716
City *State* *Zip*

Phone 850-570-2110

Email lcantwell@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

February 9, 2016
Meeting Date

SB 1316
Bill Number (if applicable)

Topic Nurse Licensure Compact

Amendment Barcode (if applicable)

Name Debra A. Harrison

Job Title Chief Nursing Officer, Mayo Clinic

Address 4500 San Pablo Road
Street

Phone 904-953-2000

Jacksonville Florida 32224
City *State* *Zip*

Email Harrison.debra@mayo.edu

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Mayo Clinic

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1370
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Medicaid Provider Overpayments
DATE:	February 9, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1370 authorizes the Agency for Health Care Administration (AHCA) to certify that a Medicaid provider is "out of business" and that any overpayments made to that provider cannot be collected. Such an authorization allows Florida to use a federal exemption from repayment of the mandatory Medicaid federal share for provider overpayments.

The bill removes obsolete technology references to expand the types of tools available to the AHCA to curb fraud and Medicaid overpayments.

The bill appears to have a positive fiscal impact to the state.

The bill provides an effective date of July 1, 2016.

II. Present Situation:

Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and financed with federal and state funds. Over 3.7 million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over $23.4 billion.[1]

Medicaid provider agreements are voluntary contracts between the provider and the AHCA under s. 409.907, F.S., and specifies that a person or entity who enrolls in Medicaid as a provider agrees to comply with all laws, rules, and policies relating to the Medicaid program. Additionally, s. 409.907(4), F.S., specifically states:

> (4) A provider agreement shall provide that, if the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the agency Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

Office of Medicaid Program Integrity

The Office of Medicaid Program Integrity (MPI), a unit within the Office of the Inspector General at AHCA, audits Medicaid providers and determines if an overpayment has occurred requiring a provider to return funds to the Medicaid program. The AHCA also works jointly with the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs to prevent, reduce, and mitigate health care fraud, waste, and abuse. Because audits are often retrospective in nature and completed on claims data that may be two to five years old, the Medicaid provider may have gone out of business, moved, or may not otherwise be able to be located when the audit has been completed.

The MPI is statutorily required to develop statistical methodologies to identify providers who exhibit aberrant billing patterns.[2] The MPI uses these methods to perform comprehensive audits and analyses of Medicaid providers. Overpayments identified through these audits are referred to the AHCA's Division of Operations, Bureau of Financial Services for collection.[3]

Any suspected criminal violation identified by the AHCA must be referred to the MFCU of the Office of the Attorney General for investigation.[4] The MFCU is responsible for investigating and prosecuting provider fraud within the Medicaid program which commonly involves fraud related to providers billing for services not provided, overcharging for services that are provided, or

---

[1] Office of Economic and Demographic Research, *Social Services Estimating Conference* (August 4, 2015) *available at* http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Dec. 11, 2015).
[2] Section 409.913(2), F.S.
[3] Agency for Health Care Administration and the Department of Legal Affairs, *The State's Efforts to Control Medicaid Fraud and Fraud and Abuse FY 2014-2015*, p. 44 (December 15, 2015) *available at* https://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2014-15_MedicaidFraudandAbuseAnnualReport.pdf (last visited Feb. 5, 2016).
[4] Section 409.913(4), F.S.

billing for services that are medically unnecessary.[5] The AHCA and the MFCU are required to submit an annual joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year.[6]

Home Health Care Services Monitoring Project

The Florida Medicaid program has implemented several programs to ensure its recipients do not receive unnecessary and inappropriate medical care and that providers bill for services actually provided. The AHCA manages a number of quality improvement and prior authorization projects to ensure that Medicaid recipients receive medically necessary, quality care in the most cost effective manner.[7] One of the Medicaid services subject to quality improvement or prior authorization is home health services. Sandata Technologies, LLC, currently verifies the utilization and delivery of home health services through a telephone verification system using a technology called biometrics.[8] The databases contain information on home health agency staff, recipients, service authorizations, visit schedules, visit verifications, and billing activity.[9]

Federal Law on Medicaid Overpayments

Federal law requires the state to refund the federal share of any overpayment made to a Medicaid provider.[10] An overpayment occurs when a Medicaid provider is paid an amount in excess of the Medicaid established allowable amount for the service.[11] The AHCA and the MFCU discover overpayments in a variety of ways, including through data mining activities of their program integrity offices and audits by third parties, such as the federal Centers for Medicare and Medicaid Services (CMS). After one year, the state must refund the federal share of the overpayment, regardless of whether the state had actually recovered the payment from the provider.[12]

CMS requires states to report overpayments from federal audits, as well as from other sources, such as state audit results, the MFCU, and others, on its quarterly requests to the federal government for federal reimbursement for services provided under the Medicaid program.[13] If a state does not return the federal share of an overpayment within a year, the state will also be liable for interest on the federal share of the overpayments not recovered and not returned.[14]

Federal law does provides an exception to the mandatory federal share repayment provision. Audits may occur several years after the overpayment to the Medicaid provider. Sometimes, the

[5] *Supra* note 3, at 1.
[6] *Supra* note 3.
[7] Agency for Health Care Administration, *Utilization Review-Quality Assurance/Quality Improvement,* *http://ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml* (last visited Feb. 9. 2016).
[8] Id.
[9] Id.
[10] 42 U.S.C. s. 1396b(d)(2)(D); 42 C.F.R. s. 433.312. States must return the federal share of an overpayment either when it is recovered or at the end of the one year period following discovery of the overpayment, whichever is earlier.
[11] 42 C.F.R. 304.
[12] 42 C.F.R. 433.312.
[13] U.S. Government Accountability Office, *Medicaid: CMS Should Ensure That States Clearly Report Overpayments,* p. 5 (December 2013) *available at* http://www.gao.gov/assets/660/659501.pdf (last visited Feb. 5, 2016).
[14] Id., and see also 42 C.F.R. 433.320(a)(4).

Medicaid provider has gone out of business by the time the overpayment has been identified. A state is not required to refund the federal portion of the overpayment if the provider has been determined bankrupt or is out of business on the date the state has discovered the overpayment, or if the provider goes out of business before the end of one year from the date of discovery.[15]

To prove the provider is out of business, the state must:[16]

- Document its efforts to locate the party and its assets consistent with state policies and procedures; and
- Provide an affidavit or certification from the appropriate state legal authority establishing that the provider is out of business and the overpayment cannot be collected under state law and procedures and citing the effective date of that determination under state law.

Since Florida does not have a state law authorizing the AHCA to certify that a provider is out of business, the state is currently required to repay the federal share of an overpayment when a provider is out of business. As a result, the AHCA reports that Florida has refunded the federal government $7.3 million in 2011-2012 fiscal year, $1.5 million in 2012-2013 fiscal year, and $2.8 million in 2013-2014 fiscal year for the federal share of Medicaid provider overpayments that could have otherwise been retained.[17]

III. Effect of Proposed Changes:

Section 1 amends s. 409.908, F.S., to authorize the AHCA to certify a Medicaid provider as "out of business." The statutory change permits the AHCA to reclaim or retain the federal portion of Medicaid overpayments that cannot currently be collected from closed providers.

Section 2 amends s. 409.9132, F.S., to remove a reference to telephonic technology for the verification of home health service visits. This section authorizes the AHCA to use technology that is effective for identifying delivery of home health services and deterring fraudulent and abusive billing for the service. Alternate advanced technology may be available at this time.

Section 3 reenacts subsection (4) of s. 409.8132, F.S., relating to the Medikids program for the purposes of incorporating the changes to s. 409.908(25), F.S. This section is included as a cross-reference of Medicaid statutes that are also applicable to the Medikids program.

Section 4 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[15] 42 C.F.R. 433.312(b).
[16] 42 C.F.R. 433.318(d).
[17] Agency for Health Care Administration, *Senate Bill 1370 Analysis*, p. 3 (January 13, 2016) (on file with the Senate Committee on Health Policy).

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:

Taxpayers will benefit from the retention of the state's federal share of Medicaid dollars.

Private vendors who provide technology that verify the delivery of home health visits may also benefit from the ability of the AHCA to use alternative methods of identifying and deterring fraud and abuse in the Medicaid program.

C. Government Sector Impact:

The AHCA estimates the bill would result in the anticipated average retention of $1 million to $3 million per state fiscal year in federal dollars to the state.[18]

Electronic verification for home health services was mandated to help curb fraud and abuse for these services. With the majority of Medicaid recipients receiving services through managed care plans, electronic visit verification has been reduced from being statewide to operating in eight counties where service utilization remains relatively high.[19] The AHCA will be able to procure a more effective form of an electronic visit verification system upon expiration of its current system with the modification under this bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[18] Id at 4.
[19] Agency for Health Care Administration, *Senate Bill 1370 Analysis* (Feb. 3, 2016) (on file with the Senate Committee on Health Policy).

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.908 and 409.9132.

This bill reenacts section 409.8132 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 9, 2016:
The CS removes obsolete technology language which limits the AHCA's ability to use other technology to identify the delivery of home health services and deter fraudulent or abuse billing practices for these services.

B. Amendments:

None.

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

567756

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/09/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Between lines 46 and 47
insert:

Section 1. Section 409.9132, Florida Statutes, is amended to read:

409.9132 Pilot project to monitor home health services.—The Agency for Health Care Administration shall expand the home health agency monitoring pilot project in Miami-Dade County on a statewide basis effective July 1, 2012, except in counties in

567756

which the program is not cost-effective, as determined by the agency. The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims electronically for the delivery of home health services. The program must verify ~~telephonically~~ visits for the delivery of home health services by using technology that is effective for identifying delivery of the home health services and deterring fraudulent or abusive billing for these services ~~voice biometrics~~. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement or expand the pilot project. Notwithstanding s. 287.057(3)(e), the agency must award the contract through the competitive solicitation process and may use the current contract to expand the home health agency monitoring pilot project to include additional counties as authorized under this section.

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

And the title is amended as follows:

Between lines 6 and 7

insert:

amending s. 409.9132, F.S.; revising the manner in which the Medicaid program verifies a vendor's visits for the delivery of home health services;

By Senator Grimsley

21-00633-16 20161370__

A bill to be entitled

An act relating to Medicaid provider overpayments; amending s. 409.908, F.S.; authorizing the Agency for Health Care Administration to certify that a Medicaid provider is out of business and that overpayments made to a provider cannot be collected under state law; reenacting s. 409.8132(4), F.S., to incorporate the amendment made to s. 409.908, F.S., in a reference thereto; providing an effective date.

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

Section 1. Subsection (25) is added to section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on

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

21-00633-16 20161370__

behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(25) In accordance with 42 C.F.R. s. 433.318(d), the agency may certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law and procedures.

Section 2. Subsection (4) of s. 409.8132, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 409.908, Florida Statutes, in a reference thereto.

Section 3. This act shall take effect July 1, 2016.

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 14, 2016

I respectfully request that **Senate Bill #1370**, relating to Medicaid Provider Overpayments, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

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 Committee on Health Policy

BILL: CS/SB 1472

INTRODUCER: Health Policy Committee and Senator Ring

SUBJECT: Prescription Medication

DATE: February 10, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1472 amends Florida law to allow health care practitioners, at the request of their patients, to include on prescriptions for medicinal drugs, including controlled substances, and the labels of the containers for those prescriptions, the medical condition for which the drug or controlled substance is prescribed; if the prescribing practitioner obtains, and documents in the patient's medical records, a verbal or written waiver of the patient's privacy rights under the Patient's Health Insurance Portability and Accountability Act (HIPAA).

II. Present Situation:

Current Florida law allows allopathic physicians (MDs), osteopathic physicians (DOs), podiatric physicians (POs), dentists (DMDs or DDSs) and veterinarians (DVM) to prescribe medicinal drugs and controlled substances.[1] A supervising physician (MD, DO) may delegate to a physician assistant (PA) the authority to prescribe medicinal drugs for the practitioner's patients.[2] A supervising physician or dentist may delegate to an advanced registered nurse practitioner (ARNP) the authority to prescribe medicinal drugs under a protocol filed with the

[1] Chapters 458, 459, 461, 466, 455 and 893, F.S.
[2] Sections 458.347(4) and 459.022(4), F.S.

