The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS
Senator Negron, Chair
Senator Rich, Vice Chair

MEETING DATE: Wednesday, April 13, 2011
TIME: 9:15 —10:45 a.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Negron, Chair; Senator Rich, Vice Chair; Senators Gaetz, Garcia, Oelrich, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 314** Health Regulation / Richter (Identical H 485, Compare H 483, Link CS/S 312)	Public Records/Dental Workforce Surveys; Provides an exemption from public records requirements for information contained in dental workforce surveys submitted by dentists or dental hygienists to the Department of Health as a condition for license renewal. Provides exceptions to the exemption. Provides for future legislative review and repeal of the exemption under the Open Government Sunset Review Act. Provides a statement of public necessity. HR 01/25/2011 Fav/CS GO 03/23/2011 Favorable BHA 04/13/2011 BC RC	
2	**CS/SB 398** Health Regulation / Jones (Compare H 633)	Chiropractic Medicine; Revises the requirements for obtaining a chiropractic medicine faculty certificate. Requires that a chiropractic physician preserve the identity of funds or property of a patient in excess of a specified amount. Requires a registered chiropractic assistant to register with the board effective April 1, 2012, and pay a fee for registration. Authorizes the spouse or adult children of a deceased chiropractic physician to hold, operate, pledge, sell, mortgage, assign, transfer, own, or control the deceased chiropractic physician's ownership interests, etc. HR 02/22/2011 Temporarily Postponed HR 03/09/2011 Fav/CS BHA 04/13/2011 BC RC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**SB 446** Hays (Identical H 225)	Dentistry and Dental Hygiene; Revises the locations at which dental hygienists may perform dental charting. Authorizing dental hygienists to perform certain duties without supervision or authorization by a dentist. Provides exceptions. Requires that dental hygienists in a health access setting provide a certain disclaimer to patients before a procedure is performed. Provides that a health access setting may bill for certain services, etc. HR 03/14/2011 Favorable BHA 04/13/2011 BC RC	
4	**CS/SB 556** Criminal Justice / Oelrich (Similar CS/CS/CS/H 353)	Temporary Assistance for Needy Families Program; Requires the Department of Children and Family Services to perform a drug test on individuals who apply for benefits funded by the Temporary Assistance for Needy Families Program. Makes individuals responsible for bearing the cost of drug testing. Requires certain notice. Provides procedures for testing and retesting. Provides for notice of local substance abuse programs. Provides that, if a parent is deemed ineligible due to failing a drug test, the eligibility of the children is not affected. CJ 03/22/2011 Fav/CS BHA 04/13/2011 BC	
5	**CS/SB 584** Health Regulation / Flores (Similar H 49)	Massage Therapy; Requires applicants to apply for a temporary permit upon forms prepared and furnished by the Department of Health in accordance with the Board of Massage Therapy's rules. Authorizes the Board of Massage Therapy to issue temporary permits to applicants who meet certain qualifications to practice massage therapy. Provides for the expiration of temporary permits. Provides limitations. Provides for a temporary permit fee. HR 03/09/2011 Fav/CS BHA 04/13/2011 BC RC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
6	**CS/SB 1410** Health Regulation / Negron (Similar CS/H 935)	Patient's Bill of Rights and Responsibilities; Authorizes a primary care provider to publish and post a schedule of certain charges for medical services offered to patients. Provides that the schedule may group the provider's services by price levels and list the services in each price level. Provides an exemption from continuing education requirements for a primary care provider who posts such a schedule. Requires a primary care provider's estimates of charges for medical services to be consistent with the prices listed on the posted schedule, etc. HR 04/04/2011 Fav/CS BHA 04/13/2011 BC RC	

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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 314
INTRODUCER:	Health Regulation Committee and Senator Richter
SUBJECT:	Public Records/Dental Workforce Surveys
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Fav/CS**
2.	Naf	Roberts	GO	**Favorable**
3.	Bradford	Hansen	BHA	**Pre-meeting**
4.			BC	
5.			RC	
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The committee substitute (CS) makes confidential and exempt from public records requirements all personal identifying information contained in records provided by dentists or dental hygienists in response to dental workforce surveys and held by the Department of Health (DOH). The CS specifies circumstances under which the confidential and exempt information may be released.

The CS provides for review and repeal of the exemption pursuant to the Open Government Sunset Review Act and provides a statement of the public necessity for the exemption.

Because this CS creates a new public records exemption, it requires a two-thirds vote of each house of the Legislature for passage.[1]

This bill has an insignificant fiscal impact on DOH associated with ensuring that policies and procedures are in place to prevent the release of the personal identifying information except under the limited situations provided for in the bill.

[1] FLA. CONST. art. I, s. 24(c).

This CS creates three undesignated sections of law.

II. Present Situation:

Public Records

The State of Florida has a long history of providing public access to governmental records. The Florida Legislature enacted the first public records law in 1892.[2] One-hundred years later, Floridians adopted an amendment to the State Constitution that raised the statutory right of access to public records to a constitutional level.[3] Article I, s. 24, of the State Constitution, provides that:

> (a) Every person has the right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

In addition to the State Constitution, the Public Records Act,[4] which pre-dates the State Constitution's public records provisions, specifies conditions under which public access must be provided to records of an agency.[5] Section 119.07(1)(a), F.S., states:

> Every person who has custody of a public record shall permit the record to be inspected and copied by any person desiring to do so, at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public records.

Unless specifically exempted, all agency records are available for public inspection. The term "public record" is broadly defined to mean:

> all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or

[2] Section 1390, 1391 F.S. (Rev. 1892).
[3] FLA. CONST. art. I, s. 24.
[4] Chapter 119, F.S.
[5] The word "agency" is defined in s. 119.011(2), F.S., to mean "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 purposes 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 Florida Constitution also establishes a right of access to any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except those records exempted by law or the State Constitution. *See supra* fn. 3.

> received pursuant to law or ordinance or in connection with the transaction of official business by any agency.[6]

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business which are used to perpetuate, communicate, or formalize knowledge.[7] All such materials, regardless of whether they are in final form, are open for public inspection unless made exempt.[8]

Only the Legislature is authorized to create exemptions to open government requirements.[9] Exemptions must be created by general law, and such law must specifically state the public necessity justifying the exemption. Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law.[10] A bill enacting an exemption[11] may not contain other substantive provisions, although it may contain multiple exemptions that relate to one subject.[12]

There is a difference between records that the Legislature has made exempt from public inspection and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such information may not be released by an agency to anyone other than to the persons or entities designated in the statute.[13] If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances.[14]

Open Government Sunset Review Act

The Open Government Sunset Review Act (Act)[15] provides for the systematic review, through a 5-year cycle ending October 2 of the fifth year following enactment, of an exemption from the Public Records Act or the Public Meetings Law.

The Act states that an exemption may be created, revised, or expanded only if it serves an identifiable public purpose and if the exemption is no broader than necessary to meet the public purpose it serves.[16] An identifiable public purpose is served if the exemption meets one of three specified criteria and if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. An exemption meets the three statutory criteria if it:

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[6] Section 119.011(12), F.S.
[7] *Shevin v. Byron, Harless, Schaffer, Reid and Associates, Inc.*, 379 So. 2d 633, 640 (Fla. 1980).
[8] *Wait v. Florida Power & Light Co.*, 372 So. 2d 420 (Fla. 1979).
[9] *Supra* fn. 1.
[10] *Memorial Hospital-West Volusia v. News-Journal Corporation*, 784 So. 2d 438 (Fla. 2001); *Halifax Hospital Medical Center v. News-Journal Corp.*, 724 So. 2d 567, 569 (Fla. 1999).
[11] Under s. 119.15, F.S., an existing exemption may be considered a new exemption if the exemption is expanded to cover additional records.
[12] *Supra* fn. 1.
[13] Florida Attorney General Opinion 85-62.
[14] *Williams v. City of Minneola*, 575 So. 2d 683, 687 (Fla. 5th DCA 1991), *review denied*, 589 So. 2d 289 (Fla. 1991).
[15] Section 119.15, F.S.
[16] Section 119.15(6)(b),F.S.

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protects information of a sensitive personal nature concerning individuals, the release of which would be defamatory or cause unwarranted damage to the good name or reputation of such individuals, or would jeopardize their safety; or
- Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information that is used to protect or further a business advantage over those who do not know or use it, the disclosure of which would injure the affected entity in the marketplace.[17]

The Act also requires the Legislature to consider the following:
- 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?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

While the standards in the Open Government Sunset Review Act may appear to limit the Legislature in the exemption review process, those aspects of the act that are only statutory, as opposed to constitutional, do not limit the Legislature because one session of the Legislature cannot bind another.[18] The Legislature is only limited in its review process by constitutional requirements.

Further, s. 119.15(8), F.S., makes explicit that:

> notwithstanding s. 768.28 or any other law, neither the state or its political subdivisions nor any other public body shall be made party to any suit in any court or incur any liability for the repeal or revival and reenactment of an exemption under this section. The failure of the Legislature to comply strictly with this section does not invalidate an otherwise valid reenactment.

Workforce Surveys

CS for SB 312 requires all Florida licensed dentists and dental hygienists to complete a workforce survey as a part of their licensure renewal, beginning in 2012. The CS for SB 312 provides that licensure renewal in 2012 is not contingent upon the completion and submission of the dental workforce survey; however, the Board may not renew the license of any dentist or dental hygienist for subsequent renewals until the survey is completed and submitted by the licensee.

[17] *Id.*
[18] *Straughn v. Camp*, 293 So. 2d 689, 694 (Fla. 1974).

Medical physicians and osteopathic physicians are required to respond to physician workforce surveys required as a condition of license renewal.[19] All personal identifying information contained in records provided by physicians in response to these physician workforce surveys are confidential and exempt under s. 458.3193, F.S.

