The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Wednesday, March 19, 2014
TIME: 11:00 a.m.—12:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 872** Richter (Similar CS/H 709, Compare CS/CS/H 711, Link S 840)	Alzheimer's Disease; Exempting grant programs administered by the Alzheimer's Disease Research Grant Advisory Board from the Administrative Procedure Act; requiring the Division of Emergency Management, in coordination with local emergency management agencies, to maintain a registry of persons with special needs; providing additional staffing requirements for special needs shelters; authorizing the Department of Health, in coordination with the division, to adopt rules relating to standards for the special needs registration program; establishing the Ed and Ethel Moore Alzheimer's Disease Research Program within the department, etc. HP 03/05/2014 Temporarily Postponed HP 03/19/2014 Fav/CS GO AP	Fav/CS Yeas 8 Nays 0
2	**SB 840** Richter (Similar CS/CS/H 711, Compare CS/H 709, Link S 872)	Public Records and Meetings/Alzheimer's Disease Research Grant Advisory Board; Providing an exemption from public records requirements for research grant applications submitted to the Alzheimer's Disease Research Grant Advisory Board under the Ed and Ethel Moore Alzheimer's Disease Research Program and records generated by the board relating to the review of the applications; providing an exemption from public meetings requirements for those portions of meetings of the board during which the research grant applications are discussed; authorizing disclosure of such confidential information under certain circumstances, etc. HP 03/05/2014 Temporarily Postponed HP 03/19/2014 Fav/CS GO RC	Fav/CS Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**CS/SB 1208** Criminal Justice / Latvala (Similar CS/H 517)	Fraudulent Controlled Substance Prescriptions; Revising provisions prohibiting possession of incomplete prescription forms; providing enhanced criminal penalties for violations involving incomplete prescription forms, etc. CJ 03/10/2014 Fav/CS HP 03/19/2014 Fav/CS AP	Fav/CS Yeas 8 Nays 0
4	**SB 1306** Altman (Identical H 1055)	Onsite Sewage Treatment and Disposal Systems; Requiring the Department of Health to establish and collect fees for combined systems; requiring the department to approve the installation of a combined system under certain circumstances; requiring a person to obtain a permit approved by the department before constructing, repairing, modifying, abandoning, or operating a combined system; providing conditions for issuance of permits relating to such systems, etc. HP 03/19/2014 Fav/CS EP AG RC	Fav/CS Yeas 8 Nays 0
5	**SB 690** Diaz de la Portilla (Similar CS/H 497)	Involuntary Examinations of Minors; Requiring school health services plans to include notification requirements when a student is removed from school, school transportation, or a school-sponsored activity for involuntary examination; requiring public schools to provide notice of the whereabouts of a student removed from school, school transportation, or a school-sponsored activity for involuntary examination; providing conditions for delay in notification, etc. HP 03/19/2014 Fav/CS ED AED AP	Fav/CS Yeas 8 Nays 0
6	**SB 824** Joyner (Similar H 465)	Hepatitis C Testing; Requiring specified persons to be offered Hepatitis C testing; providing followup health care for persons with a positive test result; requiring the Department of Health to adopt rules; providing applicability with respect to Hepatitis C testing by health care practitioners, etc. HP 03/19/2014 Fav/CS JU AHS AP	Fav/CS Yeas 6 Nays 2

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1014** Garcia (Similar H 765)	Pharmacy Benefit Managers; Specifying contract terms that must be included in a contract between a pharmacy benefit manager and a pharmacy; providing restrictions on the inclusion of prescriptions drugs on a list that specifies the maximum allowable cost for such drugs; requiring a contract between a pharmacy benefit manager and a pharmacy to include an appeal process; requiring a pharmacy benefit manager to contractually commit to providing a certain reimbursement rate for generic drugs, etc. HP 03/19/2014 Fav/CS BI AGG AP	Fav/CS Yeas 8 Nays 0
8	**SB 944** Sobel (Identical H 837)	Mental Health Treatment; Authorizing forensic and civil facilities to order the continuation of psychotherapeutics for individuals receiving such medications in the jail before admission; providing timeframes within which competency hearings must be held; revising the time for dismissal of certain charges for defendants that remain incompetent to proceed to trial; providing a timeframe within which commitment hearings must be held, etc. HP 03/19/2014 Fav/CS CJ JU CA	Fav/CS Yeas 8 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 872

INTRODUCER: Health Policy Committee and Senators Richter and Soto

SUBJECT: Alzheimer's Disease

DATE: March 19, 2014 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 872 makes a number of changes related to Alzheimer's disease that implement recommendations of the Purple Ribbon Task Force which was created by the Legislature in 2012.

The bill requires the Division of Emergency Management (DEM), in coordination with local emergency management agencies, to maintain a registry of persons with special needs using an electronic registration form and database. The bill requires memory disorder clinics, and authorizes licensed physicians and pharmacies, to provide information and assistance to individuals with special needs and their caregivers regarding special needs shelter registration.

The bill requires county health departments to staff special needs shelters with a person who is familiar with the needs of persons with Alzheimer's disease, and requires that all special needs shelters establish designated sheltering areas for persons with Alzheimer's disease or related dementia.

The bill creates the Ed and Ethel Moore Alzheimer's Disease Research Program (program) to fund research for the prevention and cure of Alzheimer's disease. The bill establishes program goals and provides for the award of grants and fellowships through a competitive, peer-reviewed process based on scientific merit. The bill also creates the Alzheimer's Disease Research Grant Advisory Board (board), which is an 11-member board of clinical professionals, to advise the

State Surgeon General on the program and funding awards made under it. The bill requires the board to report annually on a number of measures related to the program.

Finally, the bill requires the Department of Elder Affairs (DOEA) to develop performance standards for memory disorder clinics and to condition contract funding on compliance with the standards.

II. Present Situation:

Alzheimer's Disease

Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells and results in loss of memory, thinking, and language skills, and behavioral changes.[1] Alzheimer's disease was named after Dr. Alois Alzheimer, a German physician, who in the early 1900's cared for a 51-year-old woman suffering from severe dementia. Upon the woman's death, Dr. Alzheimer conducted a brain autopsy and found bundles of neurofibers and plaques in her brain, which are distinguishing characteristics of what we call Alzheimer's disease today.[2]

More than 5 million Americans currently live with Alzheimer's disease, and that number is projected to rise to 16 million by 2050.[3] As the life expectancy for Americans has continued to rise, so has the number of new cases of Alzheimer's disease. For instance, in 2000 there were an estimated 411,000 new cases of Alzheimer's disease in the United States, and in 2010 that number was estimated to be 454,000 – a 10 percent increase.[4] The number is expected to rise to 959,000 new cases of Alzheimer's disease by 2050, a 130 percent increase from 2000.[5] Specifically in Florida, approximately 360,000 people age 65 or older had Alzheimer's disease in 2000 and in 2010 that number had risen to 450,000.[6]

As the number of people with Alzheimer's disease increases, so does the cost of caring for these individuals. In 2013, the aggregate cost for health care, long-term care, and hospice for persons with Alzheimer's and other dementias was estimated to be $203 billion. That number is projected to be $1.2 trillion by 2050.[7] A major contributing factor to the cost of care for persons with Alzheimer's disease is that these individuals have more hospital stays, skilled nursing home stays, and home health care visits than older persons who do not have Alzheimer's disease. Research shows that 29 percent of individuals with Alzheimer's disease who have Medicare also have Medicaid coverage, which pays for nursing home care and other long-term care services.[8]

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[1] Alzheimer's Foundation of America, *About Alzheimer's, Definition of Alzheimer's,* http://www.alzfdn.org/AboutAlzheimers/definition.html (last visited Feb. 25, 2014).
[2] Michael Plontz, *A Brief History of Alzheimer's Disease*, TODAY'S CAREGIVER, http://www.caregiver.com/channels/alz/articles/a_brief_history.htm (last visited Feb. 25, 2014).
[3] Alzheimer's Association., *Fact Sheet: 2013 Alzheimer's Disease Facts and Figures* (March 2013), *available at* http://www.alz.org/documents_custom/2013_facts_figures_fact_sheet.pdf (last visited Feb. 25, 2014).
[4] Alzheimer's Association., *2013 Alzheimer's Disease Facts and Figures*, 9 ALZHEIMER'S & DEMENTIA (Issue 2) at 20, *available at* http://www.alz.org/downloads/facts_figures_2013.pdf (last visited Feb. 25, 2014).
[5] *Id*.
[6] *Id*. at 21.
[7] *Id.* at 49.
[8] *Id*. at 39.

The total Medicaid spending for people with Alzheimer's disease (and other dementia) in 2013 is projected to be $37 billion.[9]

In addition to the cost of health care, there is a significant cost associated with unpaid caregivers. An unpaid caregiver is primarily a family member, but can also be other relatives or friends. These caregivers often provide assistance with daily activities, such as shopping for groceries, preparing meals, bathing, dressing, grooming, assisting with mobility, helping the person take medications, making arrangements for medical care, and performing other household chores. In 2012, 15.4 million unpaid caregivers provided an estimated 17.5 billion hours of unpaid care, valued at $216.4 billion.[10] In 2010, there were 1,015,000 million caregivers in Florida who provided an estimated value of unpaid care reaching nearly $14.3 million.[11]

Florida Purple Ribbon Task Force

In 2012, the Legislature established the Purple Ribbon Task Force (task force) within the DOEA to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on a comprehensive set of issues related to Alzheimer's disease and related forms of dementia. Specifically, the task force was required to: [12]

- Submit an interim study on state trends on persons with Alzheimer's disease and their needs;
- Assess the current and future impact of Alzheimer's disease and related forms of dementia on the state;
- Examine the existing industries, services, and resources addressing the needs of persons having Alzheimer's disease or a related form of dementia and their family caregivers;
- Examine the needs of persons of all cultural backgrounds having Alzheimer's disease or a related form of dementia and how their lives are affected by the disease from younger-onset, through mid-stage, to late-stage;
- Develop a strategy to mobilize a state response to Alzheimer's disease; and,
- Hold public meetings and employ technological means to gather feedback on the recommendations submitted by persons having Alzheimer's disease or a related form of dementia and their family caregivers and by the general public.

Other issues to be addressed by the task force included:

- The role of the state in providing community-based care, long-term care, family caregiver support, and assistance to persons who are in the early stages of Alzheimer's disease, who have younger-onset Alzheimer's disease, or who have a related form of dementia;
- The development of state policy with respect to persons having Alzheimer's disease or a related form of dementia;
- Surveillance of persons having Alzheimer's disease or a related form of dementia for the purpose of accurately estimating the number of such persons in the state;
- Existing services, resources, and capacity; including:
    - The type, cost, and availability of dementia services in the state;

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[9] *Id*. at 49.
[10] This number was established by using an average of 21.9 hours of care a week with a value of $12.33 per hour. (*Id.* at 30).
[11] *Id*. at 32.
[12] Ch. 2012-172, Laws of Fla.

- o Policy requirements and effectiveness for dementia-specific training for professionals providing care;
- o Quality care measures employed by providers of care;
- o The capability of public safety workers and law enforcement officers to respond to persons having Alzheimer's disease or a related form of dementia;
- o The availability of home and community-based services and respite care for persons having Alzheimer's disease or a related form of dementia and education and support services to assist their families and caregivers;
- o An inventory of long-term care facilities and community-based services serving persons having Alzheimer's disease or a related form of dementia;
- o The adequacy and appropriateness of geriatric-psychiatric units for persons having behavior disorders associated with Alzheimer's disease or other dementia;
- o Residential assisted living options for persons having Alzheimer's disease or a related form of dementia;
- o The level of preparedness of service providers before, during, and after a catastrophic emergency involving a person having Alzheimer's disease or a related form of dementia; and
- o Needed state policies or responses.

As its final responsibility, the task force was required to submit final, date-specific recommendations in the form of an Alzheimer's disease state plan to the Governor and Legislature by August 1, 2013.

The task force has issued its final report and recommendations.[13] Pertinent to this bill are the following recommendations:

- To allocate $10 million annually to support Alzheimer's disease research through a peer-reviewed grant program;[14]
- To develop a well-coordinated and dementia-capable emergency management system, including reforms to the special needs shelter and registry function;[15] and,
- To fund memory disorder clinics according to performance standards and benchmark goals related to base level and incentive funding.[16]

Alzheimer's Research Funding

The 2014 budget passed by Congress and signed into law by the President on January 17, 2014, contains increased funding for Alzheimer's disease initiatives. The new federal funding includes a $100 million increase for the National Institute on Aging (NIA)[17] for Alzheimer's research,

[13] Florida Department of Elder Affairs, *Purple Ribbon Task Force Final Report and Recommendations* (2013), *available at* http://elderaffairs.state.fl.us/doea/purple_ribbon/PRTF_final_report.pdf (last visited Feb. 26, 2014).
[14] *Id*. at 30.
[15] *Id.* at 64 – 66.
[16] *Id.* at 72 – 73.
[17] NIA is one of the 27 institutes and centers of the National Institutes of Health. NIA is the primary federal agency supporting and conducting Alzheimer's research.

which will be added to what the National Institutes of Health (NIH) estimates will be $484 million in Alzheimer's research funding across NIH in the 2013 fiscal year.[18]

The NIA funds Alzheimer's Disease Centers (ADC) at major medical institutions with the goal of improving diagnosis and care, and ultimately finding a way to cure and possibly prevent Alzheimer's disease. Although each center has its own unique area of emphasis, a common goal of the ADCs is to enhance research on Alzheimer's disease by providing a network for sharing new ideas as well as research results. Collaborative studies draw upon the expertise of scientists from many different disciplines. Currently, there are 29 NIA-funded centers, including one at the Mayo Clinic in Jacksonville.[19]

In 2002, the Legislature created the Florida Alzheimer's Center and Research Institute (institute) at the University of South Florida (USF).[20] The institute was governed by a not-for-profit corporation, acting as an instrumentality of the state, under the direction of its 16-member Board of Directors. Its mission related to research, education, treatment, prevention, and early detection of Alzheimer's disease.[21] In 2004, the Legislature renamed the institute the Johnnie B. Byrd, Sr. Alzheimer's Center and Research and funded it with a $15 million distribution from alcoholic beverage tax collections for the purposes of conducting research, developing and operating integrated data projects, and providing assistance to memory disorder clinics.[22] The 2006 Legislature replaced the automatic distribution with a recurring appropriation from General Revenue, and clarified that researchers from any university or established research institution were eligible for funding from the institute.[23] The recurring appropriation was reduced to $13.5 million in 2007[24] and eliminated in 2008.[25] In 2009, the statute authorizing the institute was substantially revised to establish the Institute as an entity within and operated by the USF and provided that its budget included any money specifically appropriated in the General Appropriations Act, or otherwise provided to it from private, local, state, or federal sources, or income generated by activities at the Institute.[26]

Finally, s. 430.501, F.S., creates the Alzheimer's Disease Advisory Committee, appointed by the Governor, to advise the DOEA in the performance of its duties. The committee also has responsibility for awarding research grants to qualified entities from any funds made available to the DOEA through gifts, grants, or other sources.