Department of Health (DOH).[3] A practitioner's prescriptions for medicinal drugs and controlled substances for a patient can be in oral, written, or electronic formats.[4]

Written and Electronic Medicinal Prescriptions

Section 456.42, F.S., requires that all written or electronic prescriptions for medicinal drugs must be legible and contain the following:

- The name of the prescribing practitioner;
- The name and strength of the drug prescribed;
- The quantity of the drug prescribed;
- The directions for use of the drug;
- The dated prescribed; and
- The signature of the prescribing practitioner, either manually or electronically.

If the substance prescribed is a controlled substance listed under ch. 893, F.S., the following additional requirements apply to an oral,[5] written, or electronic prescription:

- The quantity is written both textually and numerically;
- Must be dated numerically with the month, day and year, or with month abbreviated, or written out in whole; and
- Must be written on counterfeit-proof prescription paper or electronically prescribed as that term is defined in s. 408.0611, F.S.[6]

Drug Dispensing Practitioners

A dispensing practitioner authorized to prescribe drugs may also dispense such drugs to her or his patients in the regular course of her or his practice.[7] If the practitioner dispenses the drugs in the manufacturer's package the following information must be added, legibly, to the label:

- Practitioner's name;
- Patient's name; and
- Date dispensed.

If a dispensing practitioner dispenses drugs that are not in the manufacturer's labeled package, they must be dispensed in a container which states the following information:

- Practitioner's name;
- Patient's name;
- Date dispensed;
- Name of drug;
- Strength of drug; and

[3] Section 464.012, F.S.
[4] Section 465.003(14), F.S.
[5] A prescription for a controlled substance listed in Schedule II may generally be dispensed only upon a written prescription of a practitioner. However, in an emergency situation a Schedule II controlled substance may be dispensed upon oral prescription but is limited to a 72-hour supply and may not be refilled. See s. 893.04(1)(f), F.S.
[6] "Electronic prescribing" means, at a minimum, the electronic review of the patient's medication history, the electronic generation of the patient's prescription, and the electronic transmission of the patient's prescription to a pharmacy. Section 408.0611(2)(a), F.S.
[7] Section 456.0276, F.S.

- Directions for use.

Section 893.05, F.S., authorizes a dispensing practitioner to dispense a controlled substance; but the label of the original container must contain the following:
- The date of delivery;
- The directions for use;
- The name and address of the practitioner;
- The name of the patient, or owner and species of animal, for which a controlled substance is prescribed; and
- A warning that it is a crime to transfer the controlled substance to another person.

Pharmacists Ordering and Dispensing Drugs

Section 465.186, F.S., permits a pharmacist to order and dispense medicinal drugs[8] under certain terms and limitations[9] from a formulary[10] approved of by the Board of Pharmacy, Formulary Committee. Any drug ordered by a pharmacist must be selected and dispensed by the pharmacist ordering the drug. The order may not be refilled. The pharmacist may not order another medicinal drug for the same condition unless it is consistent with dispensing procedures. Referral to another health care provider is appropriate if, at completion of a drug regime, there is no improvement. The pharmacist must create and maintain a prescription record and a patient profile on all patients for whom he or she prescribes and dispenses medicinal drugs.[11]
The label for the container for a medicinal drug ordered and dispensed by a pharmacist must contain the following information:
- The name of the pharmacist ordering the medication;
- The name and address of the pharmacy from which the medication was dispensed;
- The date of dispensing;
- The order number or other identification to readily identify the order;
- The name of the patient;
- The directions for use; and
- A statement that the order will not be refilled.

Section 893.04, F.S., authorized a pharmacist, in the course of his or her professional practice, to dispense controlled substances upon a written or oral[12] prescription of a practitioner.[13] The oral prescriptions must be promptly reduced to writing by the pharmacist, or recorded electronically. The written prescription must be dated and signed by the prescribing practitioner on the day when issued. The oral, written, or electronic prescription for a controlled substance must contain the following information:

[8] Rules 64B8-36.002-004, and 64B16-27.210- 230, F.A.C., implement s. 465.186, F.S. These rules set forth which medicinal drug products may be ordered and dispensed by pharmacists and the terms and conditions under which said drugs may be ordered and dispensed.
[9] Rule 64B16-27.210, and Rule 64B8-36.002, F.A.C.
[10] Rule 64B16-27.220, and Rule 64B8-36.003, F.A.C.
[11] Rule 64B16-27.210(7), F.A.C.
[12] Any controlled substance listed in Schedule III or Schedule IV may be dispensed by a pharmacist upon an oral prescription if, before filling the prescription, the pharmacist reduces it to writing or records the prescription electronically if permitted by federal law. Such prescriptions must contain the date of the oral authorization. Section 893.04(2)(c), F.S.
[13] *Supra* note 5.

- The full name and address of the person for whom the controlled substance is dispensed;
- The name and address of the owner, and species of the animal, for whom the controlled substance is dispensed;
- The full name and address of the prescribing practitioner and the practitioner's federal controlled substance registry number;
- The name of the controlled substance and the strength, quantity, and directions for use;
- The prescription number;
- The date and initials of the pharmacist filling the prescription;

The label of the container in which a controlled substance is initially delivered, or refilled, must contain the following information:

- The name and address of the dispensing pharmacy;
- The date filled;
- The prescription number as recorded in the pharmacy;
- The name of the prescribing practitioner;
- The name of the patient, or owner and species of the animal;
- The directions for the use; and
- A warning that it is a crime to transfer the controlled substance to any person other than the patient for whom prescribed.

The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996.[14] The HIPAA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information.[15] The *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) establishes a set of national standards for the protection of certain health information. The HHS issued the Privacy Rule to implement HIPAA. The Privacy Rule standards address the use and disclosure of individuals' *protected health information* by organizations subject to the privacy rule as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights (OCR) has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party. Health care providers include all "providers of services" (e.g., hospitals) and "providers of medical or health services" (e.g., physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care. The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered person or entity, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)." PHI is information, including demographic data (e.g., name, address, birth date, social security number) that relates to:

[14] Pub. Law No. 104-191, H.R. 3103, 104th Cong. (Aug. 21, 1996).
[15] U.S. Department of Health and Human Services, *Summary of the HIPAA Privacy Rule* (last revised May 2003) *available at* http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last visited Feb.3, 2016).

- 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 it can be used to identify the individual.[16]

A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered person or entity must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request.[17]

Exceptions to HIPAA

In general, State laws that are contrary to the Privacy Rule are preempted by the federal law.[18] However, preemption of a state law will not occur if HHS determines, in response to a request from a state, entity or person, that the state law:

- Is necessary to prevent fraud and abuse related to the provision of or payment for health care;
- Is necessary to ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation;
- Is necessary for state reporting on health care delivery or costs;
- Is necessary for purposes of serving a compelling public health, safety, or welfare need, and, if a Privacy Rule provision is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or
- Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances or that is deemed a controlled substance by state law.

In addition, a covered person or entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations:

- To the Individual, or his or her legal representative;
- Treatment, payment, and health care operations;
- Opportunity to agree or object;
- Incident to an otherwise permitted use and disclosure;
- Public interest and benefit activities; and
- As a limited data set for the purposes of research, public health or health care operations.[19]

Covered persons and entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

[16] 45 C.F.R. s. 160.103.
[17] See 45 C.F.R. ss. 164.502(b) and 164.514 (d).
[18] 45 C.F.R. s. 160.203.
[19] 45 C.F.R. s. 164.502(a)(1).

III. Effect of Proposed Changes:

CS/SB 1472 amends s. 456.42, F.S., to allow physicians, dentists, ARNP's, PAs, and pharmacists to include on written or electronic prescriptions, and some oral prescriptions, issued by health care practitioners licensed by law to prescribe medicinal drugs, including controlled substances listed in ch. 893, F.S., and on the labels for the containers used to dispense those prescriptions, the medical condition for which the drug is prescribed, if:

- The patient requests the health care provider to include the medical condition for which a medication is being prescribed on the prescription and medication dispensing container; and
- The prescribing healthcare practitioner obtains from the patient, or his or her legal representative, a verbal or written waiver of the patient's protected privacy rights under HIPAA which is documented in the patient's medical records.

The bill is effective July 1, 2016.

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:

Displaying the condition for which a particular medication was prescribed might prevent patients from incorrectly taking their medications, resulting in increased health care services.

The additional requirement may impact practitioner efficiency in the delivery of health care services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. None. Statutes Affected:

This bill substantially amends section 456.42 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 9, 2016:
The CS authorizes, rather than requires, a health care practitioner to include the condition for which a drug is prescribed on the prescription, and dispensing container label, upon a patient's request and consent.

B. Amendments:

None.

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

710268

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/09/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (3) is added to section 456.42, Florida Statutes, to read:

456.42 Written prescriptions for medicinal drugs.—

(3) A health care practitioner licensed by law to prescribe medicinal drugs, or controlled substances listed in chapter 893, may, upon the request of the patient or his or her legal

710268

representative, include on a written or electronic prescription the medical condition for which the drug or controlled substance is being prescribed, and direct the pharmacist or dispensing practitioner to include the condition on the label of the dispensing container, if the health care practitioner prescribing the medicinal drug or controlled substance has first obtained from the patient or his or her legal representative a written or verbal waiver, documented in the patient's medical records, of the patient's privacy rights under the Health Insurance Portability and Accountability Act, or successor acts, for the health care practitioner to include the patient's medical condition on the prescription and the dispensing container.

Section 2. This act shall take effect July 1, 2016.

========== 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 prescribing medicinal drugs and controlled substances; amending s. 456.42, F.S.; authorizing certain health care practitioners to include medical conditions on prescriptions if a certain waiver is obtained, and to direct pharmacists and dispensing practitioners to include the conditions on the labels of dispensing containers; providing an effective date.

By Senator Ring

29-01260-16 20161472__

A bill to be entitled

An act relating to prescription medication; amending s. 456.42, F.S.; revising requirements for a written prescription for a medicinal drug issued by a licensed health care practitioner to include notification of the medical condition for which the drug is prescribed; amending s. 465.0276, F.S.; revising requirements for the dispensing of complimentary packages of medicinal drugs by a licensed health care practitioner to his or her patient to include notification of the medical condition for which the drug is prescribed; amending s. 465.186, F.S.; revising requirements for the ordering and dispensing of medicinal drugs by a licensed pharmacist to include notification of the medical condition for which the drug is prescribed; amending s. 893.04, F.S.; revising requirements for the dispensing of a controlled substance by a licensed pharmacist to include notification of the medical condition for which the controlled substance is prescribed; amending s. 893.05, F.S.; revising requirements for the dispensing of a controlled substance by a practitioner to include notification of the medical condition for which the controlled substance is prescribed; providing an effective date.

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

Section 1. Subsection (1) of section 456.42, Florida Statutes, is amended to read:

456.42 Written prescriptions for medicinal drugs.—

(1) A written prescription for a medicinal drug issued by a

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

29-01260-16 20161472__

health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed, ~~and~~ the directions for use of the drug, and the medical condition for which the drug is prescribed; must be dated; and must be signed by the prescribing practitioner on the day when issued. However, a prescription that is electronically generated and transmitted must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in numerical format, ~~and~~ the directions for use of the drug, and the medical condition for which the drug is prescribed and must be dated and signed by the prescribing practitioner only on the day issued, which signature may be in an electronic format as defined in s. 668.003(4).