III. Effect of Proposed Changes:

Section 1 creates an undesignated section of law to provide that personal identifying information that is contained in records provided by dentists or dental hygienists licensed under ch. 466, F.S., in response to dental workforce surveys required as a condition of license renewal and held by the DOH is confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. The CS authorizes disclosure of such information:

- With the written consent of the individual to whom the information pertains or the individual's legally authorized representative,
- By court order upon a showing of good cause, or
- To a research entity, if the entity seeks the records or data pursuant to a research protocol approved by the DOH, maintains the records or data in accordance with the approved protocol, and enters into a purchase and data-use agreement with the department, the fee provisions of which are consistent with s. 119.07(4), F.S. The agreement must restrict the release of information that would identify individuals, limit the use of records or data to the approved research protocol, and prohibit any other use of the records or data. Copies of such records or data remain the property of the DOH. The DOH may deny a research entity's request for records or data if the protocol provides for intrusive follow-back contacts, does not plan for the destruction of confidential records after the research is concluded, is administratively burdensome, or does not have scientific merit.

The CS provides that the public records exemption created in this act is subject to the Open Government Sunset Review Act in accordance with s. 119.15, F.S., and will stand repealed on October 2, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2 creates an undesignated section of law providing justification of public necessity for the exemption. The public necessity statement states that responding to the dental workforce survey is a condition of licensure renewal for dentists and dental hygienists licensed in Florida, and that candid and honest responses to the workforce survey will ensure that timely and accurate information is available to the DOH. The failure to maintain the confidentiality of the personal identifying information would prevent the resolution of important state interests to ensure the availability of dentists or dental hygienists in this state.

Section 3 provides that this public records exemption takes effect on the same date that its linked substantive bill, CS for SB 312, takes effect.

[19] Section 381.4018, F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of article VII, section 18, of the Florida Constitution.

B. Public Records/Open Meetings Issues:

Vote Requirement
Section 24(c), art. I, of the State Constitution requires a two-thirds vote of each house of the Legislature for passage of a newly created public records or public meetings exemption. Because this CS creates a new public records exemption, it requires a two-thirds vote for passage.

Subject Requirement
Section 24(c), art. I, of the State Constitution requires the Legislature to create public records or public meetings exemptions in legislation separate from substantive law changes. This CS complies with that requirement.

Public Necessity Statement
Section 24(c), art. I, of the State Constitution requires a public necessity statement for a newly created public records or public meetings exemption. Because this CS creates a new public records exemption, it includes a public necessity statement.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of article III, subsection 19(f), of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This CS will protect personal identifying information of dentists and dental hygienists who respond to the dental workforce survey, which is a requirement of licensure renewal.

C. Government Sector Impact:

The DOH and the Board will need to ensure that policies and procedures are in place to prevent the release of the personal identifying information except under the limited situations provided for in the CS.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. 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 Regulation on January 25, 2011:
The CS differs from the bill in that it links the CS to its substantive companion bill, CS for SB 312, to which the public records exemption applies.

B. Amendments:

None.

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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 398
INTRODUCER:	Committee on Health Regulation and Senator Jones
SUBJECT:	Chiropractic Medicine
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	**Fav/CS**
2.	Bradford	Hansen	BHA	**Pre-meeting**
3.			BC	
4.			RC	
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill makes several amendments to Florida Statutes relating to the regulation of chiropractic medicine. The bill:

- Expands eligibility for obtaining a chiropractic medicine faculty certificate;
- Specifies that chiropractic continuing education courses that pertain to a specific company brand, product line, or service may not be approved;
- Amends the grounds for denial of a chiropractic physician's license or disciplinary action to specify that chiropractic physicians must preserve the identity of funds and property of a patient if the value of the funds and property is greater than $501;
- Specifies that money or other property entrusted to a chiropractic physician by a patient may not exceed the value of $1,500;
- Requires that the indirect supervision of a certified chiropractic physician's assistant (CCPA) must take place only at the supervising physician's address of record;
- Redefines the curriculum for the CCPA program by removing the requirement that the program must cover a period of 24 months;
- Requires that registered chiropractic assistants (RCAs) must register with the Board of Chiropractic Medicine (Board) and that an RCA's registration application and

registration renewal application must be signed by a chiropractic physician who is an owner of the RCA's place of employment;
- Requires an RCA to notify the Board within 30 days after changing employment and becoming employed by a new chiropractic practice;
- Requires an RCA's employer of record to notify the Board within 30 days after the RCA is no longer employed by that employer;
- Requires the Board to develop rules to facilitate the RCA registration process; and
- Expands and revises the exceptions to proprietorship and control of a chiropractic practice by persons other than licensed chiropractic physicians.

This bill will require the DOH to establish a fee of no more than $25 for RCA registration. Other costs on the DOH are indeterminate but would be covered by the Medical Quality Assurance Trust Fund.

This bill substantially amends the following sections of the Florida Statutes: 460.4062, 460.408, 460.413, 460.4165, 460.4166, and 460.4167.

II. Present Situation:

Chiropractic Medicine Faculty Certificates

The Department of Health (DOH) is authorized to issue a chiropractic medicine faculty certificate to individuals who meet certain criteria specified in the Florida Statutes. A chiropractic medicine faculty certificate authorizes the certificate holder to practice chiropractic medicine only in conjunction with his or her faculty position at a university or college and its affiliated clinics that are registered with the Board as sites at which holders of chiropractic medicine faculty certificates will be practicing. The DOH is authorized to issue a chiropractic medicine faculty certificate without examination to an individual who demonstrates to the Board of Chiropractic Medicine (Board) that he or she, among other requirements, has accepted a full-time faculty appointment to teach chiropractic medicine at a publicly-funded state university or college or at a college of chiropractic located in Florida and accredited by the Council on Chiropractic Education, and who provides a certification from the dean of the appointing college acknowledging the appointment.[1] There is no such provision for researchers or part-time faculty in the requirements for obtaining a chiropractic medicine faculty certificate, a medical faculty certificate, or an osteopathic faculty certificate.

Continuing Chiropractic Education

The Board requires licensed chiropractors to periodically demonstrate their professional competence as a condition of license renewal by completing up to 40 hours of continuing education. Florida Statutes indicate that the Board shall approve continuing education courses that build upon the basic courses required for the practice of chiropractic medicine.[2] To receive Board approval, a continuing education course must meet a number of criteria specified in rule, including the requirement for the course to be offered for the purpose of keeping the licensee apprised of advancements and new developments in areas such as general or spinal anatomy; physiology; general or neuro-muscular diagnosis; X-ray technique or interpretation; chemistry;

[1] *See* s. 460.4062(1), F.S.
[2] *See* s. 460.408(1)(b), F.S.

pathology; microbiology; public health; principles or practice of chiropractic; risk management; laboratory diagnosis; nutrition; physiotherapy; phlebotomy; acupuncture; proprietary drug administration; AIDS; and law relating to the practice of chiropractic, the Board, and the regulatory agency under which the Board operates.[3]

Grounds for Denial of a Chiropractic Medicine License or Disciplinary Action

Current law and rules of the Board allow chiropractic physicians to accept and hold in trust unearned fees in the form of cash or property other than cash which are received by a chiropractor prior to the rendering of services or the selling of goods and appliances. Chiropractors who utilize such trust funds are required to maintain trust accounting records and observe certain trust accounting procedures. Failure to preserve the identity of funds and property of a patient constitutes grounds for denial of a license or disciplinary action.[4]

Supervision of Certified Chiropractic Physician's Assistants

A CCPA may perform chiropractic services in the specialty area or areas for which he or she is trained or experienced when such services are rendered under the supervision of a licensed chiropractic physician or group of chiropractic physicians certified by the Board, under certain requirements and parameters.

"Direct supervision" is defined as responsible supervision and requires, except in case of an emergency, the physical presence of the licensed chiropractic physician on the premises for consultation and direction. "Indirect supervision" means responsible supervision and control by the supervising chiropractic physician and requires the "easy availability" or physical presence of the licensed chiropractic physician for consultation and direction of the actions of the CCPA. "Easy availability" means the supervising chiropractic physician must be in a location to enable him or her to be physically present with the CCPA within at least 30 minutes and must be available to the CCPA when needed for consultation and advice either in person or by communication devices such as telephone, two-way radio, medical beeper, or other electronic means.[5]

Under current law, indirect supervision of a CCPA is authorized if the indirect supervision occurs at the address of record or any place of practice of a chiropractic physician to whom he or she is assigned.[6] Indirect supervision is not authorized for CCPAs performing services at a health care clinic licensed under part X of ch. 400, F.S.[7]

Education and Training of Certified Chiropractic Physician's Assistants

The DOH is directed under current law to issue certificates of approval for education and training programs for CCPAs which meet Board standards. Any basic program curriculum certified by the Board must cover a period of 24 months and consist of at least 200 didactic classroom hours during the 24 months.[8]

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[3] *See* s. 64B2-13.004, F.A.C.
[4] *See* s. 460.413(1)(y), F.S., and s. 64B2-14.001, F.A.C.
[5] *See* s. 64B2-18.001(8)-(9), F.A.C.
[6] Department of Health, *Bill Analysis, Economic Statement and Fiscal Note, SB 398,* January 27, 2011, p. 3, on file with the Committee on Health Regulation.
[7] *See* s. 460.4165(14), F.S.
[8] *See* s. 460.4165(5), F.S.

Registered Chiropractic Assistants

An RCA assists in all aspects of chiropractic medical practice under the direct supervision and responsibility of a chiropractic physician or CCPA. An RCA assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions, all of which may include performing clinical procedures such as preparing patients for the chiropractic physician's care, taking vital signs, and observing and reporting patients' signs or symptoms; administering basic first aid; assisting with patient examinations or treatments other than manipulations or adjustments; operating office equipment; collecting routine laboratory specimens, administering nutritional supplements, and performing office procedures required by the chiropractic physician or the CCPA.