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[18] Alzheimer's Association, *Record $122 million increase for Alzheimer's disease signed into law by President Obama*, http://www.alz.org/news_and_events_law_by_obama.asp (last visited Feb. 26, 2014).
[19] U.S. Department of Health & Human Services, National Institute on Aging, *Alzheimer's Disease Research Centers*, http://www.nia.nih.gov/alzheimers/alzheimers-disease-research-centers#florida (last visited Feb. 26, 2014).
[20] Ch. 2002-387, s. 191, Laws of Fla.; ch. 2002-389, s. 2, Laws of Fla.
[21] *Id.*
[22] Ch. 2004-2, ss. 3 & 5, Laws of Fla.
[23] Ch. 2006-182, s.12, Laws of Fla.
[24] Ch. 2007-332, Laws of Fla.
[25] Ch. 2008-113, Laws of Fla. The Institute received $1.25 million in FY 2013–2014 funding via an allocation to the USF Medical Center in the Department of Education's budget.
[26] Ch. 2009-60, s. 5, Laws of Fla.

Special Needs Shelters

The Comprehensive Emergency Management Plan (CEMP) is the master operations document for the state in responding to all emergencies, and all catastrophic disasters, whether major or minor.[27] The CEMP, which is developed and maintained by the DEM, in coordination with local governments and agencies and organizations with emergency management responsibilities, defines the responsibilities of all levels of government and private, volunteer, and non-governmental organizations that make up the State Emergency Response Team. In general, the CEMP assumes that all emergencies and disasters are local, but local governments may require state assistance.[28]

The CEMP includes a shelter component which provides policy guidance for sheltering people with special needs.[29] Specifically, it states: [30]

> All shelters must meet physical and programmatic accessibility requirements as defined by the Americans with Disabilities Act and Florida Accessibility Codes. Special Needs Shelters provide a higher level of attendant care than general population shelters. Any facility designated as a shelter must meet minimum safety requirements. To ensure consistency with state and national standards, guidelines and best practices, the Division has adopted the American Red Cross (ARC) 4496 Standards for Hurricane Evacuation Shelter Selection.[31]

Each local emergency management agency is required to maintain a registry of persons with special needs.[32] The information is used to identify people with special needs, people who may need assistance with transportation to the shelters, and to ensure that any area affected by an emergency or disaster has adequate special needs shelter capacity, staffing, equipment, and supplies.[33]

The DEM has lead responsibility for community outreach and education about registration and shelter stays.[34] However, community-based service providers, including home health agencies, hospices, nurse registries, and home medical equipment providers, and state agencies likely to serve individuals with special needs, including the Department of Children and Families, the Department of Health (DOH), the Agency for Health Care Administration, the Department of Education, the Agency for Persons with Disabilities, and the DOEA, are directed to provide registration information

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[27] Section 252.35(2)(a), F.S.

[28] Florida Division of Emergency Management, *The State of Florida Comprehensive Emergency Management Plan*, 11, (Feb. 2012), *available at* http://floridadisaster.org/documents/CEMP/2012/2012%20State%20CEMP%20Basic%20Plan%20-%20Final.pdf (last visited Feb. 26, 2014). "Initial response is by local jurisdictions working with county emergency management agencies. It is only after local emergency response resources are exhausted, or local resources do not exist to address a given emergency or disaster that state emergency response resources and assistance may be requested by local authorities." (*Id.* at 19).

[29] A "person with special needs" means someone, who during periods of evacuation or emergency, requires sheltering assistance, due to physical impairment, mental impairment, cognitive impairment, or sensory disabilities. (Rule 64-3.010(1), F.A.C.)

[30] Florida Division of Emergency Management, *supra* note 28 at 35.

[31] *Available at* http://www.floridadisaster.org/Response/engineers/documents/newarc4496.pdf (last visited Feb. 26, 2014).

[32] Section 252.355(1), F.S.

[33] Florida Department of Health, *Senate Bill 872 Legislative Bill Analysis* (Feb. 5, 2014) (on file with the Senate Health Policy Committee).

[34] Section 252.355(2), F.S.

to all of their special needs clients and to collect registration information during the client intake process.[35]

The law further requires agencies that contract with providers for the care of people with disabilities or who are otherwise dependent on others for care to include emergency and disaster planning conditions in their service contracts. Among other provisions, the contract must include a requirement for the provider to have a procedure to help its clients register for special needs sheltering.[36]

The DOH, through the county public health units, is tasked with lead responsibility, in coordination with the local emergency management agency, to recruit and staff special needs shelters with appropriate health care personnel, pursuant to a staffing plan developed at the local level.[37] Designation and operation of the shelter, however, remains the responsibility of the local emergency management agency, [38] although subject to operational standards established by rule of the DOH.[39]

Admission to a special needs shelter is subject to an assessment of the person's eligibility. A person is eligible if he or she:[40]

- Has special needs;
- Has care needs that exceed basic first aid that is available at the general emergency shelters; and
- Has impairments that are medically stable and do not exceed the capacity, staffing, and equipment of the shelter.

A shelter may accept someone whose needs exceed the eligibility criteria. Decisions related to shelter capacity, both available skills and equipment, are made by the local emergency management agency and the county public health department.[41]

Alzheimer's Disease Initiative

In 1985, the Florida Legislature created the Alzheimer's Disease Initiative (ADI) to provide a continuum of services to individuals with Alzheimer's disease and their families.[42] The ADI has four objectives: (1) to provide supportive services; (2) to establish memory disorder clinics; (3) to provide model day care programs to test new care alternatives; and (4) to establish a research database and brain bank to support research.[43] There are 15 memory disorder clinics throughout the state, 13 of which are state funded.[44] The purpose of these clinics is to conduct research

[35] Section 252.355(1) & (6), F.S.
[36] Section 252.356(3), F.S.
[37] Section 381.0303(1) & (2), F.S.
[38] Section 381.0303(2)(d), F.S.
[39] Section 381.0303(6), F.S., requires the DOH to adopt rules for the following: the definition of "person with special needs;" shelter services; practitioner and facility reimbursement; staffing levels; supplies and equipment; registration procedures; family and caretaker needs; and pre-event planning.
[40] Rule 64-3.020, F.A.C.
[41] *Id.*
[42] *See* ss. 430.501 – 430.504, F.S.
[43] Florida Department of Elder Affairs, *Summary of Programs & Services, Alzheimer's Disease Initiative* (Jan. 2013) at 91, *available at* http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2013/2013%20SOPS%20Section%20D.pdf (last visited Feb. 25, 2014).
[44] *Id.*

related to diagnostic technique, therapeutic interventions, and supportive services for persons with Alzheimer's disease and to develop caregiver-training materials.[45] According to the ADI, the memory disorder clinics are required to:

- Provide services to persons suspected of having Alzheimer's disease or other related dementia;
- Provide 4 hours of in-service training during the contract year to all ADI respite and model day care service providers and develop and disseminate training models to service providers and the DOEA;
- Develop training materials and educational opportunities for lay and professional caregivers and provide specialized training for caregivers and caregiver organizations;
- Conduct service-related applied research;
- Establish a minimum of one annual contact with each respite care and model day care service provider to discuss, plan, develop, and conduct service-related research projects; and
- Plan for the public dissemination of research findings through professional papers and to the general public.[46]

Individuals diagnosed with or suspected of having Alzheimer's disease are eligible for memory disorder clinic services. In the fiscal year 2012-2013, Florida's memory disorder clinics received nearly $3 million in state funds and served a projected 6,722 clients.[47]

Model day care programs have been established in conjunction with memory disorder clinics to test therapeutic models and provide day care services. These programs provide a safe environment where Alzheimer's patients can socialize with each other, as well as receive therapeutic interventions designed to maintain or improve their cognitive functioning. Model day care programs also provide training for health care and social service personnel in the care of individuals with Alzheimer's disease or related memory disorders. There are currently four model day care programs in the state.[48]

The ADI also includes respite care services, which includes in-home, facility-based, emergency and extended care respite for caregivers who serve individuals with memory disorders.[49] In addition to respite care services, caregivers and consumers may receive supportive services essential to maintaining individuals with Alzheimer's disease or related dementia in their own homes. The supportive services may include caregiver training and support groups, counseling, consumable medical supplies, and nutritional supplements. Services are authorized by a case manager based on a comprehensive assessment. Alzheimer's Respite Care programs are established in all of Florida's 67 counties.[50]

Statutory Creation of Advisory Bodies, Commissions, or Boards

The statutory creation of any collegial body to serve as an adjunct to an executive agency is subject to certain provisions in s. 20.052, F.S. Such a body may only be created when it is found

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[45] Section 430.502(2), F.S.
[46] Florida Department of Elder Affairs, *supra* note 43 at 90-91.
[47] *Id*. at 96.
[48] *Id.* at 92.
[49] *Id*. at 91.
[50] *Id*.

to be necessary and beneficial to the furtherance of a public purpose, and it must be terminated by the Legislature when it no longer fulfills such a purpose. The Legislature and the public must be kept informed of the numbers, purposes, memberships, activities, and expenses of any collegial or advisory bodies.

Private citizen members of any advisory body (with exceptions for members of commissions or boards of trustees) may only be appointed by the Governor, the head of the executive agency to which the advisory body is adjunct, the executive director of the agency, or a Cabinet officer. Private citizen members of a commission or a board of trustees may only be appointed by the Governor, must be confirmed by the Senate, and are subject to the dual-office-holding prohibition of section 5(a) of Article II of the State Constitution.

Members of agency advisory bodies serve for 4-year staggered terms and are ineligible for any compensation other than travel expenses, unless expressly provided otherwise in the State Constitution. Unless an exemption is specified by law, all meetings are public, and records of minutes and votes must be maintained.

III. Effect of Proposed Changes:

Section 1 exempts grant programs administered by the Alzheimer's Disease Research Grant Advisory Board (the board) from ch. 120, F.S., the Administrative Procedure Act (APA).[51]

Section 2 requires the DEM to develop a special needs shelter registration program by January 1, 2015, and to fully implement the program by March 1, 2015. The bill shifts responsibility for maintaining a special needs registry from the local emergency management agencies to the DEM, working in coordination with the local agencies. In effect, the bill centralizes the registry into a single agency, although still providing access to the local emergency management agencies. The bill directs the DEM to develop a uniform electronic registration form and database, as a minimum component of the registration program, which the local agencies can use to upload registration information they receive. The DEM is directed to develop and post on its website a brochure describing the registration procedures.

The bill adds memory disorder clinics to the existing list of providers and agencies that are required to: give registration information to their special needs clients; and assist emergency management by collecting registration information for persons with special needs during their program intake procedures and establishing education programs for their clients about the registration process and disaster preparedness. These duties are expanded by the bill to require the providers and agencies also to provide registration information to client caregivers and to register their special needs clients annually. The bill specifies that physicians and pharmacies may, but are not required to, perform all of these same duties.

Section 3 requires county health departments to ensure that special needs shelters are staffed with a person who is familiar with the needs of persons with Alzheimer's disease. In addition, the bill requires that all special needs shelters designate areas within the shelter for persons with

[51] The APA establishes comprehensive and standardized administrative procedures pertaining to executive branch agency actions.

Alzheimer's disease or related dementia to maximize their normal routines to the greatest extent possible. The bill specifies that the DOH must work in conjunction with the DEM to adopt rules related to the special needs shelters and includes forms within the scope of the DOH's rulemaking authority.

Section 4 creates the Ed and Ethel Moore Alzheimer's Disease Research Program within the DOH to fund research leading to prevention of or a cure for Alzheimer's disease. Long-term goals of the program are to:

- Enhance the health of Floridians by researching improved prevention, diagnosis, treatment, and cure of Alzheimer's disease.
- Expand the foundation of knowledge relating to the prevention, diagnosis, treatment, and cure of Alzheimer's disease.
- Stimulate activity in the state related to Alzheimer's disease research.

The program is modeled after the James and Esther King Biomedical Research Program that is established in s. 215.5602, F.S.

The bill specifies that:

- Program funds may be used only for awards of grants and fellowships through a competitive, peer-reviewed process and expenses related to program administration. Grants will be awarded by the State Surgeon General on the basis of scientific merit.
- Funding applications may be submitted from any university or established research institute[52] in the state and qualified investigators, regardless of institution, will have equal access to compete for funding.
- Implementation of the program is contingent upon a legislative appropriation.

In addition, the bill creates the 11-member Alzheimer's Disease Research Grant Advisory Board (board) within the DOH, as follows:

- The board consists of two gerontologists, two geriatric psychiatrists, two geriatricians, two neuroscientists, and three neurologists appointed by the State Surgeon General to 4-year terms, except that six of the initial appointees shall serve 2-year terms. Initial appointments must be made by October 1, 2014. Appointees must have experience in Alzheimer's disease or related biomedical research. The board chair is elected by the members to serve as chair for 2 years. No board member may serve on the board more than two consecutive terms.
- The board must adopt internal organization procedures, as necessary, for its organization and establish and follow guidelines for ethical conduct to avoid conflicts of interest. A member may not participate in any discussion or decision related to a research proposal by any entity with which the member has a relationship, whether as governing board member, employee, or contracted party.