Section 2. Subsection (5) of section 465.0276, Florida Statutes, is amended to read:

465.0276 Dispensing practitioner.—

(5) A practitioner who confines her or his activities to the dispensing of complimentary packages of medicinal drugs to the practitioner's own patients in the regular course of her or his practice, without the payment of fee or remuneration of any kind, whether direct or indirect, and who herself or himself dispenses such drugs is not required to register pursuant to this section. The practitioner must dispense such drugs in the manufacturer's labeled package with the practitioner's name, patient's name, ~~and~~ date dispensed, and the medical condition

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

for which the drug is prescribed written on the package, or, if such drugs are not dispensed in the manufacturer's labeled package, they must be dispensed in a container which bears the following information:

(a) Practitioner's name;

(b) Patient's name;

(c) Date dispensed;

(d) Name and strength of drug; ~~and~~

(e) Directions for use; and~~.~~

(f) The medical condition for which the drug is prescribed.

Section 3. Present paragraph (g) of subsection (3) of section 465.186, Florida Statutes, is redesignated as paragraph (h) and a new paragraph (g) is added to that subsection, to read:

465.186 Pharmacist's order for medicinal drugs; dispensing procedure; development of formulary.—

(3) Affixed to the container containing a medicinal drug dispensed pursuant to this section shall be a label bearing the following information:

(g) The medical condition for which the drug is prescribed.

Section 4. Paragraphs (c) and (e) of subsection (1) of section 893.04, Florida Statutes, are amended to read:

893.04 Pharmacist and practitioner.—

(1) A pharmacist, in good faith and in the course of professional practice only, may dispense controlled substances upon a written or oral prescription of a practitioner, under the following conditions:

(c) There shall appear on the face of the prescription or written record thereof for the controlled substance the

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

following information:

1. The full name and address of the person for whom, or the owner of the animal for which, the controlled substance is dispensed.

2. The full name and address of the prescribing practitioner and the practitioner's federal controlled substance registry number shall be printed thereon.

3. If the prescription is for an animal, the species of animal for which the controlled substance is prescribed.

4. The name of the controlled substance prescribed and the strength, quantity, and directions for use thereof.

5. The medical condition for which the controlled substance is prescribed.

6.~~5.~~ The number of the prescription, as recorded in the prescription files of the pharmacy in which it is filled.

7.~~6.~~ The initials of the pharmacist filling the prescription and the date filled.

(e) Affixed to the original container in which a controlled substance is delivered upon a prescription or authorized refill thereof, as hereinafter provided, there shall be a label bearing the following information:

1. The name and address of the pharmacy from which such controlled substance was dispensed.

2. The date on which the prescription for such controlled substance was filled.

3. The number of such prescription, as recorded in the prescription files of the pharmacy in which it is filled.

4. The name of the prescribing practitioner.

5. The name of the patient for whom, or of the owner and

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species of the animal for which, the controlled substance is prescribed.

6. The directions for the use of the controlled substance prescribed in the prescription.

7. The medical condition for which the controlled substance is prescribed.

8.~~7.~~ A clear, concise warning that it is a crime to transfer the controlled substance to any person other than the patient for whom prescribed.

Section 5. Subsection (2) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(2) When any controlled substance is dispensed by a practitioner, there shall be affixed to the original container in which the controlled substance is delivered a label on which appears:

(a) The date of delivery.

(b) The directions for use of such controlled substance.

(c) The medical condition for which the controlled substance is prescribed.

(d)~~(c)~~ The name and address of such practitioner.

(e)~~(d)~~ The name of the patient and, if such controlled substance is prescribed for an animal, a statement describing the species of the animal.

(f)~~(e)~~ A clear, concise warning that it is a crime to transfer the controlled substance to any person other than the patient for whom prescribed.

Section 6. This act shall take effect July 1, 2016.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Governmental Oversight and Accountability, *Chair*
Judiciary, *Vice Chair*
Appropriations
Appropriations Subcommittee on Education
Children, Families, and Elder Affairs
Commerce and Tourism

JOINT COMMITTEE:
Joint Select Committee on Collective Bargaining

SENATOR JEREMY RING
29th District

January 19, 2016

Honorable Senator Aaron Bean, Chair
Committee on Health Policy
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Chairman Bean,

I am writing to respectfully request your cooperation in placing Senate Bill 1472, relating to Prescription Medication, on the Committee on Health Policy agenda at your earliest convenience. I would greatly appreciate the opportunity to discuss the bill at greater length before your committee.

Thank you in advance for your assistance. As always, please do not hesitate to contact me with any questions or comments you may have.

Very Truly Yours,

Jeremy Ring

Jeremy Ring
Senator District 29

cc: Sandra Stovall, Staff Director
Celia Georgiades, Committee Administrative Assistant

REPLY TO:
❒ 5790 Margate Boulevard, Margate, Florida 33063 (954) 917-1392 FAX: (954) 917-1394
❒ 405 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5029

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Governmental Oversight and Accountability, *Chair*
Judiciary, *Vice Chair*
Appropriations
Appropriations Subcommittee on Education
Children, Families, and Elder Affairs
Commerce and Tourism

JOINT COMMITTEE:
Joint Select Committee on Collective Bargaining

SENATOR JEREMY RING
29th District

February 9, 2016

Honorable Senator Aaron Bean, Chair
Committee on Health Policy
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Chairman Bean,

I appreciate you including SB 1472, relating to Prescription Drugs, on the Health Policy agenda. Unfortunately, due to quorum issues, I need to be chairing the Government Oversight and Accountability Committee at that time. Therefore, I respectfully request that my Legislative Assistant J.J. Piskadlo be allowed to present the bill on my behalf.

Thank you in advance for your assistance. As always, please do not hesitate to contact me with any questions or comments you may have.

Very Truly Yours,

Jeremy Ring

Jeremy Ring
Senator District 29

cc: Sandra Stovall, Staff Director
Celia Georgiades, Committee Administrative Assistant

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❒ 5790 Margate Boulevard, Margate, Florida 33063 (954) 917-1392 FAX: (954) 917-1394
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Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

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 Committee on Health Policy

BILL:	CS/SB 1518
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Cardiovascular Services
DATE:	February 11, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1518 authorizes nursing and technical cardiac interventional laboratory staff to earn the required hours of training experience in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open-heart-surgery program (a Level I adult cardiovascular services (ACS) program) if, throughout the training period, the cardiac interventional laboratory meets certain volume and quality performance measures. Currently this training may only be provided in a Level II ACS program, which is one that provides onsite cardiac surgery.

The bill also creates the Pediatric Cardiac Advisory Council (council) within the Department of Health (department) for the purpose of advising the department on the delivery of cardiac services to children. The bill specifies the duties and composition of the council.

The department, in coordination with the Agency for Health Administration (AHCA), is authorized to develop rules related to pediatric cardiac facilities participating in the Children's Medical Services Network. The bill creates the "Pediatric and Congenital Centers of Excellence" designation for facilities that meet standards established by the council and approved by the Director of Children's Medical Services and the State Surgeon General utilizing state and national professional standards.

Additionally, the bill provides that rules relating to pediatric cardiac services and facilities in effect on October 1, 2015, are authorized and remain in effect until amended.

The bill further requires the council to submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the State Surgeon General summarizing the council's activities for the preceding fiscal year, including specified data and performance measures of cardiac facilities participating in the Children's Medical Services Network, and recommending policy and procedural changes.

II. Present Situation:

Percutaneous cardiac intervention (PCI), also commonly known as coronary angioplasty or just angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease, including unstable angina, acute myocardial infarction, and multivessel coronary artery disease.[1]

PCI uses a catheter (a thin flexible tube) to place a small structure called a stent to open up blood vessels in the heart that have been narrowed by plaque buildup, a condition known as atherosclerosis. A catheter is inserted into the blood vessels either in the groin or in the arm. Using a special type of X-ray called fluoroscopy, the catheter is threaded through the blood vessels into the heart where the coronary artery is narrowed. When the tip is in place, a balloon tip covered with a stent is inflated. The balloon tip compresses the plaque and expands the stent. Once the plaque is compressed and the stent is in place, the balloon is deflated and withdrawn. The stent stays in the artery, holding it open.[2]

Hospital Licensure and Regulation

Hospitals are regulated by the AHCA under ch. 395, F.S., and the general licensure provisions of part II of ch. 408, F.S. Hospitals are subject to the CON provisions in part I of ch. 408, F.S. A CON is a written statement issued by the AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service.[3]

Adult cardiovascular services (ACS), including PCI were previously regulated through the CON program.[4] However, in 2004, the Legislature established a licensure process for adult interventional cardiology services (the predecessor terminology for ACS), dependent upon rulemaking, in lieu of the CON procedure.[5] Among other things, that law required the rules to establish two hospital program licensure levels: a Level I program authorizing the performance of adult primary PCI for emergency patients without onsite cardiac surgery and a Level II program authorizing the performance of PCI with onsite cardiac surgery.[6] Additionally the rules

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[1] Medscape: Percutaneous cardiac intervention, http://emedicine.medscape.com/article/161446-overview, (last visited Feb. 4, 2016).
[2] Heart and Stroke Foundation, http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3831925/k.4F32/Heart_disease__Percutaneous_coronary_intervention_PCI_or_angioplasty_with_stent.htm, (last visited Feb. 4, 2016).
[3] Section 408.032(3), F.S.
[4] *See* s. 408.036(3)(m) and (n), F.S., allowing for an exemption from the full review process for certain adult open-heart services and PCI services.
[5] Ch. 2004-383, s. 7, Laws of Fla.
[6] Level I and Level II ACS programs may also perform adult diagnostic cardiac catheterization in accordance with Rule 59A-3.2085(13), F.A.C. Adult diagnostic cardiac catheterization involves the insertion of a catheter into one or more heart chambers for the purpose of diagnosing cardiovascular diseases.

must require compliance with the most recent guidelines of the American College of Cardiology and American Heart Association guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient-selection criteria to ensure patient quality and safety.[7]

The AHCA adopted rules for Level I ACS[8] and Level II ACS.[9] The staffing rules within a Level I ACS require:

- Each cardiologist to be an experienced physician who has performed a minimum of 75 interventional cardiology procedures within the previous 12 months, or those physicians with less than 12 months experience, to fulfill specified training requirements.
- The nursing and technical catheterization laboratory staff must meet the following requirements:
  - Be experienced in handling acutely ill patients requiring intervention or balloon pump;
  - Have at least 500 hours of previous experience in dedicated cardiac interventional laboratories at a hospital with a Level II ACS program;[10]
  - Be skilled in all aspects of interventional cardiology equipment; and
  - Participate in a 24-hour-per-day, 365 day-per-year call schedule.
- The hospital to ensure that a member of the cardiac care nursing staff who is adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management be in the hospital at all times.

The staffing rules within a Level II ACS require:

- Each cardiac surgeon to be Board certified, new surgeons must be Board certified within four years after completion of their fellowship, and experienced surgeons with greater than 10 years of experience may document that their training and experience preceded the availability of Board certification, if applicable.
- Each cardiologist to be an experienced physician who has performed a minimum of 75 interventional cardiology procedures within the previous 12 months.
- The nursing and technical catheterization laboratory staff must meet the following requirements:
  - Be experienced in handling acutely ill patients requiring intervention or balloon pump;
  - Have at least 500 hours of previous experience in dedicated cardiac interventional laboratories at a hospital with a Level II ACS program;
  - Be skilled in all aspects of interventional cardiology equipment; and
  - Participate in a 24-hour-per-day, 365 day-per-year call schedule.
- The hospital to ensure that a member of the cardiac care nursing staff who is adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management be in the hospital at all times.

One of the authoritative sources referenced in the AHCA's rulemaking is The American College of Cardiology/American Heart Association Task Force on Practice Guidelines' report:

[7] *See* s. 408.0361(3), F.S.
[8] Rule 59A-3.2085(16), F.A.C.
[9] Rule 59A-3.2085(17), F.A.C.
[10] The standard in the CON exemption in s. 408.036(3)(n), F.S., for providing PCI in a hospital without an approved adult open-heart-surgery program required previous experience in dedicated interventional laboratories or surgical centers.