RCAs may be registered by the Board for a biennial fee not to exceed $25, but Board registration is not mandatory.[9] In state fiscal year 2009-2010, the DOH received 907 applications for voluntary RCA registration.[10]

Proprietorship and Control by Persons Other Than Licensed Chiropractic Physicians

Generally only a sole proprietorship, group practice, partnership, or corporation that is wholly owned by one or more chiropractic physicians, or by a chiropractic physician and the spouse, parent, child, or sibling of that chiropractic physician, may employ a chiropractic physician or engage a chiropractic physician as an independent contractor to provide chiropractic services. However, s. 460.4167, F.S., provides for a number of exceptions, which include medical doctors, osteopaths, hospitals, and state-licensed insurers, among others. No exception exists for the surviving spouse, parent, child, or sibling of a deceased chiropractic physician or for a health maintenance organization or prepaid health clinic regulated under ch. 641, F.S., to employ or engage a chiropractic physician.[11]

Current law also prohibits persons who are not chiropractic physicians, entities not wholly owned by one or more chiropractic physicians, and entities not wholly owned by chiropractic physicians and the spouse, parent, child, or sibling of a chiropractic physician, from employing or entering into a contract with a chiropractic physician and thereby exercising control over patient records, decisions relating to office personnel and hours of practice, and policies relating to pricing, credit, refunds, warranties, and advertising. No exceptions to this prohibition are contained in current law.[12]

III. Effect of Proposed Changes:

Section 1 amends s. 460.4062, F.S., relating to chiropractic medicine faculty certificates, to authorize the DOH to issue a faculty certificate to a person who performs research or has accepted a part-time faculty appointment to teach in a program of chiropractic medicine at a publicly funded state university, college, or a chiropractic college in Florida, assuming the person meets other statutory requirements for faculty certification.

[9] *See* s. 460.4166, F.S.
[10] Supra, note 5, p. 7.
[11] *See* s. 460.4167(1), F.S.
[12] *See* s. 460.4167(4), F.S.

Section 2 amends s. 460.408, F.S., relating to continuing chiropractic education, to prohibit the Board from approving continuing education courses consisting of instruction in the use, application, prescription, recommendation, or administration of a specific company's brand of products or services as contact classroom hours of continuing education. The bill also *allows* the Board to approve courses sponsored by chiropractic colleges if all other requirements of Board criteria for course approval are met, as opposed to the *required* approval of such courses in current law.

Section 3 amends s. 460.413, F.S., relating to grounds for denial of a license or disciplinary action, to specify that failing to preserve the identity of funds and property of a patient is grounds for license denial or disciplinary action only when the value of the funds and property is greater than $501. The requirement in current law that money or other property entrusted to a chiropractor for a specific purpose, including advances for costs and expenses of examination or treatment, must be held in trust and must be applied only to that purpose, is amended under the bill to prevent such advances from exceeding the value of $1,500.

Section 4 amends s. 460.4165, F.S., relating to certified chiropractic physician's assistants, to limit the venues at which CCPAs are allowed to perform chiropractic services under the indirect supervision of a chiropractic physician by removing the chiropractor's place of practice as an authorized venue. A CCPA may continue to perform chiropractic service under indirect supervision at the supervising chiropractor's address of record unless the address or record is a health clinic licensed under part X of ch. 400, F.S.

The bill removes the requirement that education and training programs for CCPAs must cover a period of 24 months.

Section 5 amends s. 460.4166, F.S., relating to registered chiropractic assistants, to specify that clinical procedures performed by an RCA include the operation of therapeutic office equipment.

The bill creates a mandatory RCA registration process, effective April 1, 2012, for any person who performs any duties of an RCA for a biennial fee not to exceed $25, unless the person is otherwise certified or licensed to perform those functions. A person employed as an RCA must apply for an initial registration with the Board by March 31, 2012, or within 30 days after becoming employed as an RCA, whichever is later. The applicant must list his or her place of employment and all chiropractors under whose supervision the applicant performs the duties of an RCA. The application must be signed by a chiropractor who is an owner of the RCA's place of employment. The initial registration becomes effective on April 1, 2012, or applies retroactively to the RCA's date of employment, whichever is later. The bill allows the RCA to be supervised by any chiropractor or CCPA employed by the RCA's employer or listed on the application.

The bill requires an RCA, within 30 days after a change of employment, to notify the Board of the new place of employment and the names of the chiropractic physicians under whose supervision the RCA performs the duties of an RCA at the new place of employment, and the notification must be signed by a chiropractor who is an owner of the RCA's new place of employment. The bill allows the RCA to be supervised by any chiropractor or CCPA employed by the RCA's new employer or listed on the notification.

The bill requires an RCA's employer as registered with the Board, within 30 days after an RCA leaves employment, to notify the Board that the RCA is no longer employed by that employer.

The bill renders an employee who performs none of the duties of an RCA as ineligible to register as an RCA.

The bill creates a registration renewal process for an RCA and requires registrations to be renewed biennially for a renewal fee not to exceed $25. The renewal application must specify the RCA's place of employment and all chiropractors under whose supervision the RCA performs the duties on an RCA. The renewal must be signed by a chiropractor who is an owner of the RCA's place of employment, and the bill allows the RCA to be supervised by any chiropractor or CCPA employed by the RCA's employer or listed on the registration renewal.

The bill requires the Board to prescribe, by rule, application forms for the initial registration of an RCA, the RCA's notice of change of employment, the employer's notice of an RCA's termination of employment, and the registration renewal for an RCA.

The bill specifies that if an RCA is employed by an entity not owned in whole or in part by a chiropractor, the RCA registration, notification, and renewal documents requiring signatures must be signed by a person having an ownership interest in the entity that employs the RCA and a licensed chiropractor who supervises the RCA.

The bill eliminates the voluntary RCA registration process under current law, effective July 1, 2011, in favor of the new mandatory RCA registration process which becomes effective April 1, 2012.

Section 6 amends s. 460.4167, F.S., relating to proprietorship by persons other than licensed chiropractic physicians, to recognize other entities such as limited liability companies, limited partnerships, professional associations, and trusts, as authorized proprietorships that may employ a chiropractic physician or engage a chiropractic physician as an independent contractor to provide chiropractic services.

More specifically, the bill creates or revises the following exceptions to the requirement that no person other than a sole proprietorship, group practice, partnership, or corporation that is wholly owned by one or more licensed chiropractic physicians, or by a licensed chiropractic physician and the spouse, parent, child, or sibling of that chiropractic physician, may employ a chiropractic physician or engage a chiropractic physician as an independent contractor to provide chiropractic services:

- A limited liability company, limited partnership, any person, professional association, or any other entity that is wholly owned by:
  - A licensed chiropractic physician and the spouse or surviving spouse, parent, child, or sibling of the chiropractic physician; or
  - A trust whose trustees are licensed chiropractic physicians and the spouse, parent, child, or sibling of a chiropractic physician;

- A limited liability company, limited partnership, professional association, or any other entity wholly owned by a licensed chiropractor or chiropractors, a licensed medical doctor or medical doctors, a licensed osteopath or osteopaths, or a licensed podiatrist or podiatrists;
- An entity that is wholly owned, directly or indirectly, by a licensed or registered hospital or other entity licensed or registered under ch. 395, F.S.;
- An entity that is wholly owned and operated by an organization that is exempt from federal taxation under s. 501(c)(3) or (4) of the Internal Revenue Code;
- A health care clinic licensed under part X of ch. 400, F.S. that provides chiropractic services by a licensed chiropractic physician; and
- A health maintenance organization or prepaid health clinic regulated under ch. 641, F.S.

Upon the death of chiropractic physician who wholly owns a sole proprietorship, group practice, partnership, corporation, limited liability company, limited partnership, any person, professional association, or any other entity, with his or her spouse, parent, child, or sibling, and that wholly-owned entity employs a licensed chiropractic physician or engages a chiropractor as an independent contractor to provide chiropractic services, the bill allows the deceased chiropractic physician's surviving spouse or adult children to hold, operate, pledge, sell, mortgage, assign, transfer, own, or control the deceased chiropractic physician's ownership interests for so long as the surviving spouse or adult children remain the sole proprietor of the chiropractic practice.

The bill also grants authority to an authorized employer of a chiropractic physician to exercise control over:

- The patient records of the employed chiropractor;
- Policies and decisions relating to pricing, credit, refunds, warranties, and advertising; and
- Decisions relating to office personnel and hours of practice.

Section 7 provides that the bill takes effect July 1, 2011.

Other Potential Implications:
The DOH advises that the mandatory regulation of RCAs may enable chiropractic physicians to seek third-party reimbursements for therapeutic services or the administration of therapeutic agents by RCAs.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill requires the Board to assess a biennial fee for RCA registration not to exceed $25.

B. Private Sector Impact:

The DOH has been asked to provide a fiscal analysis of the committee substitute.

C. Government Sector Impact:

The DOH has been asked to provide a fiscal analysis of the committee substitute.

The DOH advises that after CCPAs are no longer authorized to perform services with indirect supervision anywhere other than the address of record of their supervising chiropractors, Section 4 of the bill would affect the department's enforcement branch if complaints are filed against CCPAs who continue to perform services at a place of practice other than their supervising chiropractor's address of record, the fiscal impact of which is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 5 of the bill requires an RCA to submit an initial application within 30 days after employment, and the registration applies retroactively to the date of employment. The DOH advises that the grace period of 30 days after employment to submit the registration application could conflict with s. 456.065, F.S., which provides for civil and criminal penalties for the unlicensed practice of a profession. Under the bill, unlicensed practice for 30 days of employment is acceptable if the registration is applied for no later than the end of the 30 days. If the Board does not receive an RCA application, then retroactivity will not apply and the unregistered RCA may be prosecuted for unlicensed practice.