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[52] Currently, the DOH defines an "established research institute" as an organization that is any Florida nonprofit or foreign nonprofit covered under ch. 617, F.S., with a physical location in Florida, whose stated purpose and powers are scientific, biomedical or biotechnological research and/or development and is legally registered with the Florida Department of State, Division of Corporations. This includes federal government and non-profit medical and surgical hospitals including Veteran's Administration hospitals. Florida Department of Health, *James and Esther King Biomedical Research Program, Announcement of Funding Opportunity and Call for Applications* (2013-2014), *available at* http://www.research.fsu.edu/newsletters/2013/July/documents/2013-2014%20SUMMER%20CALL%20King%20Program.pdf (last visited Feb. 25, 2014).

- Members of the board serve without compensation.
- The DOH must provide staff to the board.
- The board's role is to:
  - Advise the State Surgeon General on the scope of the program and proposals to be funded;
  - Advise on program priorities and emphases;
  - Assist in the development of appropriate linkages to nonacademic entities; and,
  - Develop and provide oversight of mechanisms for disseminating research results.
- The board must submit a fiscal year progress report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the State Surgeon General by February 15 annually that includes:
  - A list of funded projects;
  - A list of funded researchers;
  - A list of publications in peer-reviewed journals involving research supported by grants or fellowships awarded under the Program;
  - The state ranking and total amount of Alzheimer's disease research funding received from the National Institutes of Health;
  - New grants for Alzheimer's disease research which were based on researched funded by the Program;
  - Progress toward the goals of the program; and,
  - Recommendations to further the mission of the program.

Section 5 directs the DOEA to develop performance standards for memory disorder clinics; to include the standards as a condition of each clinic's funding contract; and to measure and score each clinic based on the standards.

Base-level funding standards must address, at a minimum, quality of care, comprehensiveness of services, and access to services.

Standards for incentive funding beyond base-level funding, subject to legislative appropriation, include:

- A significant increase in the volume of clinical services;
- A significant increase in public outreach to low-income and minority populations;
- A significant increase in the acceptance of Medicaid and commercial insurance policies; and
- Significant institutional financial commitments.

Section 6 provides an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The research program created by the bill, if funded, will have a positive fiscal impact on any private institutions or researchers who are awarded grants or fellowships under the program.

It is not clear; however, whether incentive funding for the Memory Disorder Clinics, as contemplated by the bill, would be the result of a supplemental appropriation for the program, or a redistribution of the existing appropriation. Thus, it is not possible to determine the economic impact on the programs at this time.

C. Government Sector Impact:

The DEM estimates the nonrecurring cost to develop, test, and implement the electronic registry at $400,000, and the recurring cost to maintain and house the system also at $400,000. The DEM has identified federal grant funding that will cover the cost.[53]

Local governments may incur costs related to facilities they now designate as special needs shelters due to the requirement to provide dedicated space at each for persons with Alzheimer's disease. Not all facilities may be able to accommodate the dedicated space requirement. The DOH suggests that the requirement may be addressed in those shelters that cannot provide dedicated secure shelter space that would prevent wandering and elopement by providing increased security. The DOH estimates the cost at $480 per 24-hour period for each point of egress.[54]

The bill requires a minimum of one staff person at each special needs shelter who is familiar with the needs of patients with Alzheimer's disease. The DOH indicates that appropriate staffing would mean at least one nurse per facility and possibly a nurse's aide for any person who presents without a caregiver. Those county health departments whose special needs shelter personnel lack the expertise in Alzheimer's disease may need to contract for services through a nurse staffing company. The DOH estimates the cost per shelter for a 24-hour period at $1,560 for nurse coverage and an additional $432 for a nurse's aide to assist with any unaccompanied patients. Currently, there are 127 special

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[53] Florida Department of Law Enforcement, *Senate Bill 872 Legislative Bill Analysis* (Feb. 26, 2014) (on file with the Senate Health Policy Committee).

[54] Florida Department of Health, *supra* note 33.

needs shelters statewide.[55] It is not possible to estimate how many shelters would be activated or for how long in any given year.

The research program created by the bill, if funded, will have a positive fiscal impact on any public institutions or researchers employed at public institutions who are awarded grants or fellowships under the program.

The DOH anticipates expenses for the research program related to contract management, peer review, and support of the board. Total projected expenses are $629,503 in fiscal year 2014–2015 and $642,448 in fiscal year 2015–2016. Expenses include two FTE and related expenses; peer review honoraria; and board support expenses.[56]

The requirement for performance standards for the memory disorder clinics[57] may enable more effective administration of the Memory Disorder Clinic funding.

VI. Technical Deficiencies:

It may be appropriate to add language to line 302 expressly requiring that awards under the program be pursuant to a competitive, peer-reviewed process. This is a stated element of the Program, but not part of the portion of the bill that specifically addresses awards. Similar language appears in s. 215.5602(5)(b) (6), F.S., relating to the James and Esther King Biomedical Research Program, s. 381.922(3)(a), F.S., relating to the William G. "Bill" Bankhead, Jr. and David Coley Cancer Research Program, and s. 381.84(6), F.S., relating to contracts awarded under the Comprehensive Statewide Tobacco Education and Use Prevention Program. Line 302 could be amended with the language that appears in Florida's other competitive grant programs to read: "consultation with the board, on the basis of scientific merit as determined by an open, competitive, peer-reviewed process to ensure objectivity, consistency, and high quality."

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 120.80, 252.355, 381.0303, and 430.502.

This bill creates section 381.82 of the Florida Statutes.

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[55] *Id.*
[56] *Id.*
[57] The DOEA indicates it has already begun including performance standards for base level funding. Conversation with Mary Hodges, Chief, Bureau of Community& Support Services, Florida Department of Elder Affairs (Feb. 28, 2014).

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Policy on March 19, 2014:

- Requires the DEM to have developed the special needs shelter registration program by January 1, 2015, with full implementation by March 1, 2015.
- Reduces the Alzheimer's Disease Research Grant Advisory Board by one member, from 12 to 11 and revises the composition of the board by adding two neuroscientists and reducing the number of gerontologists, geriatric psychiatrists, and geriatricians each by one, from three to two.

B. Amendments:

None.

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

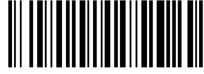
616350

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment (with title amendment)**
2
3 Delete line 86
4 and insert:
5 needs shelter registration program. The registration program
6 must be developed by January 1, 2015, and fully implemented by
7 March 1, 2015.
8
9 ================= T I T L E A M E N D M E N T ================
10 And the title is amended as follows:


616350

11 Delete line 11
12 and insert:
13 program by a specified date; requiring specified
14 agencies and authorizing

902302

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment**
2
3 Delete lines 270 - 273
4 and insert:
5 (a) The board shall consist of 11 members appointed by the
6 State Surgeon General. The board shall be composed of two
7 gerontologists, two geriatric psychiatrists, two geriatricians,
8 two neuroscientists, and three neurologists. Initial
9 appointments to

By Senator Richter

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1 A bill to be entitled
2 An act relating to Alzheimer's disease; amending s.
3 120.80, F.S.; exempting grant programs administered by
4 the Alzheimer's Disease Research Grant Advisory Board
5 from the Administrative Procedure Act; amending s.
6 252.355, F.S.; requiring the Division of Emergency
7 Management, in coordination with local emergency
8 management agencies, to maintain a registry of persons
9 with special needs; requiring the division to develop
10 and maintain a special needs shelter registration
11 program; requiring specified agencies and authorizing
12 specified health care providers to provide
13 registration information to special needs clients or
14 their caregivers and to assist emergency management
15 agencies in registering persons for special needs
16 shelters; amending s. 381.0303, F.S.; providing
17 additional staffing requirements for special needs
18 shelters; requiring special needs shelters to
19 establish designated shelter areas for persons with
20 Alzheimer's disease or related forms of dementia;
21 authorizing the Department of Health, in coordination
22 with the division, to adopt rules relating to
23 standards for the special needs registration program;
24 creating s. 381.82, F.S.; establishing the Ed and
25 Ethel Moore Alzheimer's Disease Research Program
26 within the department; requiring the program to
27 provide grants and fellowships for research relating
28 to Alzheimer's disease; creating the Alzheimer's
29 Disease Research Grant Advisory Board; providing for

30 appointment and terms of members; providing for
31 organization, duties, and operating procedures of the
32 board; requiring the department to provide staff to
33 assist the board in carrying out its duties; requiring
34 the board to annually submit recommendations for
35 proposals to be funded; requiring a report to the
36 Governor, Legislature, and State Surgeon General;
37 providing that implementation of the program is
38 subject to appropriation; amending s. 430.502, F.S.;
39 requiring the Department of Elderly Affairs to develop
40 minimum performance standards for memory disorder
41 clinics to receive base-level annual funding;
42 requiring the department to provide incentive-based
43 funding, subject to appropriation, for certain memory
44 disorder clinics; providing an effective date.
45
46 Be It Enacted by the Legislature of the State of Florida:
47
48 Section 1. Subsection (15) of section 120.80, Florida
49 Statutes, is amended to read:
50 120.80 Exceptions and special requirements; agencies.—
51 (15) DEPARTMENT OF HEALTH.—
52 <u>(a)</u> Notwithstanding s. 120.57(1)(a), formal hearings may
53 not be conducted by the State Surgeon General, the Secretary of
54 Health Care Administration, or a board or member of a board
55 within the Department of Health or the Agency for Health Care
56 Administration for matters relating to the regulation of
57 professions, as defined by chapter 456. Notwithstanding s.
58 120.57(1)(a), hearings conducted within the Department of Health

in execution of the Special Supplemental Nutrition Program for Women, Infants, and Children; Child Care Food Program; Children’s Medical Services Program; the Brain and Spinal Cord Injury Program; and the exemption from disqualification reviews for certified nurse assistants program need not be conducted by an administrative law judge assigned by the division. The Department of Health may contract with the Department of Children and Families ~~Family Services~~ for a hearing officer in these matters.

(b) This chapter does not apply to grant programs administered by the Alzheimer’s Disease Research Grant Advisory Board pursuant to s. 381.82.

Section 2. Section 252.355, Florida Statutes, is amended to read:

252.355 Registry of persons with special needs; notice; registration program.—

(1) In order to meet the special needs of persons who would need assistance during evacuations and sheltering because of physical, mental, cognitive impairment, or sensory disabilities, the division, in coordination with each local emergency management agency in the state, shall maintain a registry of persons with special needs located within the jurisdiction of the local agency. The registration shall identify those persons in need of assistance and plan for resource allocation to meet those identified needs.

(2) In order to ensure that all persons with special needs may register, the division shall develop and maintain a special needs shelter registration program.

(a) The registration program shall include, at a minimum, a

uniform electronic registration form and a database for uploading and storing submitted registration forms which may be accessed by the appropriate local emergency management agency. The link to the registration form shall be easily accessible on each local emergency management agency’s website. Upon receipt of a paper registration form, the local emergency management agency shall enter the person’s registration information into the database.

(b) To assist ~~the local emergency management agency~~ in identifying ~~such~~ persons with special needs, home health agencies, hospices, nurse registries, home medical equipment providers, the Department of Children and Families ~~Family Services~~, the Department of Health, the Agency for Health Care Administration, the Department of Education, the Agency for Persons with Disabilities, the ~~and~~ Department of Elderly Affairs, and memory disorder clinics shall, and any physician licensed under chapter 458 or chapter 459 and any pharmacy licensed under chapter 465 may, annually ~~shall~~ provide registration information to all of their special needs clients or their caregivers ~~and to all persons with special needs who receive services~~. The division shall develop a brochure that provides information regarding special needs shelter registration procedures. The brochure shall be published on the division’s website. All appropriate agencies and community-based service providers, including memory disorder clinics, home health care providers, hospices, nurse registries, and home medical equipment providers shall, and any physician licensed under chapter 458 or chapter 459 may, assist emergency management agencies by annually registering persons with special

needs for special needs shelters, collecting registration information for persons with special needs as part of the program intake process, and establishing programs to educate clients about the registration process and disaster preparedness safety procedures. A client of a state-funded or federally funded service program who has a physical, mental, or cognitive impairment or sensory disability and who needs assistance in evacuating or while in a shelter must register as a person with special needs. ~~The registry shall be updated annually.~~ The registration program shall give persons with special needs the option of preauthorizing emergency response personnel to enter their homes during search and rescue operations if necessary to ensure ~~assure~~ their safety and welfare following disasters.

(c) ~~(2)~~ The division shall be the designated lead agency responsible for community education and outreach to the public, including special needs clients, regarding registration and special needs shelters and general information regarding shelter stays.

(d) ~~(4)(a)~~ On or before May 31 of each year, each electric utility in the state shall annually notify residential customers in its service area of the availability of the registration program available through their local emergency management agency by:

1. An initial notification upon the activation of new residential service with the electric utility, followed by one annual notification between January 1 and May 31; or

2. Two separate annual notifications between January 1 and May 31.

~~(b)~~ The notification may be made by any available means, including, but not limited to, written, electronic, or verbal notification, and may be made concurrently with any other notification to residential customers required by law or rule.

(3) A person with special needs must be allowed to bring his or her service animal into a special needs shelter in accordance with s. 413.08.

(4) ~~(5)~~ All records, data, information, correspondence, and communications relating to the registration of persons with special needs as provided in subsection (1) are confidential and exempt from ~~the provisions of~~ s. 119.07(1), except that such information shall be available to other emergency response agencies, as determined by the local emergency management director. Local law enforcement agencies shall be given complete shelter roster information upon request.