ACC/AHA/SCAI 2005 Guideline Update for PCI.[11] Table 15 in that report provides criteria for the performance of primary PCI at hospitals without on-site cardiac surgery. It states:

> The nursing and technical catheterization laboratory staff must be experience in handling acutely ill patients and must be comfortable within interventional equipment. They must have acquired experience in dedicated interventional laboratories at a surgical center.

In 2014, the Society for Cardiovascular Angiography and Interventions, the American College of Cardiology Foundation, and the American Heart Association, Inc., issued the SCAI/ACC/AHA Expert Consensus Document: 2014 Update on PCI Without On-Site Surgical Backup.[12] That report acknowledged advances and best practices in PCI performed in hospitals without on-site surgery. Table IV in that report addresses personnel requirements for PCI programs without on-site surgery. It recommends the program have experienced nursing and technical laboratory staff with training in interventional laboratories. The report does not reference a requirement that the training or experience should occur in a dedicated interventional laboratory at a surgical center.

As of February 7, 2016, there are 52 hospitals providing Level I ACS services and 77 hospitals providing Level II ACS services.[13]

Children's Medical Services

Children's Medical Services (CMS) is a group of programs that serve children with special health care needs under the supervision of the department. Within CMS, individual services or programs are designed to address specific conditions or family needs such as the newborn screening program, early intervention screenings, or its managed medical assistance plan. CMS is created under ch. 391, F.S., which is divided into three parts: Part I (General Provisions), Part II (Children's Medical Services Councils and Panels), and Part III (Developmental Evaluation and Intervention Programs).

Statewide Children's Medical Services Network Advisory Council

The State Surgeon General has the discretion under s. 391.221, F.S., to appoint a 12-member Statewide Children's Medical Services Network Advisory Council to serve as an advisory body to the department. The council's duties include, but are not limited to:

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[11]Smith SC Jr, Feldman TE, Hirshfeld JW Jr, Jacobs AK, Kern MJ, King SB III, Morrison DA, O'Neill WW, Schaff HV, Whitlow PL, Williams DO. ACC/AHA/SCAI 2005 guideline update for percutaneous coronary intervention: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention). the Society for Cardiovascular Angiography and Interventions Web Site. Available at: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwizrYy2zubKAhUBfSYKHafZCiAQFggvMAI&url=http%3A%2F%2Fwww.scai.org%2Fasset.axd%3Fid%3Da1d96b40-b6c7-42e7-9b71-1090e581b58c%26t%3D634128854999430000&usg=AFQjCNF0t0334L9yMm_XLA5rl0pXoCvPDw (last visited February 7, 2016).

[12] Gregory J. Dehmer, et.al, *available at* http://circ.ahajournals.org/content/129/24/2610.full.pdf+html (last visited Feb. 7, 2016).

[13] *See* The AHCA FloridaHealthFinder.gov *available at* http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx, (last visited Feb. 2, 2016).

- Recommending standards and credentialing requirements for health care providers in the CMS Network (Network);
- Making recommendations to the director of CMS concerning the selection of CMS providers;
- Providing input to the CMS program on the policies governing the Network;
- Reviewing the financial reports and financial status of the Network and making recommendations concerning the methods of payment and costs controls for the Network;
- Reviewing and recommending the scope of benefits for the Network; and
- Reviewing Network performance measures and outcomes and making recommendations for improvements to the Network and its maintenance and collection of data and information.

Council members represent the private health care provider sector, families of children with special health care needs, AHCA, the Chief Financial Officer, the Florida Chapter of the American Academy of Pediatrics, an academic pediatric program, and the health insurance industry.[14] The four-year terms were initially staggered and no member can be appointed for more than two consecutive terms. Members do not receive any compensation for their appointment except they are reimbursed for per diem and travel in accordance with s. 112.061, F.S.[15]

The department does not currently have an appointed Statewide Children's Medical Services Network Advisory Council.

Cardiac Technical Advisory Panel

The State Surgeon General also has general authority under s. 391.223, F.S., to establish technical advisory panels to assist with the development of specific policies and procedures for the CMS program. On October 21, 2013, State Surgeon General John Armstrong created the Children's Medical Services Cardiac Technical Advisory Panel (CTAP) to provide both programmatic and technical advice to the department and its CMS program.[16] The enabling document provides several charges to the panel:

- Developing recommended standards for personnel and facilities rendering pediatric congenital cardiac services as well as heart disease;
- Developing recommendations for legislative initiatives, including appropriation items, related to the cardiac program and developing rules;
- Developing recommendations for statewide cardiac initiatives, including identifying panel members who will collaborate with other department councils or committees or state agencies;
- Assisting AHCA, or as requested by individual hospitals, or as outlined in their individual contract with CMS, with the ongoing evaluation and development of congenital cardiovascular programs;
- Making a priority weight control programs and their implementation in all pediatric cardiovascular centers and clinics; and

[14] Section 391.221(2), F.S.
[15] Section 391.221 (3), F.S.
[16] Florida Dep't of Health, *Creation of the Children's Medical Services Cardiac Technical Advisory Panel,* (October 2013) http://www.cmsctap.com/_files/documents/CTAP-Creation.pdf (Last visited Oct. 6, 2015).

- Developing recommendations to the department and AHCA for congenital heart disease quality improvement to improve patient care and health and decrease the cost of care.[17]

The CTAP membership is appointed by the State Surgeon General, in consultation with the Deputy Secretary of CMS and the Director of the Division of CMS. Eleven members are designated in the creation document. They represent pediatric cardiologists or cardiovascular surgeons from specific pediatric cardiovascular children's hospitals across the state and include two at-large physicians and a community physician who are not affiliated with one of the named facilities. Non-voting advisory members may also be named by the State Surgeon General who may deliberate, but not vote, with the panel. Alternate members for each representative of the cardiovascular children's hospitals must also be named.

Under the creation document, CTAP members select their Chairperson and Vice Chairperson through majority vote every two years. Meetings of the CMS CTAP are upon the call of the Chairperson, at the request of the State Surgeon General, the Deputy Secretary of CMS, the Director of the Division of CMS, or the majority of the voting members.[18]

Members are reimbursed for per diem and travel expenses for required attendance at in-person or video conference committee meetings or CMS site visits in accordance with s. 112.061, F.S.[19]

Department of Health's Proposed Repeal of Rule 64C-4.003, F.A.C.

Rule 64C-4.003, F.A.C., establishes and incorporates by reference quality assurance standards and criteria for the approval and operation of CMS pediatric cardiac facilities.

On October 12, 2015, the department held a rule hearing regarding the proposed repeal of the standards for pediatric cardiac facilities, Rule 64C-4.003, F.A.C., as the department determined there was no statutory authority for it to establish standards, inspect facilities, or prepare inspection reports for the technical advisory panel to review.[20] A Petition for Determination of Invalidity of Proposed Rule regarding the proposed repeal of Rule 64C-4.003, F.A.C., was filed with the Division of Administrative Hearings (DOAH). The DOAH judge issued a final order on December 16, 2015, ruling that Petitioners did not have standing to challenge the proposed rule, and therefore he was without jurisdiction to rule on the merits of the rule challenge.[21] An appeal to that order was filed in the First District Court of Appeal on December 31, 2015.

[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] Fla. Department of Health, *2016 Agency Bill Analysis - SB 378*, p. 2,(Sept. 29, 2015) (on file with the Senate Committee on Health Policy)
[21] W.D., C.V., K.E. and K.M., vs. Department of Health, Florida Division of Administrative Hearing, Case no. 15-6009RP, available at: https://www.doah.state.fl.us/ROS/2015/15006009.pdf (last visited on Feb. 8, 2016).

Cardiac Advisory Council

Prior to the 2001 Regular Session, a Cardiac Advisory Council in the Division of CMS existed.[22] The council was appointed by the secretary of the department and included eight members with technical expertise in cardiac medicine who were charged with:

- Recommending standards for personnel and facilities rendering cardiac services;
- Receiving reports of the periodic review of cardiac personnel and facilities to determine if established standards for cardiac care are met;
- Making recommendations to the director as to the approval or disapproval of reviewed personnel and facilities; and
- Providing input on all aspects of the CMS cardiac program, including the rulemaking process.[23]

The statute was repealed effective June 30, 2001, as part of an exhaustive review of more than three dozen boards, committees, commissions, and councils to determine whether to continue or abolish each entity.[24] The department recommended the repeal of the council and indicated it would absorb the functions of the council in 2001.[25]

Statutory Organization: Advisory Councils

Chapter 20, F.S., authorizes the creation of a number of different types of entities to assist state government in the efficient performance of its duties and functions. Under s. 20.03(7), F.S., a "council" or "advisory council" is defined as:

> an advisory body created by specific statutory enactment and appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives.

Advisory bodies, commissions and boards may only be created by statute in furtherance of a public purpose[26] and meet a statutorily defined purpose.[27] Such advisory bodies, commissions and boards must be terminated by the Legislature once the body, commission or board notifies the Legislature when it is no longer necessary and beneficial to the furtherance of a public purpose.[28] The Legislature and the public must be kept informed of the numbers, purposes, memberships, activities, and expenses of advisory bodies, commissions and boards.[29] Members of such bodies are appointed for staggered, four-year terms and unless otherwise provided in the

[22] *See* s. 391.222, F.S. (2000).
[23] *Id.*
[24] Chapter 2001-89, s. 27, Laws of Fla.
[25] Senate Committee on Governmental Oversight and Productivity, *CS/SB 1410 Staff Analysis and Economic Impact Statement* (March 28, 2001) *p. 9*, http://archive.flsenate.gov/data/session/2001/Senate/bills/analysis/pdf/2001s1410.go.pdf (Last visited Oct. 6, 2015).
[26] Section 20.052(1), F.S.
[27] Section 20.052(4)(a), F.S.
[28] Section 20.052(2), F.S.
[29] Section 20.052(3), F.S.

State Constitution,[30] serve without compensation, but are authorized to receive reimbursement for per diem and travel as provided in s. 112.061, F.S.[31]

Private citizen appointees to an advisory body that is adjunct to an executive agency must be appointed by the Governor, the head of the department, the executive director of the department, or a Cabinet officer.[32] Private citizen appointees to a board or commission that is adjunct to an executive agency must be appointed by the Governor, unless otherwise provided by law, confirmed by the Senate, and are subject to dual office holding provisions of s. 5(a), Art. II of the State Constitution.[33]

Unless exempted, all meetings of advisory bodies, boards and commissions are subject to public meetings requirements under s. 286.011, F.S., and minutes must be maintained for all meetings.[34]

Technical advisory panels are not separately defined in statute.

Rulemaking

Rulemaking is required by Florida's Administrative Procedure Act (APA) whenever a government agency has express authority to make rules, and must resort to rulemaking in order to implement, interpret, or prescribe law, policy, or requirements,[35] including mandatory forms.[36] Rulemaking is not discretionary under the APA.[37]

III. Effect of Proposed Changes:

Section 1 creates s. 391.224, F.S., and the Pediatric Cardiac Advisory Council (council) under the Department of Health (department) for the purpose of coordinating pediatric cardiac care in this state and advising the department and the Agency for Health Care Administration (AHCA) on the delivery of cardiac services to children.

The advisory council will be composed of no more than 13 voting members with expertise in cardiac medicine appointed by the State Surgeon General, and members will serve staggered four-year terms. Eight of the members who are either pediatric cardiologists or pediatric cardiovascular surgeons must be nominated by the chief executive officers of designated health care systems with pediatric cardiac certificates of need. A hospital with a certificate of need for a pediatric cardiac program that meets state and national standards as determined by the council following an on-site visit by a panel from the council shall have one of its pediatric cardiologists or pediatric cardiovascular surgeons who has been nominated by its chief executive officer and approved by the State Surgeon General appointed to the council as a new voting member.

[30] Section 20.052(4)(c), F.S.
[31] Section 20.052(4)(d), F.S.
[32] Section 20.052(5)(a), F.S.
[33] Section 20.052(5)(b), F.S.
[34] Section 20.052(5)(c), F.S.