Section 456.0635, F.S., requires a board or the DOH to refuse to issue or renew a license, certificate, or registration to any applicant if the applicant has been convicted of, or entered a plea of guilty or nolo conterdere to 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 controlled substances; or certain federal laws, unless the sentence and any subsequent period of probation ended more than 15 years prior to the date of the application. The bill's mandatory RCA

registration might impact the ability of certain persons to remain or become employed in a chiropractor's office.

VIII. 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 Regulation on March 9, 2011:
The CS made the following changes to the bill:

- The CS *allows* the Board to approve continuing education courses sponsored by chiropractic colleges if all other requirements of Board criteria for course approval are met, as opposed to the *required* approval of such courses in current law;
- The CS specifies that failing to preserve the identity of funds and property of a patient is grounds for license denial or disciplinary action only when the value of the funds and property is greater than $501. The requirement in current law that money or other property entrusted to a chiropractor for a specific purpose, including advances for costs and expenses of examination or treatment, must be held in trust and must be applied only to that purpose, is amended under the CS to prevent such advances from exceeding the value of $1,500; and
- The CS eliminates the voluntary registration for RCAs under current law and replaces it with a mandatory registration for all RCAs. The CS also eliminates the requirement in the original bill for chiropractors who supervise RCAs to be approved by the Board and for the Board to assess a fee up to $75 for that approval. The CS requires an RCA's initial registration, notification of change of employment, and biennial registration renewal to be signed by a chiropractor who is an owner of the RCA's place of employment, or by a non-chiropractor with an ownership interest in the place of employment and a supervising chiropractor in instances where the place of employment is not owned in whole or in part by a licensed chiropractor.

B. Amendments:

None.

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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	SB 446
INTRODUCER:	Senators Hays, Sobel, and Gaetz
SUBJECT:	Dentistry and Dental Hygiene
DATE:	April 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Favorable**
2.	Bradford	Hansen	BHA	**Pre-meeting**
3.			BC	
4.			RC	
5.				
6.				

I. Summary:

This bill generally expands the scope and area of practice of dental hygienists by authorizing dental hygienists to perform certain duties unsupervised in health access settings, which includes school-based prevention programs and accredited dental hygiene programs. The bill requires dental hygienists, who perform remediable tasks without supervision, to provide a dental referral in compliance with federal and state patient referral, anti-kickback, and patient brokering laws; encourages the establishment of a dental home; and requires the dental hygienists to maintain a certain amount of professional malpractice insurance coverage.

This bill clarifies that the authorization for dental hygienists to perform some duties does not prevent a program operated by one of the health access settings or a nonprofit organization from billing and obtaining reimbursement for the services provided by a dental hygienist.

This bill has no fiscal impact on state or local government.

This bill substantially amends the following sections of the Florida Statutes: 466.003, 466.023, 466.0235, 466.024, 466.006, and 466.0067.

This bill also reenacts s. 466.00672, F.S., for the purpose of incorporating the amendment made to s. 466.003, F.S., in the bill.

II. Present Situation:

Oral Health Care

Mouth and throat diseases, which range from cavities to cancer, cause pain and disability for millions of Americans each year. In children, cavities are the most common form of chronic disease, which often begins at early age. Tooth decay affects more than one-fourth of U.S. children aged 2 to 5 and half of those aged 12 to 15. Low-income children are hardest hit: about two-thirds of those aged 12 to 19 have had decay. Untreated cavities can cause pain, dysfunction, absence from school, difficulty concentrating, and poor appearance - problems that can greatly affect a child's quality of life and reduce a child's capacity to succeed in life.[1]

Tooth decay is also a problem for U.S. adults, especially for the increasing number of older adults who have retained most of their teeth. Despite an increase in tooth retention, tooth loss remains a problem among older adults. One-fourth of adults over age 65 have lost all of their teeth - primarily because of tooth decay. Advanced gum disease affects 4 to 12 percent of adults. Tooth loss can affect self-esteem, and it may contribute to nutrition problems by limiting the types of food that a person can eat.[2]

Shortage of Dentists

The pool of dentists to serve a growing population of Americans is shrinking. The American Dental Association found that 6,000 dentists retire each year in the U.S., while there are only 4,000 dental school graduates each year to replace them. The projected shortage of dentists is even greater in rural America. Of the approximately 150,000 general dentists in practice in the U.S., only 14 percent practice in rural areas, 7.7 percent in large rural areas, 3.7 percent in small rural areas, and 2.2 percent in isolated rural areas. In 2003, there were 2,235 federally designated dental supply shortage areas, 74 percent of which were located in non-metropolitan areas. In contrast, dental hygiene is predicted to be one of the top ten fastest growing health care professions over the next decade, growing by a projected 43 percent between 2006 and 2020.[3]

In 2010, there were 9,373 practicing dentists in Florida, meaning the ratio of dentists to the population in Florida is approximately 1 dentist for every 2,016 residents.[4] The estimated underserved population in 2008, in Florida, was 2.9 million people or 15.8 percent of the population.[5]

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[1] Centers for Disease Control and Prevention, *Oral Health: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers: At a Glance 2010*, available at: http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm (Last visited on March 11, 2011).
[2] *Id.*
[3] National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, November 2006. A copy of this report is on file with the Senate Health Regulation Committee.
[4] Professional staff of the Senate Health Regulation Committee received this information via email from the Department of Health on March 11, 2011. A copy of the email is on file with the committee.
[5] The Henry J. Kaiser Family Foundation, *Florida: Estimated Underserved Population Living in Dental Health Professional Shortage Areas (HPSAs) as of September, 2008*, available at: http://www.statehealthfacts.org/profileind.jsp?ind=681&cat=8&rgn=11 (Last visited on March 11, 2011).

Access to Dental Services in Rural Areas

Most research indicates that access to dental care is significantly more limited in rural areas than in metropolitan areas. According to the National Rural Health Association:[6]

- Even after controlling for population density and income, non-metropolitan counties have lower dentist-to-population ratios (62 dentists per 100,000 population in large metropolitan areas versus 29 dentists per 100,000 population in the most rural counties);
- Rural persons are more likely to have lost all their teeth than their non-rural counterparts; in fact, adults aged 18 to 64 are nearly twice as likely to be edentulous (toothless) if they are rural residents;
- Rural adults are significantly more likely than non-rural adults to have untreated dental decay (32.6 percent versus 25.7 percent);
- In 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so;
- Rural residents are less likely than their urban counterparts to have dental insurance; and
- Of the 2,235 Dental Health Professional Shortage Areas, 74 percent are in non-metropolitan areas.

According to the National Advisory Committee on Rural Health and Human Services, several factors contribute to the problems of rural oral health:

- *Geographic isolation*. People in remote rural areas have farther to travel to obtain care and fewer dentists, hygienists, and other professionals to provide it;
- *Lack of adequate transportation*. In many parts of rural America, private automobiles are the only source of transportation. Public transit is non-existent, as are taxicabs and other transportation for hire. Consequently, many rural residents—especially low-income residents—face great difficulty in going to the dentist or any other service provider;
- *Lack of fluoridated community water supplies*. This most basic preventative treatment against tooth decay is unavailable in countless rural communities;
- *Higher rates of poverty*. Low-income status prevents many people from seeking and obtaining oral health care. It also prevents them from purchasing dental insurance. In addition, rural employers are less likely to purchase or offer dental insurance for their employees due to the smaller average size for most rural employers;
- *Larger percentage of elderly population*. With increasing age come increasing dental and oral health problems. The percentages of rural Americans who are older and sicker are greater than those of urban Americans, and Medicare does not provide dental benefits;
- *Lower dental insurance rates*. Insurance reimbursement rates—both public and private—for dental procedures are typically lower in rural areas than in urban. However, the actual costs of providing the services are often higher in rural areas;
- *Acute provider shortages*. As indicated above, the ratio of dentists per 100,000 population in non-metropolitan counties is less than half of what it is in metropolitan counties. The acute shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students, despite the fact that dental school applications were up some 18 percent between 2004 and 2005. With the closing of seven dental schools since 1986, and

[6] National Rural Health Association, *Meeting Oral Health Care Needs in Rural America*, April 2005. A copy of this report is on file with the Senate Health Regulation Committee.

subsequent opening of only three new ones, more people want to become dentists than there are available slots. On top of that, many dentists are nearing retirement age - especially in rural areas. In addition, it can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural locations will lead to a reduced percentage of the dental school graduates locating in rural locations; and

- *Difficulty finding providers willing to treat Medicaid patients*. Because of low reimbursement rates, paperwork burdens, and a perception of a higher percentage of broken appointments, many dentists simply do not accept Medicaid or State Children's Health Insurance Program (SCHIP) patients, of which there are many in rural America due to the higher proportion of people living in poverty.[7]

The Florida county health departments have several dental facilities that cannot serve patients because they do not have any dentists to provide dental care. Several other county health departments have some dentists but are in serious need of additional dentists to deliver care to low income and underserved Floridians. The DOH has had difficulty in recruiting and retaining public health dentists. There were 106 full time equivalent (FTE) dentists in county health departments during the DOH's Fiscal Year 2009-10.[8]

Florida Board of Dentistry

Section 466.004, F.S., establishes the Board of Dentistry within the DOH. The board consists of 11 members who are appointed by the Governor and subject to confirmation by the Senate. Seven members of the board must be licensed dentists in this state; two members must be licensed dental hygienists actively engaged in the practice of dental hygiene in this state; and the remaining two members must be laypersons who are not, and have never been, dentists, dental hygienists, or members of any closely related profession or occupation.