~~(6) All appropriate agencies and community-based service providers, including home health care providers, hospices, nurse registries, and home medical equipment providers, shall assist emergency management agencies by collecting registration information for persons with special needs as part of program intake processes, establishing programs to increase the awareness of the registration process, and educating clients about the procedures that may be necessary for their safety during disasters. Clients of state or federally funded service programs with physical, mental, cognitive impairment, or sensory disabilities who need assistance in evacuating, or when in shelters, must register as persons with special needs.~~

Section 3. Present subsections (3) through (7) of section 381.0303, Florida Statutes, are redesignated as subsections (4)

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175 through (8), respectively, paragraph (b) of subsection (2) and
176 present subsection (6) are amended, and a new subsection (3) is
177 added to that section, to read:
178 381.0303 Special needs shelters.—
179 (2) SPECIAL NEEDS SHELTER PLAN; STAFFING; STATE AGENCY
180 ASSISTANCE.—If funds have been appropriated to support disaster
181 coordinator positions in county health departments:
182 (b) County health departments ~~shall~~, in conjunction with
183 the local emergency management agencies, have the lead
184 responsibility for coordination of the recruitment of health
185 care practitioners to staff local special needs shelters. County
186 health departments shall assign their employees to work in
187 special needs shelters when those employees are needed to
188 protect the health and safety of persons with special needs.
189 County governments shall assist the department with nonmedical
190 staffing and the operation of special needs shelters. The local
191 health department and emergency management agency shall
192 coordinate these efforts to ensure appropriate staffing in
193 special needs shelters, including a staff member who is familiar
194 with the needs of persons with Alzheimer's disease.
195 (3) SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE OR
196 RELATED FORMS OF DEMENTIA.—All special needs shelters must
197 establish designated shelter areas for persons with Alzheimer's
198 disease or related forms of dementia to enable those persons to
199 maintain their normal habits and routines to the greatest extent
200 possible.
201 (7) ~~(6)~~ RULES.—The department, in coordination with the
202 Division of Emergency Management, may ~~has the authority to~~ adopt
203 rules ~~necessary~~ to implement this section. Rules shall include:

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

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204 (a) The definition of a "person with special needs,"
205 including eligibility criteria for individuals with physical,
206 mental, cognitive impairment, or sensory disabilities and the
207 services a person with special needs can expect to receive in a
208 special needs shelter.
209 (b) The process for special needs shelter health care
210 practitioners and facility reimbursement for services provided
211 in a disaster.
212 (c) Guidelines for special needs shelter staffing levels to
213 provide services.
214 (d) The definition of and standards for special needs
215 shelter supplies and equipment, including durable medical
216 equipment.
217 (e) Standards for the special needs shelter registration
218 program ~~process~~, including all necessary forms and guidelines
219 for addressing the needs of unregistered persons in need of a
220 special needs shelter.
221 (f) Standards for addressing the needs of families where
222 only one dependent is eligible for admission to a special needs
223 shelter and the needs of adults with special needs who are
224 caregivers for individuals without special needs.
225 (g) The requirement of the county health departments to
226 seek the participation of hospitals, nursing homes, assisted
227 living facilities, home health agencies, hospice providers,
228 nurse registries, home medical equipment providers, dialysis
229 centers, and other health and medical emergency preparedness
230 stakeholders in pre-event planning activities.
231 Section 4. Section 381.82, Florida Statutes, is created to
232 read:

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

233 381.82 Ed and Ethel Moore Alzheimer's Disease Research
234 Program.—
235 (1) There is established the Ed and Ethel Moore Alzheimer's
236 Disease Research Program within the Department of Health. The
237 purpose of the program is to fund research leading to prevention
238 of or a cure for Alzheimer's disease. The long-term goals of the
239 program are to:
240 (a) Enhance the health of Floridians by researching
241 improved prevention, diagnosis, treatment, and cure of
242 Alzheimer's disease.
243 (b) Expand the foundation of knowledge relating to the
244 prevention, diagnosis, treatment, and cure of Alzheimer's
245 disease.
246 (c) Stimulate economic activity in the state in areas
247 related to Alzheimer's disease research.
248 (2)(a) Funds appropriated for the Ed and Ethel Moore
249 Alzheimer's Disease Research Program shall be used exclusively
250 for the award of grants and fellowships through a competitive,
251 peer-reviewed process for research relating to the prevention,
252 diagnosis, treatment, and cure of Alzheimer's disease and for
253 expenses incurred in the administration of this section.
254 Priority shall be granted to research designed to prevent or
255 cure Alzheimer's disease.
256 (b) Applications for Alzheimer's disease research funding
257 under the program may be submitted from any university or
258 established research institute in the state. All qualified
259 investigators in the state, regardless of institution
260 affiliation, shall have equal access and opportunity to compete
261 for research funding. The following types of applications may be

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262 considered for funding:
263 1. Investigator-initiated research grants.
264 2. Institutional research grants.
265 3. Predoctoral and postdoctoral research fellowships.
266 4. Collaborative research grants, including those that
267 advance the finding of cures through basic or applied research.
268 (3) There is created the Alzheimer's Disease Research Grant
269 Advisory Board within the Department of Health.
270 (a) The board shall consist of 12 members appointed by the
271 State Surgeon General. The board shall be composed of three
272 gerontologists, three geriatric psychiatrists, three
273 geriatricians, and three neurologists. Initial appointments to
274 the board shall be made by October 1, 2014. The board members
275 shall serve 4-year terms, except that, to provide for staggered
276 terms, six of the initial appointees shall serve 2-year terms
277 and six shall serve 4-year terms. All subsequent appointments
278 shall be for 4-year terms. The chair of the board shall be
279 elected from the membership of the board and shall serve as
280 chair for 2 years. An appointed member may not serve more than
281 two consecutive terms. Appointed members must have experience in
282 Alzheimer's disease or related biomedical research. The board
283 shall adopt internal organizational procedures as necessary for
284 its organization. The board shall establish and follow
285 guidelines for ethical conduct and adhere to a policy
286 established to avoid conflicts of interest. A member of the
287 board may not participate in any discussion or decision of the
288 board or a panel with respect to a research proposal by any
289 firm, entity, or agency with which the member is associated as a
290 member of the governing body or as an employee or with which the

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291 member has entered into a contractual arrangement.
292 (b) The department shall provide such staff, information,
293 and other assistance as necessary to assist the board in
294 carrying out its responsibilities. Members of the board shall
295 serve without compensation and may not receive reimbursement for
296 per diem or travel expenses.
297 (c) The board shall advise the State Surgeon General as to
298 the scope of the research program and shall submit its
299 recommendations for proposals to be funded to the State Surgeon
300 General by December 15 of each year. Grants and fellowships
301 shall be awarded by the State Surgeon General, after
302 consultation with the board, on the basis of scientific merit.
303 Other responsibilities of the board may include, but are not
304 limited to, providing advice on program priorities and emphases;
305 assisting in the development of appropriate linkages to
306 nonacademic entities, such as voluntary organizations, health
307 care delivery institutions, industry, government agencies, and
308 public officials; and developing and providing oversight
309 regarding mechanisms for the dissemination of research results.
310 (4) The board shall submit a fiscal-year progress report on
311 the programs under its purview to the Governor, the President of
312 the Senate, the Speaker of the House of Representatives, and the
313 State Surgeon General by February 15 of each year. The report
314 must include:
315 (a) A list of research projects supported by grants or
316 fellowships awarded under the program.
317 (b) A list of recipients of program grants or fellowships.
318 (c) A list of publications in peer-reviewed journals
319 involving research supported by grants or fellowships awarded

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320 under the program.
321 (d) The state ranking and total amount of Alzheimer's
322 disease research funding allocated to the state from the
323 National Institutes of Health.
324 (e) New grants for Alzheimer's disease research which were
325 funded based on research supported by grants or fellowships
326 awarded under the program.
327 (f) Progress toward programmatic goals, particularly in the
328 prevention, diagnosis, treatment, and cure of Alzheimer's
329 disease.
330 (g) Recommendations to further the mission of the program.
331 (5) Implementation of the Ed and Ethel Moore Alzheimer's
332 Disease Research Program is subject to legislative
333 appropriation.
334 Section 5. Present subsections (3) through (9) of section
335 430.502, Florida Statutes, are redesignated as subsections (6)
336 through (12), respectively, new subsections (3), (4), and (5)
337 are added to that section, and present subsections (4), (5),
338 (8), and (9) of that section are amended, to read:
339 430.502 Alzheimer's disease; memory disorder clinics and
340 day care and respite care programs.—
341 (3) The department shall develop minimum performance
342 standards for memory disorder clinics and include those
343 standards in each memory disorder clinic contract as a condition
344 for receiving base-level funding. The performance standards must
345 address, at a minimum, quality of care, comprehensiveness of
346 services, and access to services.
347 (4) The department shall develop performance goals that
348 exceed the minimum performance standards developed under

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349 subsection (3) which must be achieved in order for a memory
350 disorder clinic to be eligible for incentive funding above the
351 base level, subject to legislative appropriation. Incentive
352 funding shall be based on criteria including, but not limited
353 to:
354 (a) A significant increase in the volume of clinical
355 services.
356 (b) A significant increase in public outreach to low-income
357 and minority populations.
358 (c) A significant increase in the acceptance of Medicaid
359 and commercial insurance policies.
360 (d) Significant institutional financial commitments.
361 (5) The department shall measure and score each memory
362 disorder clinic based on minimum performance standards and
363 incentive performance goals.
364 (7)~~(4)~~ Pursuant to ~~the provisions of~~ s. 287.057, the
365 department ~~of Elderly Affairs~~ may contract for the provision of
366 specialized model day care programs in conjunction with the
367 memory disorder clinics. The purpose of each model day care
368 program must be to provide service delivery to persons suffering
369 from Alzheimer's disease or a related memory disorder and
370 training for health care and social service personnel in the
371 care of persons having Alzheimer's disease or a related memory
372 disorder ~~disorders~~.
373 (8)~~(5)~~ Pursuant to s. 287.057, the department ~~of Elderly~~
374 ~~Affairs~~ shall contract for the provision of respite care. All
375 funds appropriated for the provision of respite care shall be
376 distributed annually by the department to each funded county
377 according to an allocation formula. In developing the formula,

378 the department shall consider the number and proportion of the
379 county population of individuals who are 75 years of age and
380 older. Each respite care program shall be used as a resource for
381 research and statistical data by the memory disorder clinics
382 established in this part. In consultation with the memory
383 disorder clinics, the department shall specify the information
384 to be provided by the respite care programs for research
385 purposes.
386 (11)~~(8)~~ The department shall implement the waiver program
387 specified in subsection (10) ~~(7)~~. The agency and the department
388 shall ensure the selection of ~~that~~ providers who have a history
389 of successfully serving persons with Alzheimer's disease ~~are~~
390 ~~selected~~. The department and the agency shall develop
391 specialized standards for providers and services tailored to
392 persons in the early, middle, and late stages of Alzheimer's
393 disease and designate a level of care determination process and
394 standard that is most appropriate to this population. The
395 department and the agency shall include in the waiver services
396 designed to assist the caregiver in continuing to provide in-
397 home care. The department shall implement this waiver program
398 subject to a specific appropriation or as provided in the
399 General Appropriations Act.
400 (12)~~(9)~~ Authority to continue the waiver program specified
401 in subsection (10) ~~(7)~~ shall be automatically eliminated at the
402 close of the 2010 Regular Session of the Legislature unless
403 further legislative action is taken to continue it before ~~prior~~
404 ~~to~~ such time.
405 Section 6. This act shall take effect July 1, 2014.

GEORGIADES.CELIA

From: KOKKINOS.REBECCA
Sent: Tuesday, February 11, 2014 12:39 PM
To: BEAN.AARON
Cc: STOVALL.SANDRA; GEORGIADES.CELIA; Hudson, Matt
Subject: agenda request from Sen. Richter for SB 872 & 840

Thank you for your consideration,

Becky Kokkinos
Chief Legislative Aide to
Senator Garrett Richter
850-487-5023
404 Senate Office Building

ENTERED

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-19-14
Meeting Date

Topic: Alzheimer's - Special Needs Shelter Registry

Bill Number: SB 872 *(if applicable)*

Name: Eve Rainey

Amendment Barcode: ______ *(if applicable)*

Job Title: Exec Director

Address: 400 Capital Circle SE Suite 18-263
Street

Tallahassee FL 32301
City *State* *Zip*

Phone: 850 274-1835

E-mail: erainey@fepa.org

Speaking: ☐ For ☐ Against ☑ Information

Representing: Florida Emergency Preparedness Assoc

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic Alzheimer's Disease

Bill Number 872 *(if applicable)*

Name Layne Smith

Amendment Barcode ______ *(if applicable)*

Job Title Director, State Government Relations

Address 4500 San Pablo Road
Street

Jacksonville FL 32224
City *State* *Zip*

Phone 904-953-7334

E-mail smith.layne@mayo.edu

Speaking: ☒ For ☐ Against ☐ Information

Representing Mayo Clinic

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

19

3/18/2014
Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

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

Topic: Special Needs Shelters/Alzheimer's Disease

Bill Number: 872 *(if applicable)*

Name: Dana Farmer

Amendment Barcode: ______ *(if applicable)*

Job Title: Director of Legislative Affairs

Address: 2728 Centerview Dr., Ste 102
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone: 850.617.9709

E-mail: danaf@disabilityrightsflorida.org

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

Representing: Disability Rights Florida

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic: Alzheimer's Disease

Bill Number: 872 (if applicable)

Name: Natalie Kelly

Amendment Barcode: (if applicable)

Job Title:

Address: PO Box 923 Tallahassee
Street

Tallahassee FL 32302
City State Zip

Phone: 850) 570-5747

E-mail: Natalie@AcclaimStrategies.net

Speaking: [x] For [ ] Against [ ] Information

Representing: Alzheimer's Association

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic: Alzheimers Disease

Bill Number: 872 *(if applicable)*

Name: Laura Cantwell

Amendment Barcode: ____ *(if applicable)*

Job Title: Associate State Director

Address: 400 Carillon Pkwy, Suite 100
Street

St. Pete, FL 33716
City *State* *Zip*

Phone: 880-570-2110

E-mail: lcantwell@aarp.org

Speaking: [x] For [ ] Against [ ] Information

Representing: AARP

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic ______

Bill Number 872 *(if applicable)*

Name Chris Nuland

Amendment Barcode ______ *(if applicable)*

Job Title ______

Address 1000 Riverside Ave
Street
Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

E-mail nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Public Health Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 840

INTRODUCER: Health Policy Committee and Senator Richter

SUBJECT: Public Records and Meetings/Alzheimer's Disease Research Grant Advisory Board

DATE: March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall	HP	**Fav/CS**
2.			GO	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 840, which is tied to CS/SB 872, creates a public records exemption for information related to the Alzheimer's Disease Research Grant Advisory Board's (board) receipt and review of research grant applications. The information is designated confidential and exempt, but may be disclosed under certain circumstances. The bill also exempts from the public meetings laws those portions of the Board's meetings at which the grant applications are discussed. The bill requires that the closed meetings be recorded and disclosed under specified circumstances.

The exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2019, unless reviewed and reenacted by the Legislature.

The bill contains a public necessity statement as required by the Florida Constitution.

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

II. Present Situation:

Ed and Ethel Moore Alzheimer's Disease Research Program

CS/SB 872, which is tied to CS/SB 840, creates the Ed and Ethel Moore Alzheimer's Disease Research Program to fund research to help prevent or cure Alzheimer's disease. Awards must be made through a competitive, peer-reviewed process in any of the following categories:
- Investigator-initiated research.
- Institutional research.
- Predoctoral and postdoctoral research fellowships.
- Collaborative research.

The bill creates an 11-member Alzheimer's Disease Research Grant Advisory Board to provide the State Surgeon General input on the scope of the research program and its recommendations for proposals to be funded. The State Surgeon General, in turn, awards grants, after consulting with the board, on the basis of scientific merit. The board may also advise on program priorities; assist in developing linkages with nonacademic entities; and develop and provide oversight of mechanisms for disseminating research results.

The board reports annually to the Governor, President of the Senate, Speaker of the House of Representatives, and the State Surgeon General on elements of the program's implementation, its impact on leveraging additional funding, progress towards its goals, and recommendations to further its mission.

Implementation of the program is contingent upon an appropriation.

Public Records and Public Meetings Laws

The Florida Constitution provides every person 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 of persons acting on their behalf.[1] The records of the legislative, executive, and judicial branches are specifically included.[2]

The Florida Statutes also specify conditions under which public access must be provided to government records. The Public Records Act[3] guarantees every person's right to inspect and

[1] FLA. CONST., art. I, s. 24(a).
[2] *Id.*
[3] Chapter 119, F.S.

copy any state or local government public record[4] at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[5]

The Florida Constitution also requires that all meetings of any board or commission of any agency or authority of the state or of any county, municipal corporation, or political subdivision at which official acts are to be taken or public business of such body is to be transacted or discussed be open and noticed to the public.[6] In addition, the Sunshine Law[7] requires all meetings of any board or commission of any local agency or authority at which official acts are to be taken to be noticed and open to the public.[8]

Only the Legislature may create an exemption to public records or public meetings requirements.[9] Such an exemption must be created by general law and must specifically state the public necessity justifying the exemption.[10] Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law. A bill enacting an exemption may not contain other substantive provisions[11] and must pass by a two-thirds vote of the members present and voting in each house of the Legislature.[12]

The Open Government Sunset Review Act (the act) prescribes a legislative review process for newly created or substantially amended public records or open meetings exemptions.[13] It

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[4] Section 119.011(12), F.S., defines "public records" 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 received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean "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 Public Records Act does not apply to legislative or judicial records (*see Locke v. Hawkes*, 595 So.2d 32 (Fla. 1992)). But, *see* s. 11.0431, F.S. (Providing public access to records of the Senate and the House of Representatives, subject to specified exemptions.)

[5] Section 119.07(1)(a), F.S.

[6] Article I, Section 24(b), of the Florida Constitution.

[7] Section 286.011, F.S. Section 286.011, F.S., has been construed to apply to any gathering, formal or informal, of two or more members of the same board or commission to discuss some matter on which foreseeable action will be taken by that board or commission. *See generally Hough v. Stembridge*, 278 So.2d 288 (Fla. 3rd DCA 1973).

[8] Section 286.011(1)-(2), F.S. The intent of the Legislature is to "extend application of the 'open meeting' concept so as to bind every 'board or commission' of the state, or of any county or political subdivision over which it has dominion or control." *City of Miami Beach v. Berns*, 245 So.2d 38, 40 (Fla. 1971).

[9] FLA. CONST., art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates *confidential and* exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances (s*ee WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004), review denied 892 So.2d 1015 (Fla. 2004); *City of Riviera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 2004); and *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential and exempt from public disclosure, such record may not be released, by the custodian of public records, to anyone other than the persons or entities specifically designated in the statutory exemption (*see* Attorney General Opinion 85-62, August 1, 1985).

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

[11] The bill may; however, contain multiple exemptions that relate to one subject.

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

[13] Section 119.15, F.S. An exemption is substantially amended if the amendment expands the scope of the exemption to include more records or information or to include meetings as well as records (s. 119.15(4)(b), F.S.). The requirements of the

requires the automatic repeal of such exemption on October 2 of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.[14] The act provides that a public records or open meetings exemption may be maintained only if it serves an identifiable public purpose and is no broader than is necessary to meet such public purpose.[15]

III. Effect of Proposed Changes:

The bill creates a public records exemption for grant applications submitted to the Alzheimer's Disease Research Grant Advisory Board and the records, except the final recommendations, generated by the board during its review. The information is confidential and exempt.[16] The records may be released; however, with the express written consent of the person to whom the information pertains or the person's legally authorized representative, or by court order upon a showing of good cause.

The bill further provides that those portions of the board's meetings at which the grant applications are discussed are exempt from the public meetings law. The bill requires that the closed portions of the meetings be recorded and the recordings may be released under the same circumstances as apply to the exempt records—with the express written consent of the person to whom the information pertains or the person's legally authorized representative, or by court order upon a showing of good cause.

The bill provides for repeal of the exemptions pursuant to the Open Government Sunset Review Act on October 2, 2019, unless reviewed and reenacted by the Legislature.

The bill provides a public necessity statement, which is required by the Florida Constitution. The bill states that the public records exemption is necessary to protect the intellectual property of the applicants, to promote scientific innovation, and to ensure a peer review process that conforms to national practices. It states that the public meetings exemption is necessary to ensure candid exchanges among reviewers, thereby ensuring that decisions are based on merit and not subject to bias or undue influence.

The bill takes effect on the same date CS/SB 872 or similar legislation takes effect, if adopted during the 2014 Session.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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act do not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System (s. 119.15(2), F.S.).

[14] Section 119.15(3), F.S.

[15] Section 119.15(6)(b), F.S.

[16] There is a difference between records the Legislature designates as exempt from public record requirements and those the Legislature deems confidential and exempt. *See supra* note 9.

B. Public Records/Open Meetings Issues:

Vote Requirement

Section 24(c), Art. I of the Florida Constitution requires a two-thirds vote of the members present and voting in each house of the Legislature for passage of a newly created or expanded public records or public meetings exemption. Because this bill creates a new public records exemption, it requires a two-thirds vote for passage.

Public Necessity Statement

Section 24(c), Art. I of the Florida Constitution requires a public necessity statement for a newly created or expanded public records or public meetings exemption. This bill creates a new public records exemption; therefore, it includes a public necessity statement.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 840 protects sensitive, intellectual data, which if released, could result in economic harm to the applicants if it were obtained and used by others who might be competing for similar grants or to develop pharmaceuticals or other treatments of a proprietary nature.

C. Government Sector Impact:

The impact would be the same for applications from public institutions as described above for applications from private researchers.

In addition, the bill could create a minimal fiscal impact for the DOH, because staff responsible for complying with public records requests may need training related to the new public records exemption.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 381.82 of the Florida Statutes, as created by CS/SB 872.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Policy on March 19, 2014:

- Amends the directory and the effective date to add references to CS/SB 872, which is the substantive tied bill.
- Requires that closed portions of meetings at which applications are discussed be recorded and released in accordance with the procedures applicable to the exempt records.

B. Amendments:

None.

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

209838

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

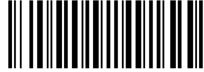
1 **Senate Amendment (with title amendment)**
2
3 Delete lines 22 - 80
4 and insert:
5 section 381.82, Florida Statutes, as created by SB 872, 2014
6 Regular Session, to read:
7 381.82 Ed and Ethel Moore Alzheimer’s Disease Research
8 Program.—
9 (3) There is created the Alzheimer’s Disease Research Grant
10 Advisory Board within the Department of Health.

209838

11 (d)1. Applications submitted to the board for Alzheimer's
12 disease research grants under this section and, with the
13 exception of final recommendations, records generated by the
14 board relating to the review of such applications are
15 confidential and exempt from s. 119.07(1) and s. 24(a), Art. I
16 of the State Constitution.
17 2. Portions of a meeting of the board at which applications
18 for Alzheimer's disease research grants under this section are
19 discussed are exempt from s. 286.011 and s. 24(b), Art. I of the
20 State Constitution. The closed portion of a meeting must be
21 recorded. The recording shall be maintained by the board and
22 shall be subject to disclosure in accordance with subparagraph
23 3.
24 3. Information that is held confidential and exempt under
25 this paragraph may be disclosed with the express written consent
26 of the individual to whom the information pertains or the
27 individual's legally authorized representative, or by court
28 order upon a showing of good cause.
29 4. This paragraph is subject to the Open Government Sunset
30 Review Act in accordance with s. 119.15 and shall stand repealed
31 on October 2, 2019, unless reviewed and saved from repeal
32 through reenactment by the Legislature.
33 Section 2. (1) The Legislature finds that it is a public
34 necessity that applications for Alzheimer's disease research
35 grants submitted to the Alzheimer's Disease Research Grant
36 Advisory Board and records generated by the board relating to
37 the review of such applications are confidential and exempt from
38 s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the
39 State Constitution. The research grant applications and the

209838

40 records generated by the board relating to the review of such
41 applications contain information of a confidential nature,
42 including ideas and processes, which could injure the affected
43 researchers and stifle scientific innovation if publicly
44 disclosed. Maintaining confidentiality is a hallmark of
45 scientific peer review when awarding grants and is practiced by
46 the National Science Foundation and the National Institutes of
47 Health. The Legislature further finds that any public benefit
48 derived from the disclosure of such information is significantly
49 outweighed by the public and private harm which could result
50 from the disclosure of such applications and records.
51 (2) The Legislature finds that it is a public necessity
52 that portions of meetings of the Alzheimer's Disease Research
53 Grant Advisory Board at which the applications are discussed be
54 held exempt from s. 286.011, Florida Statutes, and s. 24(b),
55 Article I of the State Constitution. Maintaining confidentiality
56 allows for candid exchanges among reviewers critiquing
57 applications. The Legislature further finds that closing access
58 to those portions of meetings of the board during which the
59 Alzheimer's disease research grant applications are discussed
60 serves a public good by ensuring that decisions are based upon
61 merit without bias or undue influence. This exemption is
62 narrowly drawn in that only those portions of meetings at which
63 the applications for research grants are discussed are exempt
64 from public meetings requirements.
65 Section 3. This act shall take effect on the same date that
66 SB 872 or similar legislation takes effect, if such legislation
67
68 ================= T I T L E A M E N D M E N T ================


209838

69 And the title is amended as follows:
70 Delete line 12
71 and insert:
72 applications are discussed; requiring the recording of
73 closed portions of meetings; authorizing disclosure of

By Senator Richter

23-00989-14 2014840__

1 A bill to be entitled
2 An act relating to public records and meetings;
3 amending s. 381.82, F.S.; providing an exemption from
4 public records requirements for research grant
5 applications submitted to the Alzheimer's Disease
6 Research Grant Advisory Board under the Ed and Ethel
7 Moore Alzheimer's Disease Research Program and records
8 generated by the board relating to the review of the
9 applications; providing an exemption from public
10 meetings requirements for those portions of meetings
11 of the board during which the research grant
12 applications are discussed; authorizing disclosure of
13 such confidential information under certain
14 circumstances; providing for legislative review and
15 repeal of the exemptions under the Open Government
16 Sunset Review Act; providing a statement of public
17 necessity; providing a contingent effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Paragraph (d) is added to subsection (3) of
22 section 381.82, Florida Statutes, as created by SB ____, 2014
23 Regular Session, to read:
24 381.82 Ed and Ethel Moore Alzheimer's Disease Research
25 Program.—
26 (3) There is created the Alzheimer's Disease Research Grant
27 Advisory Board within the Department of Health.
28 (d)1. Applications submitted to the board for Alzheimer's
29 disease research grants under this section and, with the

23-00989-14 2014840__

30 exception of final recommendations, records generated by the
31 board relating to the review of such applications are
32 confidential and exempt from s. 119.07(1) and s. 24(a), Art. I
33 of the State Constitution.
34 2. Portions of a meeting of the board at which applications
35 for Alzheimer's disease research grants under this section are
36 discussed are exempt from s. 286.011 and s. 24(b), Art. I of the
37 State Constitution.
38 3. Information that is held confidential and exempt under
39 this paragraph may be disclosed with the express written consent
40 of the individual to whom the information pertains or the
41 individual's legally authorized representative, or by court
42 order upon showing good cause.
43 4. This paragraph is subject to the Open Government Sunset
44 Review Act in accordance with s. 119.15 and shall stand repealed
45 on October 2, 2019, unless reviewed and saved from repeal
46 through reenactment by the Legislature.
47 Section 2. (1) The Legislature finds that it is a public
48 necessity that applications for Alzheimer's disease research
49 grants submitted to the Alzheimer's Disease Research Grant
50 Advisory Board and records generated by the board relating to
51 the review of such applications are confidential and exempt from
52 s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the
53 State Constitution. The research grant applications and the
54 records generated by the board relating to the review of such
55 applications contain information of a confidential nature,
56 including ideas and processes, which could injure the affected
57 researchers and stifle scientific innovation if publicly
58 disclosed. Maintaining confidentiality is a hallmark of

23-00989-14 2014840__

59 scientific peer review when awarding grants and is practiced by
60 the National Science Foundation and the National Institutes of
61 Health. The Legislature further finds that any public benefit
62 derived from the disclosure of such information is significantly
63 outweighed by the public and private harm which could result
64 from the disclosure of such applications and records.
65 (2) The Legislature finds that it is a public necessity
66 that portions of meetings of the Alzheimer's Disease Research
67 Grant Advisory Board at which the applications are discussed be
68 exempt from s. 286.011, Florida Statutes, and s. 24(b), Article
69 I of the State Constitution. Maintaining confidentiality allows
70 for candid exchanges among reviewers critiquing applications.
71 The Legislature further finds that closing access to those
72 portions of meetings of the board during which the Alzheimer's
73 disease research grant applications are discussed serves a
74 public good by ensuring that decisions are based upon merit
75 without bias or undue influence. This exemption is narrowly
76 drawn in that only those portions of meetings at which the
77 applications for research grants are discussed are exempt from
78 public meetings requirements.
79 Section 3. This act shall take effect on the same date that
80 SB ____ or similar legislation takes effect, if such legislation
81 is adopted in the same legislative session or an extension
82 thereof and becomes law.