[36] *Dep't of Bus. Reg., Div. of Alcoholic Bev. & Tobacco v. Martin County Liquors, Inc.*, 574 So.2d 170 (Fla. 1st DCA 1991).
[37] Section 120.54(1)(a), F.S.

The State Surgeon General is also authorized to select additional at-large members, with expertise in pediatric cardiology or adults with congenital heart disease who are not associated with one of the designated facilities. Additional advisory, non-voting members may also be appointed to the council by the State Surgeon General, one of whom must be a representative from a pediatric health advocacy group.

The voting privilege of a voting member of the advisory council must be suspended if the facility he or she represents no longer meets state and national standards as adopted by the council. Such individual may remain a member of the council in an advisory capacity but shall relinquish voting privileges until his or her facility meets required standards.

The bill requires the Council to meet at least quarterly. Meetings may also be called by the Chair, two or more voting members, or the State Surgeon General. An employee of the department or a contracted consultant paid by the department is not eligible to serve as a member or ex-officio member and no member may serve more than two consecutive terms.

Council members do not receive compensation; however, they are entitled to reimbursement in accordance with s. 112.061, F.S., for per diem and travel. Council meetings must be conducted via teleconference where that capability is available.

The council's duties include, but are not limited to:

- Recommending standards for personnel and facilities rendering cardiac services;
- Analyzing reports on the periodic review of cardiac personnel and facilities to determine if established standards for the cardiac services are met;
- Making recommendations to the CMS Director as to the approval or disapproval of personnel and facilities;
- Making recommendations as to the intervals for re-inspection of approved personnel and facilities;
- Reviewing and inspecting hospitals upon the request of the hospital, the department, or AHCA to determine if established state and national standards for cardiac services are met;
- Providing input on all aspects of the state's Children's Medical Services cardiac programs, including rulemaking;
- Addressing all components of the care of adults and children with congenital heart disease and children with acquired heart disease, as indicated and appropriate;
- Abiding by the recognized state and national professional standards of care for children with heart disease;
- Making recommendations to the State Surgeon General for legislation and appropriations for children's cardiac services; and
- Providing advisory opinions to AHCA before AHCA approves a certificate of need for children's cardiac services.

The bill also authorizes the creation of the "Pediatric and Congenital Centers of Excellence" designation. The designation may be awarded to facilities at the recommendation of the council with the approval of the Director of Children's Medical Services and the State Surgeon General utilizing state and national professional standards approved by the council. The designation shall be withdrawn automatically if a facility no longer meets those standards.

The council shall also develop and recommend to the State Surgeon General evaluation tools for measuring the goals and performance standards for the facilities seeking and receiving the designation.

The council must submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the State Surgeon General by each January 1, beginning in 2017. This report must summarize the council's activities for the preceding fiscal year and include data and performance measures for all pediatric cardiac facilities that participate in the Network relating to surgical morbidity and mortality. The annual report must also recommend any policy or procedural changes that would increase the council's effectiveness in monitoring pediatric cardiovascular programs in the state.

The department, in coordination with AHCA, shall develop rules related to pediatric cardiac facilities that participate in the Network. These rules may establish standards relating to the training and credentialing of medical and surgical personnel, facility and physician minimum case volumes, and date reporting requirements for monitoring and enhancing quality assurance. Also, the department is authorized to develop rules related to the establishment, operations, and authority of the council, and the establishment, goals, performance standards, and evaluation tools for designating facilities as "Pediatric and Congenital Cardiovascular Centers of Excellence."

The bill ratifies rules relating to pediatric services and facilities in effect on October 1, 2015, by providing these rules are authorized and shall remain in effect until amended.[38]

Section 2 amends s. 408.0361(3)(b), to require the AHCA to adopt or update rules relating to nursing and technical staff experience in dedicated cardiac interventional laboratories or surgical centers. The bill specifies that if a nurse's or technical staff member's prior experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open-heart-surgery program (Level I hospital), the previous experience qualifies only if, while the staff member acquires his or her experience, the dedicated cardiac interventional laboratory:

- Had an annual volume of 500 or more PCI procedures;
- Achieved a demonstrated PCI success rate of 95 percent or greater;
- Experienced a complication rate of less than 5 percent for PCI procedures; and
- Performed varied cardiac procedures, including, but not limited to balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

The effective date of the bill is July 1, 2016.

[38] Rule 64C-4.003, F.A.C., Diagnostic and Treatment Facilities or Services – Specific incorporates by reference the CMS Pediatric Cardiac Facilities Standards, October 2012, and requires CMS approved pediatric cardiac facilities to collect and submit quality assurance data annually relating to pediatric cardiology clinic laboratory procedures, cardiac catheterization procedures, cardiac catheterization cases-primary cardiac diagnoses, and patients with fetal diagnosis of heart conditions. The rule also provides for the approval of regional and satellite cardiac clinics for the CMS Network on a statewide basis and requires these clinics to comply with the CMS cardiac regional and satellite clinic standards, October 2012.

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:

Facilities will have the opportunity to earn a designation as a "Pediatric and Congenital Center of Excellence." This designation may distinguish one facility over another in the marketplace for the quality of care in the delivery of cardiac services to children and may impact the number of services delivered in a particular facility.

Level I hospitals may find it easier to maintain sufficient competent nursing and technical catheterization laboratory staff by allowing additional qualified programs to provide the pre-requisite training.

C. Government Sector Impact:

The council is housed in the department and makes recommendations to the State Surgeon General and the Children's Medical Services program. Since October 2013, the department has been supporting a similar technical advisory panel, the Children's Medical Services Cardiac Technical Advisory Panel, and this bill includes similar duties and responsibilities of that technical advisory panel. With passage of this bill, the technical advisory panel will no longer be necessary.

The department estimates minimal costs for the council for conference calls at $336 annually. The estimate is based on four calls per year, 40 persons per call for one hour at 3.5 cents per minute.[39]

To the extent that the bill seeks to enforce any standards on cardiac facilities, the department's authority is limited to its ability to credential facilities and providers that

[39] *Supra* note 7, at 4.

participate in the Children's Medical Services program.[40] Enforcement of facility standards related to licensure resides in AHCA which is directed to work in coordination with the council under the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.0361 and 408.036.

This bill creates section 391.224 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 9, 2016:
The committee substitute:

- Creates the Pediatric Cardiac Advisory Council within the department and requires the council to submit an annual report summarizing the council's activities and data and performance measures for all pediatric cardiac facilities that participate in the Children's Medical Services Network;
- Requires the department, in coordination with the AHCA, to develop rules related to pediatric cardiac facilities that participate in the Children's Medical Services Network and provides that rules relating to pediatric cardiac services and facilities in effect on October 1, 2015, are authorized and remain in effect until amended;
- Authorizes the department to create the "Pediatric and Congenital Centers of Excellence" designation for facilities that meet certain standards; and
- Removes the repeal of CON provisions and only addresses rulemaking to authorize certain Level I dedicated interventional cardiac laboratories to provide the prerequisite experience for nursing and technical staff.

B. Amendments:

None.

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

[40] *Supra* note 7, at 5.

740310

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/09/2016	.	
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	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (b) of subsection (3) of section 408.0361, Florida Statutes, is amended to read:

408.0361 Cardiovascular services and burn unit licensure.—

(3) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(b) For a hospital seeking a Level I program, demonstration

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that, for the most recent 12-month period as reported to the agency, it has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes. However, a hospital located more than 100 road miles from the closest Level II adult cardiovascular services program does not need to meet the 60-minute transfer time protocol if the hospital demonstrates that it has a formalized, written transfer agreement with a hospital that has a Level II program. The agreement must include written transport protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather conditions, and viability of ground and air ambulance service to transfer the patient. At a minimum, the rules for adult cardiovascular services must require nursing and technical staff to have demonstrated experience in handling acutely ill patients requiring intervention based on the staff members' previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open-heart-surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:

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1. Had an annual volume of 500 or more percutaneous cardiac intervention procedures;

2. Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures;

3. Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures; and

4. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

Section 2. This act shall take effect July 1, 2016.

========== 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 adult cardiovascular services; amending s. 408.0361, F.S.; expanding rulemaking criteria for the Agency for Health Care Administration for licensure of hospitals performing percutaneous cardiac intervention procedures; providing an effective date.

503856

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/09/2016	.	
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	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment to Amendment (740310) (with title amendment)

Between lines 4 and 5
insert:

Section 1. Section 391.224, Florida Statutes, is created to read:

391.224 Pediatric Cardiac Advisory Council.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds significant benefits in the

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continued coordination of activities by several state agencies regarding access to pediatric cardiac care in this state. It is the intent of the Legislature that the Department of Health, the department's cardiac consultants, and the Agency for Health Care Administration maintain their long-standing interagency teams and agreements for the development and adoption of guidelines, standards, and rules for those portions of the state cardiac care system within the statutory authority of each agency. This coordinated approach will continue to ensure the necessary continuum of care for the pediatric cardiac patient. The department has the leadership responsibility for this activity.

(b) It is further the intent of the Legislature to establish the Pediatric Cardiac Advisory Council, a statewide, inclusive council within the department.

(2) PEDIATRIC CARDIAC ADVISORY COUNCIL.—

(a) The State Surgeon General shall appoint the Pediatric Cardiac Advisory Council for the purpose of advising the department on the delivery of cardiac services to children.

(b) The chair of the council shall be elected from among the council members every 2 years and may not serve more than two consecutive terms.

(c) The council shall meet upon the call of the chair or two or more voting members or upon the call of the State Surgeon General, but must meet at least quarterly. Council meetings must be conducted by teleconference or through other electronic means when feasible.

(d) The council shall be composed of no more than 13 voting members with technical expertise in cardiac medicine. Members shall be appointed by the State Surgeon General for staggered

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terms of 4 years. An employee of the department or a contracted consultant paid by the department may not serve as an appointed member or ex officio member of the council. Council members shall include the following voting members:

1. Pediatric cardiologists or pediatric cardiovascular surgeons who have been nominated by their respective chief executive officers and approved by the State Surgeon General from the following facilities for as long as such facilities maintain their pediatric certificates of need:

a. All Children's Hospital in St. Petersburg;

b. Arnold Palmer Hospital for Children in Orlando;

c. Joe DiMaggio Children's Hospital in Hollywood;

d. Nicklaus Children's Hospital in Miami;

e. St. Joseph's Children's Hospital in Tampa;

f. University of Florida Health Shands Hospital in Gainesville;

g. University of Miami Holtz Children's Hospital in Miami; and

h. Wolfson Children's Hospital in Jacksonville.

A hospital with a certificate of need for a pediatric cardiac program that meets state and national standards as determined by the council following an onsite visit by a panel from the council shall have one of its pediatric cardiologists or pediatric cardiovascular surgeons who has been nominated by its chief executive officer and approved by the State Surgeon General appointed to the council as a new voting member. The voting privilege of a voting member of the council appointed pursuant to this subparagraph shall be suspended if the facility

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he or she represents no longer meets state and national standards as adopted by the council. Such individual may remain a member of the council in an advisory capacity but shall relinquish voting privileges until his or her facility meets such standards.

2. Two physicians at large, not associated with a facility that has a representative appointed as a voting member of the council, who are pediatric cardiologists or subspecialists with special expertise or experience in dealing with children or adults with congenital heart disease. These physicians shall be selected by the State Surgeon General in consultation with the Deputy Secretary for Children's Medical Services and the Director of Children's Medical Services.

3. One community physician who has ongoing involvement with and special interest in children with heart disease and who is not associated with a facility represented in subparagraph 1. or one community-based medical internist having experience with adults with congenital heart disease. The community physician shall be selected by the State Surgeon General in consultation with the Deputy Secretary of Children's Medical Services and the Director of the Division of Children's Medical Services.