Each member of the board who is a licensed dentist must have been actively engaged in the practice of dentistry primarily as a clinical practitioner for at least 5 years immediately preceding the date of her or his appointment to the board and must remain primarily in clinical practice during all subsequent periods of appointment to the board. At least one member of the board must be 60 years of age or older. Members shall be appointed for 4-year terms, but may serve no more than a total of 10 years.

Dental Hygienists

In Florida, dental hygienists are regulated by ss. 466.023, 466.0235, and 466.024, F.S. Dental hygienists are focused on preventing dental disease. They are educated and trained to evaluate the patient's oral health; expose, process and interpret dental X-ray films; and remove calculus deposits, stains, and plaque above and below the gumline.[9] They also apply preventive agents such as fluorides and sealants to teeth when allowed by state regulations.[10]

[7] *Id.* (citing the National Advisory Committee on Rural Health and Human Services).
[8] *Supra* fn. 4.
[9] Section 466.023, F.S.
[10] *See* Rule 64B5-16.006, Remediable Tasks Delegable to a Dental Hygienist, F.A.C.

Dental hygienists provide education about oral health care, selecting toothbrushes, the use of dental floss, and oral health problems related to diet or use of tobacco products. Additionally, dental hygienists receive training in assisting and reception responsibilities so they can be comprehensive team members in the dental practice.

Current law, s. 466.024, F.S., sets forth tasks that may be delegated and authorizes the board to identify additional tasks that are remedial and may be delegated. Other tasks cannot be performed by a dental hygienist without supervision. Delegable tasks under this section of law include:

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance;
- Placing periodontal dressings;
- Removing periodontal or surgical dressings;
- Removing sutures;
- Placing or removing rubber dams;
- Placing or removing matrices;
- Placing or removing temporary restorations;
- Applying cavity liners, varnishes, or bases;
- Polishing amalgam restorations;
- Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth; and
- Obtaining bacteriological cytological specimens not involving cutting of the tissue.

These limits on delegable tasks prevent the maximization of the existing workforce by prohibiting dental hygienists from providing preventive services, such as placing sealants, in public health settings without a dentist present or without prior authorization.

Other factors also limit the ability of the state to use dental hygienists to expand access to dental care. Currently, a dental hygienist may not treat a patient that has no record within the past 13 months with a facility dentist.[11] This means that, for example, when a child shows up to receive a dental hygiene cleaning or fluoride treatment, the dental hygienist on staff may not provide these routine services without a dentist first authorizing the treatment. In effect, this means that the county health department must turn away patients at facilities that have no dentist, or limited dentists, on staff. This also means that the department's dental hygiene workforce is not being fully utilized.

III. Effect of Proposed Changes:

This bill generally expands the scope and area of practice of dental hygienists by authorizing dental hygienists to perform certain duties unsupervised in health access settings.

Section 1 amends s. 466.003, F.S., to change the definition of the term "health access setting" to include a school-based prevention program and an accredited dental hygiene program. The term "school-based prevention program" is defined to mean preventative oral health services offered at a school by one of the entities included in the definition of a health access setting or by a

[11] *See* Rule 64B5-16.001, Definitions of Remediable Tasks and Supervision Levels, F.A.C.

nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c)(3) of the Internal Revenue Code.

Section 2 amends s. 466.023, F.S., to authorize dental hygienists to perform their duties in a health access setting and perform certain services without supervision, including apply fluorides, instruct a patient in oral hygiene care, and supervise the oral hygiene care of a patient.

Section 3 amends s. 466.0235, F.S., to authorize a dental hygienist, without supervision and within the lawful scope of his or her duties as authorized by law, perform dental charting of hard and soft tissues in health access settings.

Section 4 amends s. 466.024, F.S., to authorize dental hygienists licensed in Florida to perform certain remedial tasks in health access settings without the physical presence of, prior examination by, or authorization of, a dentist. Specifically, dental hygienists are authorized to:

- Perform dental charting, which is defined under s. 466.0235, F.S., as a recording of visual observations of clinical conditions of the oral cavity without the use of X-rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets;
- Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature;
- Record a patient's case history;
- Apply topical fluorides, including fluoride varnishes, which are approved by the American Dental Association or the Food and Drug Administration;
- Apply dental sealants; and
- Remove calculus (dental tartar) deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus, if a dentist licensed under ch. 466, F.S., or a physician licensed under ch. 458 or ch. 459, F.S., gives medical clearance before the dental hygienist removes such deposits, accretions, and stains. A dentist is required to conduct a dental examination on a patient within 13 months after a dental hygienist removes such deposits, accretions, and stains and additional oral hygiene services of this type may not be performed without a clinical examination by a dentist who is licensed under ch. 466, F.S.

The authorization to perform the above services does not authorize a dental hygienist to perform root planing or gingival curettage[12] without supervision by a dentist.

A dental hygienist must provide to the patient in writing before any remediable task is performed in a health access setting without the physical presence of, prior examination by, or authorization of a dentist a disclaimer which must state that the services being offered are not a substitute for a comprehensive dental exam by a dentist and the diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions will be completed only by a dentist in the context of delivering a comprehensive dental exam.

[12] Gingival curettage is a surgical procedure designed to remove the soft tissue lining of the periodontal pocket with a curet, leaving only a gingival connective tissue lining. American Academy of Periodontology, *The American Academy of Periodontology Statement Regarding Gingival Curettage*, available at: http://www.perio.org/resources-products/pdf/38-curettage.pdf (Last visited on March 10, 2011).

This section clarifies that authorization for dental hygienists to perform the above services does not prevent a program operated by one of the health access settings or a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c)(3) of the Internal Revenue Code from billing and obtaining reimbursement for such services or from making or maintaining any records necessary to obtain reimbursement.

This section requires dental hygienists who perform, without supervision, the above-listed remedial tasks to provide a dental referral in strict compliance with federal and state patient referral, anti-kickback, and patient brokering laws and encourages the establishment of a dental home. A dental hygienist performing such tasks must also maintain professional malpractice insurance coverage that has minimum limits of $100,000 per occurrence and $300,000 in the aggregate through the employing health access setting or individual policy.

Section 5 amends s. 466.006, F.S., to make cross-reference corrections to conform to changes made by the bill and clarifies that an applicant for a dental license must successfully complete the National Board of Dental Examiners dental examination within 10 years after the date of application. Currently, an applicant can take the examination anytime within 10 years of the date of application, including prior to the application.

Section 6 amends s. 466.0067, F.S., to correct a cross-reference to conform to changes made by the bill.

Section 7 reenacts s. 466.00672, F.S., for the purpose of incorporating the amendment made by the bill to s. 466.003, F.S.

Section 8 provides that the bill shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Patients particularly in rural areas my find improved access to dental services.

C. Government Sector Impact:

To the extent that patients have increased access to dental services, publically funded dental programs like Medicaid may see increased billings.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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The Committee on Budget Subcommittee on Health and Human Services Appropriations (Oelrich) recommended the following:

Senate Amendment (with title amendment)

Delete lines 32 - 71

and insert:

(b) An individual who tests positive for controlled substances as a result of a drug test required under this section is ineligible to receive TANF benefits for 1 year after the date of the positive drug test unless the individual meets the requirements of paragraph (2)(j).

(2) The department shall:

(a) Provide notice of drug testing to each individual at the time of application. The notice must advise the individual

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that drug testing will be conducted as a condition for receiving TANF benefits and that the individual must bear the cost of testing. The individual shall be advised that the required drug testing may be avoided if the individual does not apply for TANF benefits. Dependent children under the age of 18 are exempt from the drug-testing requirement.

(b) Require that for two-parent families, both parents must comply with the drug-testing requirement.

(c) Require that any teen parent who is not required to live with a parent, legal guardian, or other adult caretaker relative in accordance with s. 414.095(14)(c) must comply with the drug-testing requirement.

(d) Advise each individual to be tested, before the test is conducted, that he or she may, but is not required to, advise the agent administering the test of any prescription or over-the-counter medication he or she is taking.

(e) Require each individual to be tested to sign a written acknowledgment that he or she has received and understood the notice and advice provided under paragraphs (a) and (d).

(f) Assure each individual being tested a reasonable degree of dignity while producing and submitting a sample for drug testing, consistent with the state's need to ensure the reliability of the sample.

(g) Specify circumstances under which an individual who fails a drug test has the right to take one or more additional tests.

(h) Inform an individual who tests positive for a controlled substance and is deemed ineligible for TANF benefits that the individual may reapply for those benefits 1 year after

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the date of the positive drug test unless the individual meets the requirements of paragraph (j). If the individual tests positive again, he or she is ineligible to receive TANF benefits for 3 years after the date of the second positive drug test unless the individual meets the requirements of paragraph (j).

(i) Provide any individual who tests positive with a list of licensed substance abuse treatment providers that are available in the area in which he or she resides, that meet the requirements of s. 397.401, and that are licensed by the department. Neither the department nor the state is responsible for providing or paying for substance abuse treatment as part of the screening conducted under this section.

(j) Provide a procedure whereby an individual who tests positive under this section and is denied TANF benefits as a result may reapply for those benefits after 6 months if the individual documents successful completion of a substance abuse treatment program offered by a provider that meets the requirements of s. 397.401 and is licensed by the department. An individual who has met the requirements of this paragraph and reapplies for TANF benefits must also pass an initial drug test and meet the requirements of subsection (1). Any drug test conducted while the individual is undergoing substance abuse treatment must meet the requirements of subsection (1). The cost of any drug testing and substance abuse treatment provided under this section is the responsibility of the individual being tested and receiving treatment. An individual who fails the drug test required under subsection (1) may reapply for benefits under this paragraph only once.