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

GEORGIADES.CELIA

From: KOKKINOS.REBECCA
Sent: Tuesday, February 11, 2014 12:39 PM
To: BEAN.AARON
Cc: STOVALL.SANDRA; GEORGIADES.CELIA; Hudson, Matt
Subject: agenda request from Sen. Richter for SB 872 & 840

Thank you for your consideration,

Becky Kokkinos
Chief Legislative Aide to
Senator Garrett Richter
850-487-5023
404 Senate Office Building

ENTERED

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/CS/SB 1208

INTRODUCER: Health Policy Committee; Criminal Justice Committee; and Senator Latvala

SUBJECT: Fraudulent Controlled Substance Prescriptions

DATE: March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Erickson	Cannon	CJ	**Fav/CS**
2.	Looke	Stovall	HP	**Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1208 amends s. 893.13, F.S., to increase the penalty, from a first degree misdemeanor to a third degree felony, for a first time violation of the prohibition on a non-authorized person possessing a prescription form that has not been signed and completed by the practitioner whose name is printed on the prescription form.[1]

II. Present Situation:

Currently, s. 893.13(7)(a)7., F.S., prohibits any person from possessing a prescription form that has not been completed and signed by the practitioner whose name is printed on the form, unless the person possessing the form is the practitioner, the practitioner's agent, a pharmacist, or an authorized prescription form supplier. The first violation of this provision is punishable as a first degree misdemeanor[2] while second and subsequent violations are punishable as third degree felonies.[3]

---

[1] *See* s. 893.13(7)(a)7., F.S.

[2] A first degree misdemeanor is punishable with either or both of a prison sentence of up to 1 year and a fine of up to $1,000. *See* ss. 775.082 and 775.083, F.S.

[3] A third degree felony is punishable with either or both of a prison sentence of up to 5 years and a fine of up to $5,000. If the person is a habitual felony offender, as defined in s. 775.084(1)(a), F.S., the court may increase the sentence to up to 10 years in prison and, according to s. 775.082(10), F.S., if total sentence points scored under the Criminal Punishment Code are 22 points or fewer, the court must impose a non-state prison sanction, unless the court makes written findings that this sanction could present a danger to the public. *See* ss. 775.082, 775.083, and 775.084, F.S.

Section 893.04(1)(b) and (c), F.S., requires that a written prescription must be dated and signed by the prescribing practitioner on the same day issued and the following information must appear on the face of the prescription:

- The full name and address for whom the controlled substance is dispensed, or the owner of the animal for which the prescription was written;
- The full names and address of the prescribing practitioner and the practitioner's federal controlled substance registry number;
- The species of animal for which the prescription was writing, if written for an animal;
- The name of the controlled substance and the strength, quantity, and directions for use; and,
- The date.[4]

In addition, s. 456.42, F.S., requires that the prescription be legibly written or typed and, if written for a controlled substance listed in ch. 893, F.S., the prescription must be on a standardized counterfeit-proof prescription pad produced by a vendor approved by the Department of Health (DOH).

Currently, there are 545 vendors that are approved by the DOH to sell counterfeit-proof prescription pads.[5] Vendors are required to apply to the DOH for approval and produce counterfeit-proof prescription pads that adhere to the DOH's specifications.[6] Vendors are also responsible for the secure production and distribution of the pads and must adhere to the DOH's regulations including maintaining records and information about the production and distribution of the pads and submitting a monthly report to the DOH with details about each transaction they enter into.[7]

III. Effect of Proposed Changes:

The bill amends s. 893.13, F.S., to increase the penalty for a first-time violation of the prohibition on a non-authorized person possessing a prescription that has not been completed and signed by the practitioner whose name is on the prescription form. The penalty is increased from a first degree misdemeanor to a third degree felony.[8] The bill also makes other technical changes to that section of law.

The bill establishes an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[4] For prescriptions written for controlled substances listed in ch. 893, F.S., the date must be written with an abbreviated month. *See* s. 456.42, F.S.
[5] A list of vendors can be found at http://ww2.doh.state.fl.us/ppv_search/default.aspx, last visited on Mar. 14, 2014.
[6] *See* Rule 64B-3.005, F.A.C
[7] *Id.*
[8] Section 893.13(7)(a)7., F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Both the Department of Corrections[9] and the Legislature's Office of Economic and Demographic Research estimate that CS/CS/SB 1208 will have an insignificant prison bed impact.[10]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 893.13 of the Florida Statutes.

IX. Additional Information:

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

CS/CS by Health Policy on March 19, 2014:
Reinstates current law with respect to requiring a prescription to be "completed and signed by the practitioner whose name appears thereon."

[9] *See* Department of Corrections bill analysis for SB 1208, on file with Health Policy Committee Staff.
[10] *See* Criminal Justice Impact Conference estimate for HB 517, available at: http://edr.state.fl.us/Content/conferences/criminaljusticeimpact/index.cfm, last visited on Mar. 14, 2014.

CS by Criminal Justice on March 10, 2014:
Rewords the description of the prescription fraud act in s. 893.13(7)(a)7., F.S. As a result of this rewording, it appears the practitioner whose name appears printed on the form will still have to sign the form but the form can be completed by either the practitioner or another authorized person (current law: completed and signed by the practitioner).

B. Amendments:

None.

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

252746

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment**
2
3 Delete lines 35 - 37
4 and insert:
5 7. Possess a prescription form which has not been completed
6 and signed by the practitioner whose name appears printed
7 thereon. This subparagraph does not apply

By the Committee on Criminal Justice; and Senator Latvala

591-02377-14 20141208c1

A bill to be entitled

An act relating to fraudulent controlled substance prescriptions; amending s. 893.13, F.S.; revising provisions prohibiting possession of incomplete prescription forms; providing enhanced criminal penalties for violations involving incomplete prescription forms; providing an effective date.

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

Section 1. Paragraphs (a), (c), and (d) of subsection (7) of section 893.13, Florida Statutes, are amended to read:

893.13 Prohibited acts; penalties.—

(7)(a) A person may not:

1. Distribute or dispense a controlled substance in violation of this chapter.

2. Refuse or fail to make, keep, or furnish any record, notification, order form, statement, invoice, or information required under this chapter.

3. Refuse entry into any premises for any inspection or refuse to allow any inspection authorized by this chapter.

4. Distribute a controlled substance named or described in s. 893.03(1) or (2) except pursuant to an order form as required by s. 893.06.

5. Keep or maintain any store, shop, warehouse, dwelling, building, vehicle, boat, aircraft, or other structure or place which is resorted to by persons using controlled substances in violation of this chapter for the purpose of using these substances, or which is used for keeping or selling them in

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violation of this chapter.

6. Use to his or her own personal advantage, or reveal, any information obtained in enforcement of this chapter except in a prosecution or administrative hearing for a violation of this chapter.

7. Possess a prescription form unless it ~~which~~ has ~~not~~ been ~~completed and~~ signed by the practitioner whose name appears printed thereon and completed. This subparagraph does not apply if~~, unless~~ the person in possession of the form is that practitioner, is an agent or employee of that practitioner, is a pharmacist, or is a supplier of prescription forms who is authorized by that practitioner to possess those forms.

8. Withhold information from a practitioner from whom the person seeks to obtain a controlled substance or a prescription for a controlled substance that the person making the request has received a controlled substance or a prescription for a controlled substance of like therapeutic use from another practitioner within the previous 30 days.

9. Acquire or obtain, or attempt to acquire or obtain, possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge.

10. Affix any false or forged label to a package or receptacle containing a controlled substance.

11. Furnish false or fraudulent material information in, or omit any material information from, any report or other document required to be kept or filed under this chapter or any record required to be kept by this chapter.

12. Store anhydrous ammonia in a container that is not approved by the United States Department of Transportation to

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hold anhydrous ammonia or is not constructed in accordance with sound engineering, agricultural, or commercial practices.

13. With the intent to obtain a controlled substance or combination of controlled substances that are not medically necessary for the person or an amount of a controlled substance or substances that is not medically necessary for the person, obtain or attempt to obtain from a practitioner a controlled substance or a prescription for a controlled substance by misrepresentation, fraud, forgery, deception, subterfuge, or concealment of a material fact. For purposes of this subparagraph, a material fact includes whether the person has an existing prescription for a controlled substance issued for the same period of time by another practitioner or as described in subparagraph 8.

(c) A ~~Any~~ person who violates ~~the provisions of~~ subparagraphs (a)1.-6. ~~(a)1.-7.~~ commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, ~~;~~ except that, upon a second or subsequent violation, the person commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) A ~~Any~~ person who violates ~~the provisions of~~ subparagraphs (a)7.-12. ~~(a)8.-12.~~ commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 2. This act shall take effect October 1, 2014.

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THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Ethics and Elections, *Chair*
Budget - Subcommittee on General Government Appropriations
Budget - Subcommittee on Transportation, Tourism, and Economic Development Appropriations
Community Affairs
Environmental Preservation and Conservation
Rules
Judiciary
Appropriations
Select Committee on Gaming

SENATOR JACK LATVALA
20th District

March 11, 2014

The Honorable Aaron Bean, Chair
Senate Committee on Health Policy
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Bean:

I respectfully request that Senate Bill 1208/Fraudulent Controlled Substance Prescriptions be placed on the agenda of the Senate Committee on Health Policy at your earliest convenience. The bill was favorably referred from the Senator Committee on Criminal Justice on March 10, 2014.

The current law is vague regarding the legality of possessing a fraudulent prescription that is partially completed. The result is that it is challenging for law enforcement to build a case against someone who fills in any portion of a fraudulently obtained script.

This bill would clarify that regardless of how much, or little, a fraudulent script is filled out, it is still against the law. It would also increase the penalty for possession of a fraudulent script from a 1st degree misdemeanor to a 3rd degree felony.

If you have any questions regarding this legislation, please contact me. Thank you for your consideration.

Sincerely,

Jack Latvala
State Senator
District 20

Cc: Sandra Stovall, Staff Director; Celia Georgiades, Administrative Assistant

REPLY TO:
☐ 26133 U.S. Highway 19 North, Suite 201 Clearwater, FL 33763 (727) 793-2797
☐ 408 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5020

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

Don Gaetz
President of the Senate

Garrett Richter
President Pro Tempore

ENTERED

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic Fraudulent

Bill Number SB 1208
(if applicable)

Name Larry Gonzalez

Amendment Barcode
(if applicable)

Job Title General Counsel, FSHP*

Address 223 S. Gadsden St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-222-0465

E-mail lawgonz@earthlink.net

Speaking: [x] For [ ] Against [ ] Information

Representing *Florida Society of Health-System Pharmacists

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

3/19/14
Meeting Date

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

Topic ______________________ Bill Number 1208 (if applicable)

Name Holly Miller Amendment Barcode ______________ (if applicable)

Job Title Gov't Affairs Counsel

Address ______________________ Phone 850 224 6496

Street

E-mail hmiller@flmedical.org

City State Zip

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

Representing FMA

Appearing at request of Chair: [ ] Yes [X] No Lobbyist registered with Legislature: [X] Yes [ ] No

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

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

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 1306

INTRODUCER: Health Policy Committee and Senator Altman

SUBJECT: Onsite Sewage Treatment and Disposal Systems

DATE: March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			EP	
3.			AG	
4.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1306 amends s. 381.00655, F.S., to allow an existing onsite sewage treatment and disposal systems (OSTDS) to continue to be used after the property is hooked up to a sewer system if the Department of Environmental Protection (DEP) approves the use of all or part of the OSTDS as an integral part of the sewer system.

II. Present Situation:

In Florida, there are two ways in which domestic wastewater is collected and treated. Approximately one-third of Florida's population uses a septic system, referred to as an onsite sewage treatment and disposal system,[1] while the remainder of the population is served by centralized domestic wastewater facilities. There are an estimated 2.6 million OSDTS in

[1] An OSTDS can contain any one of the following components: a septic tank; a subsurface drainfield; an aerobic treatment unit; a graywater tank; a laundry wastewater tank; a grease interceptor; a pump tank; a waterless, incinerating or organic waste-composting toilet; and a sanitary pit privy. Septic tanks are tanks in the ground that treat sewage without the presence of oxygen. Sewage flows from a home or business through a pipe into the first chamber, where solids are removed. The liquid then flows into the second chamber where anaerobic bacteria in the sewage break down the organic matter, allowing cleaner water to flow out of the second chamber. See General facts and Statistics about Wastewater in Florida, Found at http://www.dep.state.fl.us/water/wastewater/facts.htm, last visited on Mar. 13, 2014. Also see, The EPA's *Primer for Municipal Wastewater Treatment Systems*, 2005, p. 22, found at: http://water.epa.gov/aboutow/owm/upload/2005_08_19_primer.pdf, last visited on Mar. 13, 2014.

operation in Florida[2] and over 2,100 domestic wastewater treatment facilities that treat over 1.5 billion gallons of water per day.[3]

Florida law makes the Department of Health (DOH), specifically the environmental health sections of the county health departments, responsible for regulating OSTDS and the DEP responsible for permitting and compliance activities for centralized domestic (municipal) wastewater treatment facilities.[4] In 1983, the DEP and the DOH entered into an interagency agreement to coordinate the regulation of onsite sewage systems, septage and residuals, and marina pumpout facilities.[5] This agreement sets up procedures for addressing interagency issues including jurisdiction.[6]

When a sewer system is put in place, s. 381.00655, F.S., requires the owner of a property with a properly functioning OSTDS to connect to an available sewerage system within 365 days after receiving written notification by the owner of the sewerage system that the system is available for connection. In addition, DOH Rule 64E-6.011, F.A.C., requires that an OSTDS be abandoned after connecting to a sewer system and further use is prohibited. However, with a permit from the DEP, the owner may continue to use the tank as part of the sewer system or convert it into a cistern for non-potable uses.[7]

III. Effect of Proposed Changes:

The bill amends s. 381.00655, F.S., to allow an existing OSTDS to continue to be used after the property is hooked up to a sewer system if the DEP approves the use of all or part of the OSTDS as an integral part of the sewer system.