(e) The State Surgeon General may appoint nonvoting advisory members to the council in consultation with the Deputy Secretary for Children's Medical Services and the Director of Children's Medical Services. Among such nonvoting advisory members appointed to the council shall be one representative from a pediatric health advocacy group. Such members may participate in council discussions and subcommittees created by the council, but may not vote.

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(f) The duties of the council include, but are not limited to:

1. Recommending standards for personnel, diagnoses, clinics, and facilities rendering cardiac services to the department and the Division of Children's Medical Services.

2. Analyzing reports on the periodic review of cardiac personnel, diagnoses, clinics, and facilities to determine if established state and national standards for cardiac services are met.

3. Making recommendations to the Director of Children's Medical Services as to the approval or disapproval of reviewed cardiac care personnel, diagnoses, clinics, and facilities.

4. Making recommendations as to the intervals for reinspection of approved personnel, diagnoses, clinics, and facilities for cardiac care.

5. Reviewing and inspecting hospitals upon the request of the hospitals, the department, or the Agency for Health Care Administration to determine if established state and national standards for cardiac services are met.

6. Providing input on all aspects of the state's Children's Medical Services cardiac programs, including rulemaking.

7. Addressing all components of the care of adults and children with congenital heart disease and children with acquired heart disease, as indicated and appropriate.

8. Abiding by the recognized state and national professional standards of care for children with heart disease.

9. Making recommendations to the State Surgeon General for legislation and appropriations for children's cardiac services.

10. Providing advisory opinions to the Agency for Health

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Care Administration before the agency approves a certificate of need for children's cardiac services.

(g) A council member shall serve without compensation, but is entitled to reimbursement for per diem and travel expenses in accordance with s. 112.061.

(h) At the recommendation of the Pediatric Cardiac Advisory Council and with the approval of the Director of Children's Medical Services, the State Surgeon General shall designate facilities meeting the council's approved state and national professional standards of care for children with heart disease as "Pediatric and Congenital Cardiovascular Centers of Excellence." The designation is withdrawn automatically if a particular center no longer meets such standards.

1. The council shall develop and recommend to the State Surgeon General measurable performance standards and goals for determining whether a facility meets the requirements for designation as a "Pediatric and Congenital Cardiovascular Center of Excellence."

2. The council shall develop and recommend to the State Surgeon General evaluation tools for measuring the goals and performance standards of the facilities seeking and receiving the "Pediatric and Congenital Cardiovascular Center of Excellence" designation.

(3) ANNUAL REPORT.—The council shall submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the State Surgeon General by January 1 of each year, beginning in 2017. The report must summarize the council's activities for the preceding fiscal year and include data and performance measures for all pediatric

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cardiac facilities that participate in the Children's Medical Services Network relating to surgical morbidity and mortality. The report must also recommend any policy or procedural changes that would increase the council's effectiveness in monitoring the pediatric cardiovascular programs in the state.

(4) RULEMAKING.—The department, in coordination with the Agency for Health Care Administration, shall develop rules related to pediatric cardiac facilities that participate in the Children's Medical Services Network. The rules may establish standards relating to the training and credentialing of medical and surgical personnel, facility and physician minimum case volumes, and data reporting requirements for monitoring and enhancing quality assurance. The department may adopt rules relating to the establishment, operations, and authority of the Pediatric Cardiac Advisory Council and the establishment, goals, performance standards, and evaluation tools for designating facilities as Pediatric and Congenital Cardiovascular Centers of Excellence. The rules relating to pediatric cardiac services and facilities in effect on October 1, 2016, are authorized pursuant to this subsection and shall remain in effect until amended pursuant to this subsection.

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

And the title is amended as follows:

Delete line 57

and insert:

An act relating to cardiovascular services; creating s. 391.224, F.S.; providing legislative findings and intent; creating the Pediatric Cardiac Advisory

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Council; determining the chair of the advisory council; establishing the membership of the advisory council; identifying the duties of the advisory council; setting the minimum qualifications for the designation of a facility as a Pediatric and Congenital Cardiovascular Center of Excellence; requiring a report to the Governor, the Legislature, and the State Surgeon General; requiring the Department of Health to develop rules relating to pediatric cardiac services and facilities in the Children's Medical Services Network; authorizing the department to adopt rules relating to the council and the designation of facilities as Pediatric and Congenital Cardiovascular Centers of Excellence; authorizing and preserving until amended specified rules relating to pediatric cardiac services and facilities;

By Senator Grimsley

21-01207-16 20161518__

A bill to be entitled

An act relating to adult cardiovascular services; amending s. 408.0361, F.S.; expanding rulemaking criteria for the Agency for Health Care Administration for licensure of hospitals performing percutaneous coronary intervention; deleting provisions relating to newly licensed hospitals seeking a specified program status; repealing s. 408.036(3)(m) and (n), F.S., relating to exemptions for certificate of need projects subject to review relating to adult open-heart services in a hospital and percutaneous coronary intervention; providing an effective date.

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

Section 1. Section 408.0361, Florida Statutes, is amended to read:

408.0361 Cardiovascular services and burn unit licensure.—

(1) Each provider of diagnostic cardiac catheterization services shall comply with rules adopted by the agency that establish licensure standards governing the operation of adult inpatient diagnostic cardiac catheterization programs. The rules shall ensure that such programs:

(a) Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.

(b) Perform only adult inpatient diagnostic cardiac catheterization services and will not provide therapeutic cardiac catheterization or any other cardiology services.

(c) Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety.

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(d) Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

(e) Demonstrate a plan to provide services to Medicaid and charity care patients.

(2) Each provider of adult cardiovascular services or operator of a burn unit shall comply with rules adopted by the agency that establish licensure standards that govern the provision of adult cardiovascular services or the operation of a burn unit. Such rules shall consider, at a minimum, staffing, equipment, physical plant, operating protocols, the provision of services to Medicaid and charity care patients, accreditation, licensure period and fees, and enforcement of minimum standards. ~~The certificate-of-need rules for adult cardiovascular services and burn units in effect on June 30, 2004, are authorized pursuant to this subsection and shall remain in effect and shall be enforceable by the agency until the licensure rules are adopted. Existing providers and any provider with a notice of intent to grant a certificate of need or a final order of the agency granting a certificate of need for adult cardiovascular services or burn units shall be considered grandfathered and receive a license for their programs effective on the effective date of this act. The grandfathered licensure shall be for at least 3 years or until July 1, 2008, whichever is longer, but shall be required to meet licensure standards applicable to existing programs for every subsequent licensure period.~~

(3) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) Establishment of two hospital program licensure levels:

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

a Level I program authorizing the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program authorizing the performance of percutaneous cardiac intervention with onsite cardiac surgery.

(b) For a hospital seeking a Level I program, demonstration that, for the most recent 12-month period as reported to the agency, it has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes. However, a hospital located more than 100 road miles from the closest Level II adult cardiovascular services program does not need to meet the 60-minute transfer time protocol if the hospital demonstrates that it has a formalized, written transfer agreement with a hospital that has a Level II program. The agreement must include written transport protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather conditions, and viability of ground and air ambulance service to transfer the patient. At a minimum, the rules must require the following:

1. Cardiologists must be experienced interventionalists who have performed a minimum of 50 interventions annually, averaged over 2 years, that were performed in institutions performing more than 200 total intervention procedures annually and more than 36 primary intervention procedures annually.

2. The hospital must provide a minimum of 36 primary interventions annually in order to continue to provide the service.

3. The hospital must offer sufficient physician, nursing, and laboratory staff to provide the services 24 hours a day, 7 days a week.

4. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on the staff members' previous experience in dedicated interventional laboratories or surgical centers. In order for experience acquired at a dedicated interventional laboratory at a hospital without an approved adult open-heart-surgery program to qualify, the cardiac interventional laboratory must have, throughout the training period:

a. Had an annual volume of 200 or more percutaneous coronary intervention procedures;

b. Achieved a demonstrated success rate of 95 percent or greater for percutaneous coronary intervention procedures;

c. Experienced a complication rate of less than 5 percent for percutaneous coronary intervention procedures;

d. Experienced required emergent coronary artery bypass grafting on less than 2 percent of the patients undergoing a percutaneous coronary intervention procedure; and

e. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

5. Cardiac care nursing staff must be adept in hemodynamic monitoring, operation of temporary pacemakers, intra-aortic

balloon pump management, management of indwelling arterial and venous sheaths, and identifying potential complications.

6. Hospitals implementing the service must first undertake a training program of 3 to 6 months' duration, which includes establishing standards and testing logistics, creating quality assessment and error management practices, and formalizing patient-selection criteria.

7. The applicant must certify that the hospital will use at all times the patient-selection criteria for the performance of primary angioplasty at hospitals without adult open-heart-surgery programs issued by the American College of Cardiology and the American Heart Association.

8. The hospital must agree to submit a quarterly report to the agency detailing patient characteristics, treatment, and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this paragraph. This report must be submitted within 15 days after the close of each calendar quarter.

(c) For a hospital seeking a Level II program, demonstration that, for the most recent 12-month period as reported to the agency, it has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

(d) Compliance with the most recent guidelines of the American College of Cardiology and American Heart Association guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient

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

selection criteria to ensure patient quality and safety.

(e) Establishment of appropriate hours of operation and protocols to ensure availability and timely referral in the event of emergencies.

(f) Demonstration of a plan to provide services to Medicaid and charity care patients.

~~(4) In order to ensure continuity of available services, the holder of a certificate of need for a newly licensed hospital that meets the requirements of this subsection may apply for and shall be granted Level I program status regardless of whether rules relating to Level I programs have been adopted. To qualify for a Level I program under this subsection, a hospital seeking a Level I program must be a newly licensed hospital established pursuant to a certificate of need in a physical location previously licensed and operated as a hospital, the former hospital must have provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations for the most recent 12-month period as reported to the agency, and the newly licensed hospital must have a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes. A hospital meeting the requirements of this subsection may apply for certification of Level I program status before taking possession of the physical location of the former hospital, and the effective date of Level I program status shall be concurrent with the effective date of the newly issued hospital license.~~

(4) ~~(5)~~ (a) The agency shall establish a technical advisory

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

panel to develop procedures and standards for measuring outcomes of adult cardiovascular services. Members of the panel shall include representatives of the Florida Hospital Association, the Florida Society of Thoracic and Cardiovascular Surgeons, the Florida Chapter of the American College of Cardiology, and the Florida Chapter of the American Heart Association and others with experience in statistics and outcome measurement. Based on recommendations from the panel, the agency shall develop and adopt rules for the adult cardiovascular services that include at least the following:

1. A risk adjustment procedure that accounts for the variations in severity and case mix found in hospitals in this state.

2. Outcome standards specifying expected levels of performance in Level I and Level II adult cardiovascular services. Such standards may include, but shall not be limited to, in-hospital mortality, infection rates, nonfatal myocardial infarctions, length of stay, postoperative bleeds, and returns to surgery.

3. Specific steps to be taken by the agency and licensed hospitals that do not meet the outcome standards within specified time periods, including time periods for detailed case reviews and development and implementation of corrective action plans.

(b) Hospitals licensed for Level I or Level II adult cardiovascular services shall participate in clinical outcome reporting systems operated by the American College of Cardiology and the Society for Thoracic Surgeons.

Section 2. Paragraphs (m) and (n) of subsection (3) of

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

section 408.036, Florida Statutes, are repealed.

Section 3. This act shall take effect July 1, 2016.