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71 ================ T I T L E A M E N D M E N T ================
72 And the title is amended as follows:
73 Delete line 11
74 and insert:
75 abuse programs; providing conditions for an individual
76 to reapply for Temporary Assistance for Needy Families
77 benefits; providing that, if a parent is deemed

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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 556
INTRODUCER:	Criminal Justice Committee and Senators Oelrich, Dockery, and Garcia
SUBJECT:	Drug Screening/Beneficiaries/Temporary Assistance
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Cellon	Cannon	CJ	**Fav/CS**
2.	Carpenter	Hansen	BHA	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill creates s. 414.145, F.S., establishing that the Department of Children and Families (DCF) shall create a drug screening program for temporary cash assistance (TANF) applicants as a condition of eligibility. The bill provides the following:

- Adult applicants for TANF, to include both parents in a two-parent household, or caretaker relative who is included in the cash assistance group, shall be drug screened;
- Applicants that fail the drug screen have the right to submit to an additional drug screening under circumstances to be specified by DCF. The applicant who tests positive is ineligible for TANF benefits for one year. If, after one year, the person applies for TANF benefits and tests positive again, he or she shall be disqualified from receiving temporary cash assistance for 3 years;
- The applicant who has failed a drug screen may designate another individual, who must pass the drug screening, to receive the cash assistance benefits on behalf of a minor child;
- The methods of drug screening and confirmatory testing, including policies and procedures for specimen collection, testing, storage, and transportation are to be consistent with s. 112.0455, F.S.;
- The cost of screening and confirmatory testing shall be paid by the individual applicant;

- DCF shall provide any individual who tests positive for drugs with information concerning drug abuse and treatment programs in the area in which he or she resides. The bill specifies that neither DCF nor the state is responsible for providing or paying for substance abuse treatment as part of screening under this section; and
- There is no date specified in the bill for the beginning of the drug screening of TANF applicants although the bill provides an effective date of July 1, 2011.

This bill has no direct fiscal impact on the Department of Children and Family Services, and necessary changes to the ACCESS Program's information systems to accommodate new reporting and notice requirements can be handled within existing resources.

This bill creates section 414.145 of the Florida Statutes.

II. Present Situation:

Temporary Assistance for Needy Families (TANF)
Under the welfare reform legislation of 1996, the Personal Responsibility and Work Opportunity Reconciliation Act – PWRORA – Public Law 104-193, the Temporary Assistance for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program.

The law ended federal entitlement to assistance and instead created TANF as a block grant that provides States, territories and tribes federal funds each year. These funds cover benefits, administrative expenses, and services targeted to needy families.

TANF became effective July 1, 1997, and was reauthorized in February 2006 under the Deficit Reduction Act of 2005.[1] States receive block grants to operate their individual programs and to accomplish the goals of the TANF program. Those goals include:

- Assisting needy families so that children can be cared for in their homes;
- Reducing the dependency of needy parents by promoting job preparation, work, and marriage;
- Preventing out-of-wedlock pregnancies; and
- Encouraging the formation and maintenance of two-parent families.[2]

Currently, DCF administers the TANF program in conjunction with the Agency for Workforce Innovation (AWI). Current law provides that families are eligible for cash assistance for a lifetime cumulative total of 48 months (4 years).[3] DCF reports that approximately 113,346 people are receiving temporary cash assistance.[4] The FY 2010-2011 appropriation of TANF funds to support temporary cash assistance was $211,115,965.

[1] US Dept. of Health and Human Services, Administration on Children and Families http://www.acf.hhs.gov/programs/ofa/tanf/about.html (last visited on 2/15/11).
[2] *Id*
[3] s. 414.105, F.S.
[4] DCF Quick Facts, Access Program, January 1, 2011.

The TANF program expires on September 30, 2011, and must be reauthorized by Congress to continue.

Pilot Project for Drug Testing TANF Applicants

From January 1999 to May 2001, DCF in consultation with Workforce Florida implemented a pilot project in Regions 3 and 8 to drug screen and drug test applicants for TANF.[5] A Florida State University researcher under contract to evaluate the pilot program did not recommend continuation or statewide expansion of the project. Overall research and findings concluded that there is very little difference in employment and earnings between those who test positive versus those who test negative. Researchers concluded that the cost of the pilot program was not warranted.

Sanctions to Welfare and Food Assistance Recipients Resulting from Felony Drug Convictions

Federal law provides that an individual convicted (under federal or state law) of any offense which is classified as a felony related to the possession, use or distribution of a controlled substance shall not be eligible for assistance under the TANF program or benefits under the food stamp program or any program carried out under the Food and Nutrition Act of 2008.[6]

The same section of Federal law provides that each state has the right to exempt individuals from having benefits withheld due to a felony drug charge.[7] Florida has opted to exempt individuals from this provision and does not deny benefits for a felony drug conviction, unless the conviction is for drug trafficking.[8]

Drug Testing Welfare and Food Assistance Recipients

Federal law regarding the use of TANF funds provides that states may test welfare recipients for use of controlled substances and sanction those recipients who test positive.[9]

Protective Payees

The TANF program requires that people receiving cash assistance must satisfy work requirements established in federal law. Florida statutes provide that the Agency for Workforce Innovation develop specific activities that satisfy the work requirements.[10]

In the event that a TANF recipient is noncompliant with the work activity requirements, DCF has authority to terminate cash assistance to the family.[11] In the event that assistance is terminated, DCF will establish a protective payee that will receive TANF funds on behalf of any children in the home who are under the age of 16.[12] The protective payee shall be designated by DCF and may include:[13]

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[5] Evaluation Report, Robert E. Crew, Florida State University (on file with House committee staff).
[6] P.L. 104-193, Section 115, 42 U.S.C. 862(a)
[7] *Id*
[8] s. 414.095, F.S.
[9] P.L. 104-193, Section 902, 21 U.S.C. 862(b)
[10] s. 445.024, F.S.
[11] s. 414.065, F.S.
[12] *Id*
[13] *Id*

- A relative or other individual who is interested in or concerned with the welfare of the child or children and agrees in writing to utilize the assistance in the best interest of the child or children;
- A member of the community affiliated with a religious, community, neighborhood, or charitable organization who agrees in writing to utilize the assistance in the best interest of the child or children; and
- A volunteer or member of an organization who agrees in writing to fulfill the role of protective payee and utilize the assistance in the best interest of the child or children.

Agency for Health Care Administration – Laboratory Certifications
The Agency for Health Care Administration (AHCA) regulates facilities that perform clinical, anatomic, or cytology lab services to provide information or materials for use in diagnosis, prevention, or treatment of a disease or in the identification or assessment of a medical or physical condition in accordance with Chapters 408 and 483, F.S. These are considered clinical labs.

Additionally, AHCA regulates facilities for "Drug Free Workplaces," pursuant to s. 112.0455, F.S. These types of labs perform chemical, biological, or physical instrumental analyses to determine the presence or absence of specified drugs or their metabolites in job applicants of any agency in state government.[14] AHCA does not have the authority to drug screen temporary cash assistance benefits in either of these labs.

Department of Health and Human Services Division of Workplace Programs
The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Division of Workplace Programs (DWP) provide oversight for the Federal Drug Free Workplace Program. DWP certifies labs that conduct forensic drug testing for federal agencies and for some federally-regulated industries.[15]

III. Effect of Proposed Changes:

The bill creates s. 414.145, F.S., providing that the Department of Children and Family Services (DCF) will create a drug screening program that requires individuals who apply for temporary cash assistance benefits (TANF) to consent to being drug screened as a condition of eligibility. There is no implementation date for the program in the bill. Existing beneficiaries of the TANF program are not covered by the bill.

DCF must provide notice of the potential of drug screening to all applicants and shall require an applicant to sign an acknowledgement form that he or she has received notice of DCF's drug screen policy and that he or she can refuse to undergo the screen.

The screening shall be consistent with drug testing under The Drug-Free Workplace Act, s. 112.0455, F.S.

The bill provides that an adult applicant will be disqualified from receiving TANF benefits if:

[14] Chapter 408, F.S.
[15] *Id*

- They refuse to submit to a drug screen or confirmatory test; or
- They test positive for drugs as a result of a confirmation test.

If an applicant fails a confirmation test they will be ineligible for TANF benefits for 1 year. Upon application for TANF benefits after a one-year period, if the applicant tests positive again, he or she is disqualified from receiving TANF for 3 years.

In a two-parent household, both parents must be tested. Any caretaker relative included in the TANF group must also be tested.

The bill establishes that in the event the individual has minor children, the individual can designate an immediate family member or another individual approved by DCF to receive funds on behalf of the children. The designated individual must pass the drug screen.

DCF shall provide an individual who tests positive for drugs information concerning substance abuse treatment programs that may be available in their area. Neither DCF nor the state is responsible for providing or paying for substance abuse treatment for these individuals as part of the screening conducted in this section of law.

Applicants for cash assistance shall be responsible for the cost of both the initial drug screen and the confirmatory test (if needed).

Rule making authority is provided in order for DCF to implement the drug screening program.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirement of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

In a Michigan case welfare recipients sought an injunction to stop enforcement of a state statute authorizing suspicionless drug testing of applicants for and recipients of benefits. The U.S. District Court issued the temporary injunction and the State of Michigan

appealed. The Circuit Court of Appeal overturned the District Court's ruling in 2003.[16] In doing so the court thoroughly analyzed the evidence presented by the state to show the state's "special need" for the suspicionless drug testing. The Court relied, in part, on the 2002 U.S. Supreme Court decision in *Board of Education v. Earls* that approved of drug testing of students who participate in extracurricular activities.[17]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will have an impact on applicants who are required to undergo a drug screen or confirmation test as a condition of eligibility for temporary cash assistance funds. The department estimates that initial drug screening will cost $10 per person and confirmatory tests will cost approximately $25 per person.

C. Government Sector Impact:

It is unknown whether the fiscal effect of this bill will be positive or negative for the state. Because of the bill's provision that a TANF applicant or recipient, who is a parent with a minor child, and who fails the drug screen, may designate another recipient on the child's behalf, it is less likely TANF funds would be "saved" in every case of a positive drug screen.