The bill establishes an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

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[2] Onsite Sewage, found at http://www.floridahealth.gov/healthy-environments/onsite-sewage/index.html, last visited on Mar. 13, 2014.
[3] Id.
[4] Domestic Wastewater, found at http://www.dep.state.fl.us/water/wastewater/dom/index.htm, last visited Mar. 13, 2014.
[5] The agreement can be found at http://www.dep.state.fl.us/legal/Operating_Agreement/agreements/DOH/HOHOSTDS_9_10_01.pdf, last visited on Mar. 13, 2014.
[6] See http://www.dep.state.fl.us/water/wastewater/dom/septic.htm, last visited on Mar. 14, 2014.
[7] See also, DOH analysis of SB 1306, on file with Senate Health Policy Committee.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 381.00655 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Policy on March 19, 2014:
The CS amends the bill by removing all changes creating the "combined system" permit type from s. 381.0065, F.S., and replacing that with language amending s. 381.00655, F.S., which allows an existing OSTDS to continue to be used after the property is hooked up to a sewer system if the DEP approves the use of all or part of the OSTDS as an integral part of the sewer system.

B. Amendments:

None.

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

219978

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment (with title amendment)**

2

3 Delete everything after the enacting clause

4 and insert:

5 Section 1. Paragraph (c) is added to subsection (1) of

6 section 381.00655, Florida Statutes, to read:

7 381.00655 Connection of existing onsite sewage treatment

8 and disposal systems to central sewerage system; requirements.—

9 (1)

10 (c) An existing onsite sewage treatment and disposal

219978

11 system, including the drainfield, is not considered abandoned if
12 the Department of Environmental Protection or the department's
13 designee approves the use of all or a portion of the existing
14 onsite sewage treatment and disposal system as an integral part
15 of a sanitary sewer system.
16
17 ================= T I T L E A M E N D M E N T ================
18 And the title is amended as follows:
19 Delete everything before the enacting clause
20 and insert:
21 A bill to be entitled
22 An act relating to onsite sewage treatment and
23 disposal systems; amending s. 381.00655, F.S.;
24 providing that an existing onsite sewage treatment and
25 disposal system is not considered abandoned if the
26 Department of Environmental Protection approves the
27 use of all or a portion of the existing onsite sewage
28 treatment and disposal system as an integral part of a
29 sanitary sewer system.; providing an effective date.

By Senator Altman

1 A bill to be entitled
2 An act relating to onsite sewage treatment and
3 disposal systems; amending s. 381.0065, F.S.;
4 providing legislative intent; defining the term
5 "combined system"; requiring the Department of Health
6 to establish and collect fees for combined systems;
7 requiring the department to approve the installation
8 of a combined system under certain circumstances;
9 requiring a person to obtain a permit approved by the
10 department before constructing, repairing, modifying,
11 abandoning, or operating a combined system; providing
12 conditions for issuance of permits relating to such
13 systems; providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Section 381.0065, Florida Statutes, is amended
18 to read:
19 381.0065 Onsite sewage treatment and disposal systems;
20 regulation.—
21 (1) LEGISLATIVE INTENT.—
22 (a) It is the intent of the Legislature that proper
23 management of onsite sewage treatment and disposal systems is
24 paramount to the health, safety, and welfare of the public.
25 (b) It is the intent of the Legislature that where a
26 publicly owned or investor-owned sewerage system is not
27 available, the department shall issue permits for the
28 construction, installation, modification, abandonment, or repair
29 of onsite sewage treatment and disposal systems under conditions

30 as described in this section and rules adopted under this
31 section. It is further the intent of the Legislature that the
32 installation and use of onsite sewage treatment and disposal
33 systems not adversely affect the public health or significantly
34 degrade the groundwater or surface water.
35 (c) It is the intent of the Legislature that where a
36 publicly owned or investor-owned sewerage system is available,
37 the department shall issue permits for the construction of a
38 combined system when connection to the publicly owned or
39 investor-owned sewerage system results in the use of any part of
40 an onsite sewage treatment and disposal system.
41 (2) DEFINITIONS.—As used in ss. 381.0065-381.0067, the
42 term:
43 (a) "Available," as applied to a publicly owned or
44 investor-owned sewerage system, means that the publicly owned or
45 investor-owned sewerage system is capable of being connected to
46 the plumbing of an establishment or residence, is not under a
47 Department of Environmental Protection moratorium, and has
48 adequate permitted capacity to accept the sewage to be generated
49 by the establishment or residence; and:
50 1. For a residential subdivision lot, a single-family
51 residence, or an establishment, any of which has an estimated
52 sewage flow of 1,000 gallons per day or less, a gravity sewer
53 line to maintain gravity flow from the property's drain to the
54 sewer line, or a low pressure or vacuum sewage collection line
55 in those areas approved for low pressure or vacuum sewage
56 collection, exists in a public easement or right-of-way that
57 abuts the property line of the lot, residence, or establishment.
58 2. For an establishment with an estimated sewage flow

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exceeding 1,000 gallons per day, a sewer line, force main, or lift station exists in a public easement or right-of-way that abuts the property of the establishment or is within 50 feet of the property line of the establishment as accessed via existing rights-of-way or easements.

3. For proposed residential subdivisions with more than 50 lots, for proposed commercial subdivisions with more than 5 lots, and for areas zoned or used for an industrial or manufacturing purpose or its equivalent, a sewerage system exists within one-fourth mile of the development as measured and accessed via existing easements or rights-of-way.

4. For repairs or modifications within areas zoned or used for an industrial or manufacturing purpose or its equivalent, a sewerage system exists within 500 feet of an establishment's or residence's sewer stub-out as measured and accessed via existing rights-of-way or easements.

(b)1. "Bedroom" means a room that can be used for sleeping and that:

a. For site-built dwellings, has a minimum of 70 square feet of conditioned space;

b. For manufactured homes, is constructed according to the standards of the United States Department of Housing and Urban Development and has a minimum of 50 square feet of floor area;

c. Is located along an exterior wall;

d. Has a closet and a door or an entrance where a door could be reasonably installed; and

e. Has an emergency means of escape and rescue opening to the outside in accordance with the Florida Building Code.

2. A room may not be considered a bedroom if it is used to

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access another room except a bathroom or closet.

3. "Bedroom" does not include a hallway, bathroom, kitchen, living room, family room, dining room, den, breakfast nook, pantry, laundry room, sunroom, recreation room, media/video room, or exercise room.

(c) "Blackwater" means that part of domestic sewage carried off by toilets, urinals, and kitchen drains.

(d) "Combined system" means a system that includes any part of an onsite sewage and disposal system that is also connected to a publicly owned or investor-owned sewerage system regulated under chapter 403.

(e) ~~(d)~~ "Domestic sewage" means human body waste and wastewater, including bath and toilet waste, residential laundry waste, residential kitchen waste, and other similar waste from appurtenances at a residence or establishment.

(f) ~~(e)~~ "Graywater" means that part of domestic sewage that is not blackwater, including waste from the bath, lavatory, laundry, and sink, except kitchen sink waste.

(g) ~~(f)~~ "Florida Keys" means those islands of the state located within the boundaries of Monroe County.

(h) ~~(g)~~ "Injection well" means an open vertical hole at least 90 feet in depth, cased and grouted to at least 60 feet in depth which is used to dispose of effluent from an onsite sewage treatment and disposal system.

(i) ~~(h)~~ "Innovative system" means an onsite sewage treatment and disposal system that, in whole or in part, employs materials, devices, or techniques that are novel or unique and that have not been successfully field-tested under sound scientific and engineering principles under climatic and soil

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conditions found in this state.

(j) ~~(i)~~ "Lot" means a parcel or tract of land described by reference to recorded plats or by metes and bounds, or the least fractional part of subdivided lands having limited fixed boundaries or an assigned number, letter, or any other legal description by which it can be identified.

(k) ~~(j)~~ "Mean annual flood line" means the elevation determined by calculating the arithmetic mean of the elevations of the highest yearly flood stage or discharge for the period of record, to include at least the most recent 10-year period. If at least 10 years of data is not available, the mean annual flood line shall be as determined based upon the data available and field verification conducted by a certified professional surveyor and mapper with experience in the determination of flood water elevation lines or, at the option of the applicant, by department personnel. Field verification of the mean annual flood line shall be performed using a combination of those indicators listed in subparagraphs 1.-7. that are present on the site, and that reflect flooding that recurs on an annual basis. In those situations where any one or more of these indicators reflect a rare or aberrant event, such indicator or indicators may ~~shall~~ not be used ~~utilized~~ in determining the mean annual flood line. The indicators that may be considered are:

1. Water stains on the ground surface, trees, and other fixed objects;

2. Hydric adventitious roots;

3. Drift lines;

4. Rafted debris;

5. Aquatic mosses and liverworts;

6. Moss collars; and

7. Lichen lines.

(l) ~~(k)~~ "Onsite sewage treatment and disposal system" means a system that contains a standard subsurface, filled, or mound drainfield system; an aerobic treatment unit; a graywater system tank; a laundry wastewater system tank; a septic tank; a grease interceptor; a pump tank; a solids or effluent pump; a waterless, incinerating, or organic waste-composting toilet; or a sanitary pit privy that is installed or proposed to be installed beyond the building sewer on land of the owner or on other land to which the owner has the legal right to install a system. The term includes any item placed within, or intended to be used as a part of or in conjunction with, the system. This term does not include package sewage treatment facilities and other treatment works regulated under chapter 403.

(m) ~~(l)~~ "Permanent nontidal surface water body" means a perennial stream, a perennial river, an intermittent stream, a perennial lake, a submerged marsh or swamp, a submerged wooded marsh or swamp, a spring, or a seep, as identified on the most recent quadrangle map, 7.5 minute series (topographic), produced by the United States Geological Survey, or products derived from that series. "Permanent nontidal surface water body" shall also mean an artificial surface water body that does not have an impermeable bottom and side and that is designed to hold, or does hold, visible standing water for at least 180 days of the year. However, a nontidal surface water body that is drained, either naturally or artificially, where the intent or the result is that such drainage be temporary, shall be considered a permanent nontidal surface water body. A nontidal surface water

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175 body that is drained of all visible surface water, where the
176 lawful intent or the result of such drainage is that such
177 drainage will be permanent, may ~~shall~~ not be considered a
178 permanent nontidal surface water body. The boundary of a
179 permanent nontidal surface water body shall be the mean annual
180 flood line.
181 (n) ~~(m)~~ “Potable water line” means any water line that is
182 connected to a potable water supply source, but the term does
183 not include an irrigation line with any of the following types
184 of backflow devices:
185 1. For irrigation systems into which chemicals are not
186 injected, any atmospheric or pressure vacuum breaker or double
187 check valve or any detector check assembly.
188 2. For irrigation systems into which chemicals such as
189 fertilizers, pesticides, or herbicides are injected, any reduced
190 pressure backflow preventer.
191 (o) ~~(n)~~ “Septage” means a mixture of sludge, fatty
192 materials, human feces, and wastewater removed during the
193 pumping of an onsite sewage treatment and disposal system.
194 (p) ~~(o)~~ “Subdivision” means, for residential use, any tract
195 or plot of land divided into two or more lots or parcels of
196 which at least one is 1 acre or less in size for sale, lease, or
197 rent. A subdivision for commercial or industrial use is any
198 tract or plot of land divided into two or more lots or parcels
199 of which at least one is 5 acres or less in size and which is
200 for sale, lease, or rent. A subdivision shall be deemed to be
201 proposed until such time as an application is submitted to the
202 local government for subdivision approval or, in those areas
203 where no local government subdivision approval is required,

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204 until such time as a plat of the subdivision is recorded.
205 (q) ~~(p)~~ “Tidally influenced surface water body” means a body
206 of water that is subject to the ebb and flow of the tides and
207 has as its boundary a mean high-water line as defined by s.
208 177.27(15).
209 (r) ~~(q)~~ “Toxic or hazardous chemical” means a substance that
210 poses a serious danger to human health or the environment.
211 (3) DUTIES AND POWERS OF THE DEPARTMENT OF HEALTH.—The
212 department shall:
213 (a) Adopt rules to administer ss. 381.0065-381.0067,
214 including definitions that are consistent with the definitions
215 in this section, decreases to setback requirements where no
216 health hazard exists, increases for the lot-flow allowance for
217 performance-based systems, requirements for separation from
218 water table elevation during the wettest season, requirements
219 for the design and construction of any component part of an
220 onsite sewage treatment and disposal system, application and
221 permit requirements for persons who maintain an onsite sewage
222 treatment and disposal system, requirements for maintenance and
223 service agreements for aerobic treatment units and performance-
224 based treatment systems, and recommended standards, including
225 disclosure requirements, for voluntary system inspections to be
226 performed by individuals who are authorized by law to perform
227 such inspections and who shall inform a person having ownership,
228 control, or use of an onsite sewage treatment and disposal
229 system of the inspection standards and of that person’s
230 authority to request an inspection based on all or part of the
231 standards.
232 (b) Perform application reviews and site evaluations, issue

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233 permits, and conduct inspections and complaint investigations
234 associated with the construction, installation, maintenance,
235 modification, abandonment, operation, use, or repair of an
236 onsite sewage treatment and disposal system for a residence or
237 establishment with an estimated domestic sewage flow of 10,000
238 gallons or less per day, or an estimated commercial sewage flow
239 of 5,000 gallons or less per day, which is not currently
240 regulated under chapter 403.
241 (c) Develop a comprehensive program to ensure that onsite
242 sewage treatment and disposal systems regulated by the
243 department are sized, designed, constructed, installed,
244 repaired, modified, abandoned, used, operated, and maintained in
245 compliance with this section and rules adopted under this
246 section to prevent groundwater contamination and surface water
247 contamination and to preserve the public health. The department
248 is the final administrative interpretive authority regarding
249 rule interpretation. In the event of a conflict regarding rule
250 interpretation, the State Surgeon General, or his or her
251 designee, shall timely assign a staff person to resolve the
252 dispute.
253 (d) Grant variances in hardship cases under the conditions
254 prescribed in this section and rules adopted under this section.
255 (e) Permit the use of a limited number of innovative
256 systems for a specific period ~~of time~~, when there is compelling
257 evidence that the system will function properly and reliably to
258 meet the requirements of this section and rules adopted under
259 this section.
260 (f) Issue annual operating permits under this section.
261 (g) Establish and collect fees as established under s.