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 14, 2016

I respectfully request that **Senate Bill #1518,** relating to Adult Cardiovascular Services and **Senate Bill #1604** relating to Drugs, Devices, and Cosmetics be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Denise Grimsley

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/9/16
Meeting Date

1518
Bill Number (if applicable)

740310
Amendment Barcode (if applicable)

Topic ~~Chris Nuland~~

Name Chris Nuland

Job Title

Address 1000 Riverside Ave
Street

Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Society of Thoracic & Cardiovascular Surgeons

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/5/16
Meeting Date

1518
Bill Number (if applicable)

740310
Amendment Barcode (if applicable)

Topic Adult Care Svcs

Name Martha DeCastro

Job Title VP Nursing

Address 3Mc E College
Street

Phone 222-9402

ntl
City *State* *Zip*

Email martha@fha.org

Amendment

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Hospital Assoc

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1620
INTRODUCER:	Senator Hutson
SUBJECT:	Concussions and Head Injuries In Children
DATE:	February 4, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1620 requires nurses, physicians, and physician assistants, whose practice involves the treatment of children, to complete 2 hours of continuing education (CE) relating to concussions and head injuries in children every biennial renewal cycle.

II. Present Situation:

Chapters 458 and 459, F.S., set out the licensure requirements for allopathic and osteopath physicians, and physician assistants. According to the Division of Medical Quality Assurance (MQA) Annual Report and Long Range Plan for Fiscal Year 2014-2015 there are 48,941 in state active allopathic physicians,[1] 6,216 osteopathic physicians,[2] and 6,744 physician assistants holding active licenses in Florida.[3] Common to all these licensees is the CE requirement under s. 456.013, F.S., which requires that each licensee complete at least 40 hours of continuing education every 2 years. The law also allows each board to determine whether any specific continuing education requirements not otherwise mandated by law will be required. Included in the mandatory 40 hours is 2 hours of CE relating to the prevention of medical errors in both the initial licensure process and every biennial renewal process.

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[1] Florida Dep't of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan Fiscal Year 2014-2015*, p. 11-13, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf, (last visited Feb. 1, 2016). The 48,941 active allopathic physicians includes: 226 house physicians; 146 limited license physicians; 335 critical need physicians, 8 medical expert physicians, 1 Mayo Clinic limited license physician; 40 medical facility physicians; 2 public health physicians; and 1 public psychiatry physician.

[2] *Id.* The 7,216 osteopathic physicians includes 5,264 osteopathic physicians, 5 osteopathic limited license physicians, and 2 osteopathic expert physician.

[3] *Supra* note 1.

Chapter 464, part I, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health (DOH) and are regulated by the Board of Nursing (BON).[4] During the 2014-2015 state fiscal year, there were 18,276 advanced registered nurse practitioners (ARNPs), 157 clinical nurse specialists (CNSs), 253,338 registered nurses (RNs), and 73,942 licensed practical nurses (LPNs) that hold current, active Florida licenses.[5]

The following is a summary of the current CE requirements for allopathic physicians and PAs licensed under ch. 458, F.S., osteopathic physicians and PAs licensed under ch. 459, F.S., and all nurses licensed under ch. 464, part I, F.S., and the applicable Rules of the Florida Administrative Code: [6]

CE Requirements	MD	DO	PA	ARNP/CNS/RN/LPN
Total CE hours for Renewal	40 hrs. in 24 mo.	40 hrs. in 24 mo.	100 hrs. in 24 mos.[7]	24 hrs.in 24 mos.[8]
Prevention of Medical Errors[9]	40 hrs. in 24 mo.[10]	2 hrs. in 24 mo.	1 hr. 1st Renewal	2 hrs. in 24 mos.
HIV & AIDS Category I	100 hrs. in 24 mo.	2 hrs. in 24 mo.	1 hr. 1st Renewal	2 hr. 1st Renewal
Domestic Violence	2 hrs. every 3rd renewal	2 hrs. every 3rd renewal [11]	2 hrs. every 3rd renewal	2 hrs. every 3rd renewal
Risk Management	5 hrs. in 24 mos.	5 hrs. in 24 mos.	5 hrs. in 24 mos.	5 hrs. in 24 mos.
Medical Ethics	None	1 hr. in 24 mos.	None	None
FL Laws and Rules	None	1 hr. in 24 mos.	None	2 hrs. every renewal

[4] The Board of Nursing is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. Seven of the 13 members must be nurses who reside in Florida and have been engaged in the practice of professional nursing for at least 4 years. Of those seven members, one must be an advanced registered nurse practitioner, one a nurse educator at an approved nursing program, and one a nurse executive. Three members of the BON must be licensed practical nurses who reside in the state and have engaged in the practice of practical nursing for at least 4 years. The remaining three members must be Florida residents who have never been licensed as nurses and are in no way connected to the practice of nursing, any health care facility, agency, or insurer. Additionally, one member must be 60 years of age or older. *See* s. 464.004(2), F.S.

[5] *Supra* note 1.

[6] *See* Rule 64B8-13.005, F.A.C., for allopathic physicians; Rule 64B15-13.001, F.A.C., for osteopathic physicians; Rule 64B8-30.005, F.A.C., for physician assistants, and Rule 64B8-31.007, F.A.C., for anesthesiologist assistants.

[7] *See* Rule 64B8-30.005(1)(c), F.A.C., requiring that a minimum of 50 hours must be Category I CE approved by the American Academy of Physician Assistants, the Accreditation Council for Continuing Medical Education, the American Medical Association, the American Osteopathic Association Council on Continuing Medical Education, or the American Academy of Family Physicians. The remaining 50 hours may be Category II CE. If not NCCPA certified, the Physician Assistant must be able to produce evidence of the 100 hours of reported CE for the relevant biennium.

[8] All ARNPs, CNSs, RNs, and LPNs are required to complete one hour of CE for every month of the licensure cycle, or 24 hours per biennial renewal cycle. *See* 64B9-5.002, F.A.C.

[9] All licensees under chs. 458, 459, and 464, Part I, F.S, are required to do CE on prevention of medical errors every renewal cycle which are include in the total number of CEs required. *See* s. 456.013(7), F.S.

[10] *See* Rule 64B15-13.001, F.A.C., requiring that at least 20 of the 40 hours of the CE required under this rule shall be American Osteopathic Association approved Category I-A CE related to the practice of osteopathic medicine or under osteopathic auspices.

[11] All licensees under chs. 458, 459, and 464, part I, F.S, are required to do CE on prevention of medical errors every renewal cycle but those hours count toward the total number of CEs required. *See* s. 456.013(7), F.S.,

CE Requirements	MD	DO	PA	ARNP/CNS/RN/LPN
Fed & State Law Prescribing Controlled Substances	**None**	**1 hr. in 24 mos.**	**None**	**None**
Recognizing Impairment in the Workplace	**None**	**None**	**None**	**2 hrs. every 2nd renewal**

Reporting of all CE hours is mandatory for these professions through the licensee's CE Broker account.

Currently there is no statute or rule that requires an allopathic physician, osteopathic physician, physician assistant, or nurse to complete CEs on concussions and head injuries in children at either the initial licensure or renewal.

III. Effect of Proposed Changes:

SB 1620 amends ss. 458.319, 458.347, 459.008, 459.022, and 464.013, F.S. to require physicians, physician assistants, and all nurses (ARNP, CNS, RN and LPN), whose practice involves the treatment of children to complete at least 2 hours of CE on concussions and head injuries in children. The course must include, at a minimum, education on the prevention, symptoms, risks, treatment, and long-term effects of concussions and other head injuries on children.

The bill also makes technical changes to s. 458.319(1), F.S.

The bill has an effective date of July 1, 2016.

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:

Physicians, physician assistants, and nurses (ARNP, CNS, RN and LPN), whose practice involves the treatment of children, will need to devote at least two CE hours each renewal cycle to this topic. The fiscal impact should be minimal because these are not additional hours.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.319, 458.347, 459.008, 459.022, and 464.013.

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 Hutson

6-00879C-16 20161620__

A bill to be entitled

An act relating to concussions and head injuries in children; amending ss. 458.319, 458.347, 459.008, 459.022, and 464.013, F.S.; requiring certain nurses, physicians, and physician assistants to complete continuing education relating to concussions and head injuries in children; providing an effective date.

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

Section 1. Subsection (1) of section 458.319, Florida Statutes, is amended to read:

458.319 Renewal of license.—

(1)(a) The department shall renew a license upon receipt of the renewal application, evidence that the applicant has actively practiced medicine or has been on the active teaching faculty of an accredited medical school for at least 2 years of the immediately preceding 4 years, and a fee not to exceed $500; provided, however, that if the licensee is either a resident physician, assistant resident physician, fellow, house physician, or intern in an approved postgraduate training program, as defined by the board by rule, the fee shall not exceed $100 per annum. If the licensee has not actively practiced medicine for at least 2 years of the immediately preceding 4 years, the board shall require that the licensee successfully complete a board-approved clinical competency examination before ~~prior to~~ renewal of the license. For purposes of this paragraph, the term "actively practiced medicine" means that practice of medicine by physicians, including those employed by any governmental entity in community or public health, as defined by this chapter, including physicians practicing administrative medicine.

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(b) An applicant for a renewed license whose practice of medicine involves the treatment of children must also complete at least 2 hours of continuing medical education on concussions and head injuries in children, including, at a minimum, the prevention, symptoms, risks, treatment, and long-term effects of concussions and other head injuries.

(c) An applicant for a renewed license must also submit the information required under s. 456.039 to the department on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the Department of Health for the statewide criminal background check of the applicant. The applicant must submit a set of fingerprints to the Department of Health on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the department for a national criminal background check of the applicant for the initial renewal of his or her license after January 1, 2000. If the applicant fails to submit either the information required under s. 456.039 or a set of fingerprints to the department as required by this section, the department shall issue a notice of noncompliance, and the applicant will be given 30 additional days to comply. If the applicant fails to comply within 30 days after the notice of noncompliance is issued, the department or board, as appropriate, may issue a citation to the applicant and may fine the applicant up to $50 for each day that the applicant is not in compliance with the requirements of s. 456.039. The citation must clearly state that the applicant may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the applicant disputes the matter in the citation,

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the procedures set forth in s. 456.073 must be followed. However, if the applicant does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. Service of a citation may be made by personal service or certified mail, restricted delivery, to the subject at the applicant's last known address. If an applicant has submitted fingerprints to the department for a national criminal history check upon initial licensure and is renewing his or her license for the first time, then the applicant need only submit the information and fee required for a statewide criminal history check.

Section 2. Paragraph (d) of subsection (7) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(7) PHYSICIAN ASSISTANT LICENSURE.—

(d) Each licensed physician assistant shall biennially complete 100 hours of continuing medical education or shall hold a current certificate issued by the National Commission on Certification of Physician Assistants. A physician assistant whose practice involves the treatment of children must also complete at least 2 hours of continuing medical education on concussions and head injuries in children, including, at a minimum, the prevention, symptoms, risks, treatment, and long-term effects of concussions and other head injuries.

Section 3. Subsection (1) of section 459.008, Florida Statutes, is amended to read:

459.008 Renewal of licenses and certificates.—

(1)(a) The department shall renew a license or certificate

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upon receipt of the renewal application and fee.

(b) An applicant for a renewed license whose practice of medicine involves the treatment of children must also complete at least 2 hours of continuing medical education on concussions and head injuries in children, including, at a minimum, the prevention, symptoms, risks, treatment, and long-term effects of concussions and other head injuries.

(c) An applicant for a renewed license must also submit the information required under s. 456.039 to the department on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the Department of Health for the statewide criminal background check of the applicant. The applicant must submit a set of fingerprints to the Department of Health on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the department for a national criminal background check of the applicant for the initial renewal of his or her license after January 1, 2000. If the applicant fails to submit either the information required under s. 456.039 or a set of fingerprints to the department as required by this section, the department shall issue a notice of noncompliance, and the applicant will be given 30 additional days to comply. If the applicant fails to comply within 30 days after the notice of noncompliance is issued, the department or board, as appropriate, may issue a citation to the applicant and may fine the applicant up to $50 for each day that the applicant is not in compliance with the requirements of s. 456.039. The citation must clearly state that the applicant may choose, in lieu of accepting the citation, to follow the procedure under s.