Currently, DCF does not drug screen any individual as a condition of eligibility for cash assistance. DCF estimates that between 170-340 people (based on current caseloads) would test positive as a result of a drug screen. This estimate may be low.

The Substance Abuse and Mental Health Administration, which is part of the U.S. Department of Health and Human Services found that 9.6 percent of people living in households that receive government assistance used illicit drugs (in the previous month) compared with a 6.8 percent rate among families who receive no assistance.[18]

As mentioned in the Present Situation section of the analysis, a drug-screening pilot project was conducted in the Jacksonville area and parts of Putnam County between 1999 and 2001. During the project, 8,797 applicants or recipients were tested. Of those 8,797 applicants who were tested, 335 applicants tested positive for a controlled substance. The Orlando Sentinel reported that the cost of the pilot project was $2.7 million.[19]

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[16] *Marchwinski v. Howard*, 309 F.3d 330 (6th Cir. 2002).
[17] *Earls*, 122 S.Ct. 2559 (2002).
[18] *Should Welfare Recipients Get Drug Testing?*, Alan Greenblatt, www.npr.org, March 31, 2010.
[19] Orlando Sentinel editorial, *Our take on: Welfare drug tests*, October 30, 2010.

The bill states that neither the department nor the state is responsible for paying for substance abuse treatment for individuals as part of the screening conducted in this section. This could create problems for DCF when individuals who failed TANF drug screening seek help at a DCF-licensed substance abuse treatment facility or provider. It appears that DCF would need to establish a system to cross-reference those denied temporary cash assistance due to drug screening with those who are seeking substance abuse treatment. It is unknown at this time what the cost of developing such a cross-referencing system would be.

The department does not have exact estimates of the costs to changing its information systems required by the bill but states that these changes can be done within existing resources. Specifically, changes to the ACCESS program's information systems would be necessary to address new reporting and notice requirements by the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Criminal Justice on March 22, 2011:

- Created a different section of law – by changing s. 414.095 to s. 414.145, F.S., in the bill;
- Eliminated Supplemental Nutrition Assistance Program (SNAP) applicants from the provisions in the bill;
- Eliminated the legislative intent, definitions, program implementation date, details related to specimen collection and preservation, and DCF's reporting requirement from the bill;
- Modified the period of ineligibility for TANF upon an initial failed drug screen from 3 years to one year. Provided that upon re-application in one year, if the applicant tests positive again, he or she is ineligible for 3 years;
- Restored current law in s. 414.095, F.S., regarding convictions for trafficking in drugs as a reason to deny benefits; and
- Provided that testing shall be consistent with s. 112.0455, F.S., the Drug-Free Workplace Act.

B. Amendments:

None.

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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 584
INTRODUCER:	Health Regulation Committeee and Senator Flores
SUBJECT:	Massage Therapy
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Fav/CS**
2.	Bradford	Hansen	BHA	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This committee substitute (CS) of SB 584 authorizes a person, who meets certain licensure requirements and graduates from a massage therapy school that is accredited and approved by the Board of Massage Therapy (board), to obtain a temporary permit from the board to practice massage therapy. The temporary permit is valid for 6 months after its issuance by the board, until the applicant fails the massage licensure examination, or until the applicant receives a massage therapist license, whichever occurs first. The CS allows those with a temporary permit to practice massage only under the supervision of a licensed massage therapist, who has an active and unencumbered license.

The CS requires an applicant seeking a temporary permit to practice massage therapy to pay a one-time fee of $50. The estimated revenue the DOH expects to generate from the temporary permit fees is $130,300 annually. Any costs associated with this new regulatory function will be covered by the fees generated.

The CS provides an effective date of January 3, 2012.

This CS substantially amends the following sections of the Florida Statutes: 480.041 and 480.044.

II. Present Situation:

Background

The American Massage Therapy Association (AMTA)[1] estimated that in 2010, massage therapy was a $12-17 billion industry. The AMTA also estimated that there are approximately 280,000 to 320,000 massage therapists and massage school students in the United States. According to the U.S. Department of Labor in 2010, employment for massage therapists is expected to increase 19 percent from 2008 to 2018, faster than the average for all occupations.[2]

In May 2008, median hourly wages of massage therapists, including gratuities, were $16.78. The middle 50 percent earned between $11.36 and $25.14. The lowest 10 percent earned less than $8.01, and the highest 10 percent earned more than $33.47. Because many therapists work part time, yearly earnings can vary considerably, depending on the therapist's schedule. Generally, massage therapists earn some portion of their income as gratuities. For those who work in a hospital or other clinical setting, however, tipping is not common.[3]

Currently, 43 states and the District of Columbia regulate massage therapists or provide voluntary state certification.[4] In states that regulate massage therapy, massage therapists must meet the legal requirements to practice, which may include minimum hours of initial training and passing an exam. In states that do not regulate massage therapy, this task may fall to local municipalities. Most states that license massage therapists require a passing grade on the Massage & Bodywork Licensing Exam (MBLEx) or one of two exams provided by the National Certification Board for Therapeutic Massage & Bodywork.[5]

Florida Regulation of Massage Therapists and Massage Establishments

Massage therapists and massage establishments in Florida are regulated by the board, within the DOH, under the Massage Practice Act, ch. 480, F.S., and Chapter 64B7, Florida Administrative Code. A person must be licensed as a massage therapist to practice massage for compensation, unless otherwise specifically exempted under the Massage Practice Act.[6] In order to be licensed as a massage therapist, an applicant must:

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[1] AMTA is the largest non-profit, professional association serving more than 56,000 massage therapists, massage students, and massage schools. *See* AMTA, *2011 Massage Therapy Industry Fact Sheet*, available at: http://www.amtamassage.org/articles/2/PressRelease/detail/2320 (Last visited on March 4, 2011).

[2] U.S. Department of Labor, Bureau of Labor Statistics; *Occupational Outlook Handbook, 2010-11 Edition: Massage Therapists*; available at http://www.bls.gov/oco/ocos295.htm#projections_data (Last visited on March 1, 2011).

[3] *Id.*

[4] AMTA, *2011 Massage Therapy Industry Fact Sheet*, available at: http://www.amtamassage.org/articles/2/PressRelease/detail/2320 (Last visited on March 4, 2011). A list of states and a summary of their massage regulations is available at: http://www.massagetherapy.com/_content/careers/MTreg.pdf (Last visited on March 4, 2011). Currently, Alaska, Idaho, Kansas, Minnesota, Oklahoma, Vermont, and Wyoming do not regulate massage therapy.

[5] AMTA, *2011 Massage Therapy Industry Fact Sheet*, available at: http://www.amtamassage.org/articles/2/PressRelease/detail/2320 (Last visited on March 4, 2011).

[6] Section 480.047(1)(a), F.S. *See also* s. 480.033(4), F.S.

- Be at least 18 years old or have received a high school diploma or graduate equivalency diploma;
- Complete a course of study at a board-approved massage school[7] or apprenticeship program; and
- Pass an examination,[8] which is currently offered in English and in Spanish.[9]

Licensed massage therapists may practice in a licensed massage establishment, at a client's residence or office, or at a sports event, convention or trade show.[10] Sexual misconduct, defined as a violation of the professional relationship through the use of such relationship to engage or attempt to engage in sexual activity outside the scope of the profession, is strictly prohibited.[11]

A person may be approved by the board to become an apprentice to study massage under the instruction of a licensed massage therapist, if the person meets the qualifications stated in Rule 64B7-29.002, Florida Administrative Code. To qualify for an apprenticeship, the applicant must have secured the sponsorship of a sponsoring massage therapist, complete a DOH application, pay a $100 fee, and must not be enrolled simultaneously as a student in a board-approved massage school.[12]

Section 480.43, F.S., provides that a massage establishment license is required at any facility where massage therapy services are offered by a licensed massage therapist and directs the board to adopt application criteria. It also provides that massage establishment licenses may not be transferred to a new owner, but may be transferred to a new location if the new location is inspected and approved by the board and an application and inspection fee has been paid. A license may be transferred from one business name to another if approved by the board and if an application fee has been paid.

The board's rules include insurance requirements, compliance with building codes, and safety and sanitary requirements, and require a licensed massage therapist to be onsite any time a client is receiving massage services.[13] Upon receiving an application, the DOH inspects the establishment to ensure it meets the licensure requirements.[14] Once licensed, the DOH inspects the establishment at least annually.[15]

An application for a massage establishment license may be denied for an applicant's conviction of crimes related to the practice of massage, and must be denied for convictions of enumerated crimes within 15 years of application[16] and for past sexual misconduct.[17]

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[7] A list of board-approved massage schools is available at: http://www.doh.state.fl.us/mqa/massage/lst_ma-school.pdf (Last visited on March 4, 2011).
[8] Section 480.042, F.S.
[9] Rule 64B7-25.001(3), F.A.C.
[10] Section 480.046(1)(n), F.S.
[11] Section 480.0485, F.S. *See also* Rule 64B7-26.010, F.A.C.
[12] *See* rule 64B7-27.005, for the apprentice fee amount.
[13] Rule 64B7-26.003, F.A.C.
[14] Rule 64B7-26.004, F.A.C.
[15] Rule 64B7-26.005, F.A.C.
[16] Section 456.0635, F.S.
[17] Section 456.063, F.S.

It is a misdemeanor of the first degree to operate an unlicensed massage establishment.[18] Currently, upon receiving a complaint that unlicensed activity is occurring, the DOH's Medical Quality Assurance inspectors coordinate with local law enforcement. Unlicensed practice of massage therapy is punishable as a third-degree felony.[19] The DOH may issue cease and desist notices, enforceable by filing for an injunction or writ of mandamus and seek civil penalties against the unlicensed party in circuit court.[20] The DOH may also impose, by citation, an administrative penalty up to $5,000. While the DOH has investigative authority, it does not have arrest authority or sworn law enforcement personnel.