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456.073. If the applicant disputes the matter in the citation, the procedures set forth in s. 456.073 must be followed. However, if the applicant does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. Service of a citation may be made by personal service or certified mail, restricted delivery, to the subject at the applicant's last known address. If an applicant has submitted fingerprints to the department for a national criminal history check upon initial licensure and is renewing his or her license for the first time, then the applicant need only submit the information and fee required for a statewide criminal history check.

Section 4. Paragraph (c) of subsection (7) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(7) PHYSICIAN ASSISTANT LICENSURE.—

(c) Each licensed physician assistant shall biennially complete 100 hours of continuing medical education or shall hold a current certificate issued by the National Commission on Certification of Physician Assistants. A physician assistant whose practice involves the treatment of children must also complete at least 2 hours of continuing medical education on concussions and head injuries in children, including, at a minimum, the prevention, symptoms, risks, treatment, and long-term effects of concussions and other head injuries.

Section 5. Subsection (3) of section 464.013, Florida Statutes, is amended to read:

464.013 Renewal of license or certificate.—

(3) The board shall by rule prescribe up to 30 hours of continuing education biennially as a condition for renewal of a license or certificate. A nurse whose practice involves the treatment of children must also complete at least 2 hours of continuing education on concussions and head injuries in children, including, at a minimum, the prevention, symptoms, risks, treatment, and long-term effects of concussions and other head injuries. A nurse who is certified by a health care specialty program accredited by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification is exempt from continuing education requirements. The criteria for programs shall be approved by the board.

Section 6. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 21, 2016

I respectfully request that **Senate Bill #1620**, relating to Concussions and Head Injuries in Children, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Travis Hutson
Florida Senate, District 6

File signed original with committee office

S-020 (03/2004)

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Committee on Health Policy **Judge:**

Started: 2/9/2016 10:05:31 AM
Ends: 2/9/2016 11:44:47 AM **Length: 01:39:17**

10:05:30 AM Meeting called to order
10:05:43 AM Quorum Present
10:05:58 AM Tab SB 1370; SB 1620 TP
10:06:20 AM Sen Grimsley explains
10:07:33 AM BC 567756 Sen Grimsley explains
10:08:10 AM A Adopted
10:08:32 AM Vice Chair Sobel question
10:08:49 AM Sen Grimsley responds
10:09:10 AM Sen Grimsley waives to close
10:09:44 AM Roll Call SB 1370
10:09:59 AM SB 1370 CS passes favorably
10:10:20 AM Tab 2 SB 236
10:10:59 AM Sen Grimsley explains
10:11:32 AM Vice Chair calls for question
10:11:40 AM Sen Joyner question
10:11:58 AM Sen Grimsley responds
10:12:23 AM Sen Joyner follow up question
10:12:29 AM Sen Grimsley responds
10:12:34 AM Sen Joyner further follow up
10:12:40 AM Sen Grimsley responds
10:12:54 AM Sen Joyner further follow up question
10:13:07 AM Sen Grimsley responds
10:13:20 AM Sen Joyner further follow up question
10:13:28 AM Sen Grimsley responds
10:13:33 AM Vice Chair Sobel question
10:13:40 AM Sen Sobel responds
10:14:21 AM Sen Sobel further explains
10:14:25 AM Vice Chair Sobel
10:14:44 AM Sen Joyner comment
10:15:07 AM Sen Grimsley comment
10:15:29 AM Sen Galvano comment
10:15:58 AM Vice Chair Sobel
10:16:04 AM Sen Galvano clarifies information
10:16:22 AM Sen Grimsley waives to close
10:16:31 AM Roll call
10:16:43 AM SB 236 passes favorably
10:17:00 AM Tab 4 SB 946
10:17:44 AM Sen Grimsley explains
10:18:20 AM Vice Chair calls for questions
10:18:32 AM Sen Grimsley explains the A 172548
10:18:56 AM Vice Chair Sobel calls for questions
10:19:22 AM Sen Grimsley waives to close on the A
10:19:35 AM Stan Whitaker, Fl Assoc. of Nurse Practioners, waives in support
10:20:02 AM Chris Floyd, Phillis Oeters, Laura Cantwell waives in support
10:20:08 AM Stan Whitaker, Luara Cantwell waives in support
10:20:13 AM Ron Watson waives in support
10:20:21 AM Young lady speaks
10:21:17 AM Brittany Hunt, Florida Chamber of Commerce waives in suupport
10:21:24 AM Alisa Lapolt, Florida Nurses Assoc. waives in support
10:21:28 AM Lori Killinger, Florida Assoc of Nurses & Martha DeCastro waives in support
10:21:42 AM Indivdual for appearance waive in support
10:21:51 AM Call for questions

10:21:56 AM Sen Grimsley waives to close on SB as A
10:22:08 AM Roll Call
10:22:26 AM SB 946 passes favorably
10:22:51 AM Sen voted in favor
10:23:17 AM Tab 10 SB 1472 Sen Ring
10:24:01 AM Leg aid AJ explains in lieu of Sen Ring
10:25:33 AM Sen Joyner comment
10:26:34 AM Aid Responds
10:26:37 AM Sen Joyner follow up question
10:26:49 AM Aid explains
10:27:09 AM Sen Joyner follow up question
10:27:17 AM Aid responds
10:27:21 AM Sen Joyner follow up
10:27:27 AM Aid responds
10:27:35 AM Vice Chair Sobel question
10:28:04 AM Aid responds
10:28:12 AM Vice Chair Soble follow up
10:28:18 AM Aid responds
10:28:22 AM Aid and Vice Chair Soble discussion
10:28:49 AM Aid waives to close
10:29:09 AM Roll Call
10:29:27 AM CS SB 1472 passes favorably
10:29:48 AM Tab 3 SB 858 Sen Legg
10:30:02 AM Sen Legg explains
10:30:35 AM Vice Chair Soble calls for question
10:30:46 AM Vice Chair Soble question
10:30:54 AM Sen response
10:31:03 AM Dr. Hassiem A. Kambing, florida Mental Health Counselor Assoc, waives in support
10:31:15 AM Sen waives to close
10:31:23 AM Roll call
10:31:32 AM SB 858 passes favorably
10:31:41 AM Tab 5 CS/SB 1142 Sen Hays
10:32:06 AM Sen Hays Legislative Assistant ,Amy, explains
10:32:49 AM Vice Chair Sobel calls for questions
10:33:01 AM Chris Nuland, Fl Chapter American College of Physicians, waives in support
10:33:15 AM Steve Winn, Fl Osteopathic Medical Assoc, waives in support
10:35:14 AM Fely Curva, Budd Bell Clearinghouse on Human Services, waives in support
10:36:18 AM Mike Ruppal, The Aids Institute, speaks in support
10:36:26 AM Doug Bell; Ralph Nobo; Doug Bell;Toni Large waives in support
10:36:33 AM Marnie George waives in support
10:37:18 AM Vice Chair Sobel comment
10:37:29 AM Sen Joyner question
10:38:07 AM Legislative Assistant responds
10:38:24 AM Sen Joyner follow up
10:39:14 AM Legislative Asst responds
10:39:25 AM Jennifer, Staff attorney, explains regarding affect of changes on the plans
10:40:16 AM Vice Chair Sobel
10:40:20 AM Sen Joyner comments
10:40:51 AM LA, Amy, waives to close
10:41:07 AM Roll Call SB 1142
10:41:12 AM SB 1142 passes favorably
10:41:39 AM Tab 1 SB 206
10:41:47 AM Sen Clemens explains
10:42:15 AM Vice Chair Sobel calls for questions
10:42:26 AM Sen Clemens waives to close
10:42:34 AM Roll call
10:42:38 AM SB 206 passes favorably
10:42:52 AM Tab 6 SB 1240 Sen Sobel
10:43:04 AM Vice Chair Sobel explains strike all
10:45:25 AM Sen Grimsley calls for questions
10:45:28 AM Sen Joyner question
10:46:21 AM Vice Chair Sobel responds

10:46:38 AM Karen Woodall, Execuitve Director for Florida Center for Fiscal and Economic Policy waives in support of A
10:47:03 AM A is adopted
10:47:07 AM Dr. Paul Robinson, Fl Chap of AAP, speaks in support
10:50:29 AM Michael McQuone, Florida conference of Catholic Bishops, waives in support
10:50:55 AM Amy Liem, Fl Dental Assoc., waives in support
10:54:11 AM Ron Watson, Fl CHAIN, waives in support
10:55:32 AM Abbie Woodard, parent, speaks in support
10:56:21 AM Casey Stoutamire, Fl Dental Assoc., waives in support
10:57:05 AM Karen Woodall, Fl Center for Fiscal Economic Policy speaks in support
10:58:16 AM Vice Chair Sobel closes on the bill
10:59:04 AM Roll Call
10:59:45 AM CS/SB 1240 passes favorably
11:00:21 AM Tab 11 SB 1518
11:00:28 AM Sen Grimsley BC 740310 explains
11:01:29 AM Vice Chair Sobel calls for questions
11:02:01 AM Martha Decastro, Fl Household Assoc., Waives in support
11:02:05 AM A further explained
11:02:17 AM A 503856 strike all 740310
11:02:31 AM Sen Grimsley explains the A
11:02:38 AM Vice Chair calls for questions
11:02:53 AM Sen Grimsley waives to close
11:03:08 AM A is adopted
11:03:20 AM Sen Grimsley waives to close on the A
11:03:39 AM SB as A
11:03:48 AM Debate on bill as A
11:03:57 AM Sen Grimsley waives to close
11:04:06 AM Roll Call
11:04:17 AM CS/SB 1518 passes favorably
11:04:36 AM Tab 8 SB 1316
11:04:42 AM Sen Grimsley explains
11:08:25 AM Vice Chair calls for question
11:08:37 AM Sen Joyner question
11:09:39 AM Grimsley refers Joyner to Staff analysis
11:10:08 AM Sen Joyner follow up question
11:10:42 AM Sen Grimsley responds
11:10:50 AM Sen Joyner further follow up
11:11:10 AM Rick Masters, Nurse License Compact Admin, speaks to inform as well as in support
11:12:11 AM Sen Joyner follow up
11:12:41 AM Masters responds
11:13:16 AM Sen Joyner further follow up
11:13:31 AM Masters
11:13:36 AM Vice Chair Sobel question
11:13:46 AM Masters responds
11:14:32 AM Vice Chair Sobel follow up question
11:15:08 AM Masters responds
11:16:25 AM Paul Jess, Florida Justice Assoc, speaks in opposition
11:18:09 AM Martha DeCastro, Fl Hospital Assoc. Pillis, Oteres waive in support
11:19:18 AM Dr. Debra Harrison, Mayo clinic, speaks in support
11:22:19 AM Laura Cantwell, AARP, waive in support
11:23:03 AM Bob Reynolds, waives in support
11:23:16 AM Alisa Lapolt, Florida Nurses Assoc and Melanie Arnold, Fl HCA, waives in support
11:23:31 AM Rebecca Fotsch, National Council for State Board of Nursing, Information
11:23:56 AM Sen Grimsley closes on the bill
11:24:45 AM Sen Joyner comment
11:25:20 AM Roll Call
11:25:33 AM SB 1316 passes favorably
11:26:00 AM SB 1306
11:26:13 AM Sen Grimsley explains
11:26:49 AM Vice Chair calls for questions
11:27:46 AM Sen Braynon question
11:27:54 AM Sen Grimsley responds

11:28:01 AM Sen Braynon follow up question
11:28:10 AM Sen Joyner question
11:29:15 AM Attorney Masters speaks in response to Sen Joyners question
11:29:59 AM Sen Joyner follow up question and comment
11:30:14 AM Atty Masters responds
11:31:32 AM Sen Joyner comment
11:32:13 AM Sen Gaetz question
11:33:59 AM Sen Grimsley response
11:34:06 AM Masters response
11:34:20 AM Sen Gaetz comment and question
11:35:14 AM Sen Grimsley responds
11:36:14 AM Jennifer, Staff Attorney, responds
11:37:33 AM Jennifer, Staff Attorney responds
11:38:48 AM Meeting adjourned