III. Effect of Proposed Changes:

Section 1 amends s. 480.041, F.S., to authorize the board to issue a temporary permit to practice massage therapy to an applicant who graduates from a massage therapy school that is board-approved and accredited by an accrediting agency recognized by the U.S. Department of Education.

An applicant only qualifies to apply for a temporary permit if he or she is at least 18 years of age or has received a high school diploma or graduate equivalency diploma, has completed a course of study at an accredited and board-approved massage school, and has not yet taken the examination required for licensure. An applicant must apply to the DOH in writing upon forms prepared and furnished by the DOH. Applicant's who receive a temporary permit are subject to the provisions in s. 480.046, F.S., which specifies circumstances under which the DOH can deny a license or conduct a disciplinary action.

This section specifically exempts applicants for temporary permits from the:

- Licensure requirements that require a passing grade on an examination administered by the DOH;
- Board's rules that require education, examination, and certification for the practice of colonic irrigation;
- Board's rules relating to licensing procedures for those desiring to be licensed in Florida and who hold an active license in, and have practiced in, another state, territory, or jurisdiction of the U.S. or any foreign national jurisdiction which has licensing standards substantially similar to, equivalent to, or more stringent than the standards in Florida for licensure.

The temporary permit is only valid for 6 months after issuance by the board, until the applicant fails the massage licensure examination, or receives a massage therapist license, whichever occurs first. A person practicing massage therapy under a temporary permit must be supervised by a licensed massage therapist who has a full, active, and unencumbered license.

Section 2 amends s. 480.044, F.S., to require the board to set a $50 fee for temporary permits for providing massage therapy services.

Section 3 provides an effective date of January 3, 2012.

[18] Section 480.047, F.S.
[19] Section 456.065, F.S.
[20] *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Applicants seeking a temporary permit to perform massage therapy services will be required to pay a fee of $50.

B. Private Sector Impact:

Businesses offering massage therapy services may be able to offer services to the public for less money if persons with temporary permits, while supervised, are able to provide such services at a reduced rate.

C. Government Sector Impact:

The DOH has estimated that approximately 2,606 applicants would have requested a temporary permit if 75 percent of the 3,475 applicants for massage therapy licensure in fiscal year 2009-10 requested a temporary permit. The DOH has reported that it will not require additional resources to implement the provisions of this bill and will absorb the costs associated with rulemaking responsibilities and the changes that will be needed for the DOH's application forms and database. The estimated revenue the DOH expects to generate from the temporary permit fees is $130,300.[21]

VI. Technical Deficiencies:

The bill in lines 61-64 requires applicants seeking a temporary permit to meet all of the qualifications for licensure under s. 480.041, F.S., except for a provision under paragraph (1)(b) pertaining to the completion of an apprenticeship program and paragraphs (1)(c), (4)(b), and (4)(c). Paragraphs (4)(b) and (4)(c) require the *board to adopt rules* concerning the practice of

[21] Department of Health, *Bill Analysis, Economic Statement, and Fiscal Note for SB 584*, dated February 8, 2011. A copy of this analysis is on file with the Senate Health Regulation Committee.

colonic irrigation and licensing procedures for practitioners licensed in other states. Therefore, it may be more appropriate to say in lines 61-64 that an applicant must meet all of the licensure requirements except for a provision under paragraph (1)(b) pertaining to the completion of an apprenticeship program, paragraph (1)(c), and any rules adopted under paragraphs (4)(b) and (4)(c).

VII. Related Issues:

In lines 75-78, it is unclear whether the intent is to require a licensed massage therapist to provide "direct supervision" of a person practicing massage therapy under a temporary permit. Furthermore, the term "supervision" is not defined in ch. 480, F.S., the Massage Practice Act.

On January 28, 2011, during a board meeting, the board voted unanimously to oppose this bill. The board gave the following reasons:

- Temporary permits do not serve the public health and safety;
- Temporary permit holders do not meet basic entry level requirements with regards to practicing with reasonable skill and safety because they have not proven competency by passing the entry level examinations. The examinations are provided daily via computer based testing and may be taken prior to or immediately after graduation from an approved program.
- Supervision required is not sufficiently defined without rulemaking authority by the board.
- The bill will increase regulatory costs.[22]

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by the Health Regulation Committee on March 9, 2011:

The CS differs from the bill in that it:

- Authorizes the Department of Health to prepare and furnish the appropriate application forms to applicants seeking temporary permits to practice massage therapy.
- Sets the temporary permit fee at $50 to avoid rulemaking procedures to determine a fee.
- Extends the effective date to January 3, 2012, to allow the Department of Health time to implement provisions of the bill.
- Clarifies that the board may only issue a temporary permit to an applicant who graduates from a massage school that is accredited by an accrediting agency recognized by the U.S. Department of Education.
- Clarifies that an applicant may not complete an apprentice program in lieu of completing a course of study at a board-approved massage school in order to be eligible to apply for a temporary permit.

[22] *Supra* fn. 21.

- Specifies that an applicant may apply for a temporary permit if the applicant has completed a course of study at a massage school that has been board-approved and accredited by an accrediting agency recognized by the U.S. Department of Education.

B. Amendments:

None.

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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 1410
INTRODUCER:	Health Regulation Committee and Senator Negron
SUBJECT:	Health Care Price Transparency
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HR	**Fav/CS**
2.	Bradford	Hansen	BHA	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill amends the Patient's Bill of Rights to authorize a primary care provider to publish a schedule of charges for the medical services that the provider offers to patients. As an incentive to posting the schedule, the primary care practitioner is exempt from the general continuing education requirements for a single 2-year period. If posted, the schedule is to include the prices charged to an uninsured person paying by cash, check, credit card, or debit card for at least the 50 services most frequently provided by that primary care provider.

If a person requests an estimate of charges for medical services before the services are provided, the estimate by a primary care provider must be consistent with the posted schedule.

This bill has no fiscal impact on state or local government. Primary care physicians may incur an indeterminate cost to post and maintain the schedule of charges in the reception area. However, this cost might be offset by the savings due to the exemption from continuing education requirement.

This bill substantially amends s 381.026, Florida Statutes

II. Present Situation:

The Florida Patient's Bill of Rights and Responsibilities

The Florida Patient's Bill of Rights and Responsibilities[1] is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility.[2] The rights of patients include: standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.

Currently under the financial information and disclosure provisions:

- A health care provider or health care facility must disclose to a Medicare-eligible patient when requested whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility;
- A health care provider or health care facility is required to furnish to a person, upon request, an estimate of charges for medical services before providing the services. In addition, a health care provider or health care facility must provide an uninsured person, before planned nonemergency medical services, a reasonable estimate of the charges for the medical services and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. These estimates are required to be written in a language that is comprehensible to an ordinary layperson. However, the provider or facility may exceed the estimates or make additional charges based on changes in the patient's condition or treatment needs;
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the Agency for Health Care Administration's (Agency) website;[3]
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary; and
- A patient has the right to receive an itemized bill and explanation of the charges upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or the Agency may impose an

[1] Section 381.026, Florida Statutes.
[2] A health care facility is a facility licensed under ch. 395, F.S., and a health care provider means a physician, osteopathic physician, or a podiatric physician licensed under chapters 458, 459, or 461, respectively.
[3] The Florida Center for Health Information and Policy Analysis (Florida Center) within the Agency is responsible for collecting, compiling, analyzing, and disseminating health-related data and statistics. The information is published on the FloridaHealthFinder website at http://www.floridahealthfinder.gov. This website currently discloses and allows price comparisons for certain inpatient and outpatient procedures in licensed health care facilities and certain prescription drugs. Long-range plans include the availability of similar price comparisons for physician services. *See* s. 408.05(3)(k), F.S.

administrative fine when a provider or facility fails to make available to patients a summary of their rights.[4]

III. Effect of Proposed Changes:

Section 1 amends s. 381.026, F.S., relating to the Florida Patient's Bill of Rights and Responsibilities, to authorize a primary care provider, as defined in the bill, to publish a schedule of charges for the medical services that the provider offers. If a primary care provider publishes and maintains the schedule, then he or she is exempt from the general continuing education requirements that are applicable to all health care practitioners and rules implementing those requirements for a single 2-year period.

If posted, the schedule of charges must include the prices that the provider charges to an uninsured person paying by cash, check, credit card, or debit card. The schedule of charges must be posted in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size. Additionally, the schedule must include at least 50 services that are most frequently provided by that primary care provider. Rather than listing a price for each individual service, the schedule may group the services by three prices levels, listing the services in each price level.

The bill defines a primary care provider as a medical physician licensed under ch. 458, F.S., an osteopathic physician licensed under ch. 459, F.S., or a podiatric physician licensed under ch. 461, F.S., who provides medical services to patients which are commonly provided without referral from another health care provider. The types of providers include those who practice family medicine, general medicine, general pediatrics, or general internal medicine.

The bill requires that the estimate of charges furnished by a primary care provider pursuant to a request from an uninsured person before the medical services are provided must be consistent with the schedule posted in the reception area.

Section 2 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

[4] Section 381.0261, F.S.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The primary care physicians may incur an indeterminate cost to post and maintain the schedule of charges in the reception area. However, this cost might be offset by the savings due to the exemption from continuing education requirement. Uninsured patients of primary care physicians will have ready access to the charges for certain health care services provided by that physician's office.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. 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 Regulation on April 4, 2011:
Removes obstetricians and gynecologists from the definition of primary care provider; provides for the size of the posting and contents; makes the posting optional rather than mandatory; provides an exemption from general continuing education requirements for a single 2-year period for posting the schedule; and removes the disciplinary authority for not posting (with Title amendment).

B. Amendments:

None.