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262 381.0066 for services provided with respect to onsite sewage
263 treatment and disposal systems and combined systems.
264 (h) Conduct enforcement activities, including imposing
265 fines, issuing citations, suspensions, revocations, injunctions,
266 and emergency orders for violations of this section, part I of
267 chapter 386, or part III of chapter 489 or for a violation of
268 any rule adopted under this section, part I of chapter 386, or
269 part III of chapter 489.
270 (i) Provide or conduct education and training of department
271 personnel, service providers, and the public regarding onsite
272 sewage treatment and disposal systems.
273 (j) Supervise research on, demonstration of, and training
274 on the performance, environmental impact, and public health
275 impact of onsite sewage treatment and disposal systems within
276 this state. Research fees collected under s. 381.0066(2)(k) must
277 be used to develop and fund hands-on training centers designed
278 to provide practical information about onsite sewage treatment
279 and disposal systems to septic tank contractors, master septic
280 tank contractors, contractors, inspectors, engineers, and the
281 public and must also be used to fund research projects which
282 focus on improvements of onsite sewage treatment and disposal
283 systems, including use of performance-based standards and
284 reduction of environmental impact. Research projects shall be
285 initially approved by the technical review and advisory panel
286 and shall be applicable to and reflect the soil conditions
287 specific to Florida. Such projects shall be awarded through
288 competitive negotiation, using the procedures provided in s.
289 287.055, to public or private entities that have experience in
290 onsite sewage treatment and disposal systems in Florida and that

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are principally located in Florida. Research projects may ~~shall~~ not be awarded to firms or entities that employ or are associated with persons who serve on either the technical review and advisory panel or the research review and advisory committee.

(k) Approve the installation of individual graywater disposal systems in which blackwater is treated by a central sewerage system.

(l) Regulate and permit the sanitation, handling, treatment, storage, reuse, and disposal of byproducts from any system regulated under this chapter and not regulated by the Department of Environmental Protection.

(m) Permit and inspect portable or temporary toilet services and holding tanks. The department shall review applications, perform site evaluations, and issue permits for the temporary use of holding tanks, privies, portable toilet services, or any other toilet facility that is intended for use on a permanent or nonpermanent basis, including facilities placed on construction sites when workers are present. The department may specify standards for the construction, maintenance, use, and operation of any such facility for temporary use.

(n) Regulate and permit maintenance entities for performance-based treatment systems and aerobic treatment unit systems. To ensure systems are maintained and operated according to manufacturer’s specifications and designs, the department shall establish by rule minimum qualifying criteria for maintenance entities. The criteria shall include: training, access to approved spare parts and components, access to

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manufacturer’s maintenance and operation manuals, and service response time. The maintenance entity shall employ a contractor licensed under s. 489.105(3)(m), or part III of chapter 489, or a state-licensed wastewater plant operator, who is responsible for maintenance and repair of all systems under contract.

(o) Approve the installation of a combined system when connection to a publicly owned or investor-owned sewerage system results in the use of any part of an onsite sewage and disposal system.

(4) PERMITS; INSTALLATION; AND CONDITIONS.—A person may not construct, repair, modify, abandon, or operate an onsite sewage treatment and disposal system or combined system without first obtaining a permit approved by the department. The department may issue permits to carry out this section, but may ~~shall~~ not make the issuance of such permits contingent upon prior approval by the Department of Environmental Protection, except that the issuance of a permit for work seaward of the coastal construction control line established under s. 161.053 shall be contingent upon receipt of any required coastal construction control line permit from the Department of Environmental Protection and the construction of a combined system shall be contingent upon approval of the receiving force main system by the Department of Environmental Protection. A construction permit is valid for 18 months from the issuance date and may be extended by the department for one 90-day period under rules adopted by the department. A repair permit is valid for 90 days from the date of issuance. An operating permit must be obtained before ~~prior to~~ the use of any aerobic treatment unit or if the establishment generates commercial waste. Buildings or

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establishments that use an aerobic treatment unit or generate commercial waste shall be inspected by the department at least annually to assure compliance with the terms of the operating permit. The operating permit for a commercial wastewater system is valid for 1 year from the date of issuance and must be renewed annually. The operating permit for an aerobic treatment unit is valid for 2 years from the date of issuance and must be renewed every 2 years. If all information pertaining to the siting, location, and installation conditions or repair of an onsite sewage treatment and disposal system remains the same, a construction or repair permit for the onsite sewage treatment and disposal system may be transferred to another person, if the transferee files, within 60 days after the transfer of ownership, an amended application providing all corrected information and proof of ownership of the property. There is no fee associated with the processing of this supplemental information. A person may not contract to construct, modify, alter, repair, service, abandon, or maintain any portion of an onsite sewage treatment and disposal system without being registered under part III of chapter 489. A property owner who personally performs construction, maintenance, or repairs to a system serving his or her own owner-occupied single-family residence is exempt from registration requirements for performing such construction, maintenance, or repairs on that residence, but is subject to all permitting requirements. A municipality or political subdivision ~~of the state~~ may not issue a building or plumbing permit for any building that requires the use of an onsite sewage treatment and disposal system or combined system unless the owner or builder has received a

construction permit for such system from the department. A building or structure may not be occupied and a municipality, political subdivision, or any state or federal agency may not authorize occupancy until the department approves the final installation of the onsite sewage treatment and disposal system or combined system. A municipality or political subdivision ~~of the state~~ may not approve any change in occupancy or tenancy of a building that uses an onsite sewage treatment and disposal system until the department has reviewed the use of the system with the proposed change, approved the change, and amended the operating permit.

(a) Subdivisions and lots in which each lot has a minimum area of at least one-half acre and either a minimum dimension of 100 feet or a mean of at least 100 feet of the side bordering the street and the distance formed by a line parallel to the side bordering the street drawn between the two most distant points of the remainder of the lot may be developed with a water system regulated under s. 381.0062 and onsite sewage treatment and disposal systems, if ~~provided~~ the projected daily sewage flow does not exceed an average of 1,500 gallons per acre per day~~,~~ and if ~~provided~~ satisfactory drinking water can be obtained and all distance and setback, soil condition, water table elevation, and other related requirements of this section and rules adopted under this section can be met.

(b) Subdivisions and lots using a public water system as defined in s. 403.852 may use onsite sewage treatment and disposal systems, if ~~provided~~ there are no more than four lots per acre, if ~~provided~~ the projected daily sewage flow does not exceed an average of 2,500 gallons per acre per day, and if

~~provided that~~ all distance and setback, soil condition, water table elevation, and other related requirements that are generally applicable to the use of onsite sewage treatment and disposal systems are met.

(c) Notwithstanding paragraphs (a) and (b), for subdivisions platted of record on or before October 1, 1991, when a developer or other appropriate entity has previously made or makes provisions, including financial assurances or other commitments, acceptable to the Department of Health, that a central water system will be installed by a regulated public utility based on a density formula, private potable wells may be used with onsite sewage treatment and disposal systems until the agreed-upon densities are reached. In a subdivision regulated by this paragraph, the average daily sewage flow may not exceed 2,500 gallons per acre per day. This section does not affect the validity of existing prior agreements. After October 1, 1991, the exception provided under this paragraph is not available to a developer or other appropriate entity.

(d) Paragraphs (a) and (b) do not apply to any proposed residential subdivision with more than 50 lots or to any proposed commercial subdivision with more than 5 lots where a publicly owned or investor-owned sewerage system is available. It is the intent of this paragraph not to allow development of additional proposed subdivisions in order to evade the requirements of this paragraph.

(e) Onsite sewage treatment and disposal systems must not be placed closer than:

1. Seventy-five feet from a private potable well.

2. Two hundred feet from a public potable well serving a

residential or nonresidential establishment having a total sewage flow of greater than 2,000 gallons per day.

3. One hundred feet from a public potable well serving a residential or nonresidential establishment having a total sewage flow of less than or equal to 2,000 gallons per day.

4. Fifty feet from any nonpotable well.

5. Ten feet from any storm sewer pipe, to the maximum extent possible, but in no instance shall the setback be less than 5 feet.

6. Seventy-five feet from the mean high-water line of a tidally influenced surface water body.

7. Seventy-five feet from the mean annual flood line of a permanent nontidal surface water body.

8. Fifteen feet from the design high-water line of retention areas, detention areas, or swales designed to contain standing or flowing water for less than 72 hours after a rainfall or the design high-water level of normally dry drainage ditches or normally dry individual lot stormwater retention areas.

(f) Except as provided under paragraphs (e) and (t), ~~no~~ limitations may not ~~shall~~ be imposed by rule~~,~~ relating to the distance between an onsite disposal system and any area that either permanently or temporarily has visible surface water.

(g) ~~All provisions of~~ This section and rules adopted under this section relating to soil condition, water table elevation, distance, and other setback requirements must be equally applied to all lots, with the following exceptions:

1. Any residential lot that was platted and recorded on or after January 1, 1972, or that is part of a residential

465 subdivision that was approved by the appropriate permitting
466 agency on or after January 1, 1972, and that was eligible for an
467 onsite sewage treatment and disposal system construction permit
468 on the date of such platting and recording or approval shall be
469 eligible for an onsite sewage treatment and disposal system
470 construction permit, regardless of when the application for a
471 permit is made. If rules in effect at the time the permit
472 application is filed cannot be met, residential lots platted and
473 recorded or approved on or after January 1, 1972, shall, to the
474 maximum extent possible, comply with the rules in effect at the
475 time the permit application is filed. At a minimum, however,
476 those residential lots platted and recorded or approved on or
477 after January 1, 1972, but before January 1, 1983, shall comply
478 with those rules in effect on January 1, 1983, and those
479 residential lots platted and recorded or approved on or after
480 January 1, 1983, shall comply with those rules in effect at the
481 time of such platting and recording or approval. In determining
482 the maximum extent of compliance with current rules that is
483 possible, the department shall allow structures and
484 appurtenances thereto which were authorized at the time such
485 lots were platted and recorded or approved.
486 2. Lots platted before 1972 are subject to a 50-foot
487 minimum surface water setback and are not subject to lot size
488 requirements. The projected daily flow for onsite sewage
489 treatment and disposal systems for lots platted before 1972 may
490 not exceed:
491 a. Two thousand five hundred gallons per acre per day for
492 lots served by public water systems as defined in s. 403.852.
493 b. One thousand five hundred gallons per acre per day for

494 lots served by water systems regulated under s. 381.0062.
495 (h)1. The department may grant variances in hardship cases
496 which may be less restrictive than the provisions specified in
497 this section. If a variance is granted and the onsite sewage
498 treatment and disposal system construction permit has been
499 issued, the variance may be transferred with the system
500 construction permit, if the transferee files, within 60 days
501 after the transfer of ownership, an amended construction permit
502 application providing all corrected information and proof of
503 ownership of the property and if the same variance would have
504 been required for the new owner of the property as was
505 originally granted to the original applicant for the variance.
506 There is no fee associated with the processing of this
507 supplemental information. A variance may not be granted under
508 this section until the department is satisfied that:
509 a. The hardship was not caused intentionally by the action
510 of the applicant;
511 b. No reasonable alternative, taking into consideration
512 factors such as cost, exists for the treatment of the sewage;
513 and
514 c. The discharge from the onsite sewage treatment and
515 disposal system will not adversely affect the health of the
516 applicant or the public or significantly degrade the groundwater
517 or surface waters.
518
519 Where soil conditions, water table elevation, and setback
520 provisions are determined by the department to be satisfactory,
521 special consideration must be given to those lots platted before
522 1972.

2. The department shall appoint and staff a variance review and advisory committee, which shall meet monthly to recommend agency action on variance requests. The committee shall make its recommendations on variance requests at the meeting in which the application is scheduled for consideration, except for an extraordinary change in circumstances, the receipt of new information that raises new issues, or when the applicant requests an extension. The committee shall consider the criteria in subparagraph 1. in its recommended agency action on variance requests and shall also strive to allow property owners the full use of their land where possible. The committee consists of the following:

a. The State Surgeon General or his or her designee.

b. A representative from the county health departments.

c. A representative from the home building industry recommended by the Florida Home Builders Association.

d. A representative from the septic tank industry recommended by the Florida Onsite Wastewater Association.

e. A representative from the Department of Environmental Protection.

f. A representative from the real estate industry who is also a developer in this state who develops lots using onsite sewage treatment and disposal systems, recommended by the Florida Association of Realtors.

g. A representative from the engineering profession recommended by the Florida Engineering Society.

Members shall be appointed for a term of 3 years, with such appointments being staggered so that the terms of no more than

two members expire in any one year. Members shall serve without remuneration, but if requested, shall be reimbursed for per diem and travel expenses as provided in s. 112.061.

(i) A construction permit may not be issued for an onsite sewage treatment and disposal system in any area zoned or used for industrial or manufacturing purposes, or its equivalent, where a publicly owned or investor-owned sewage treatment system is available, or where a likelihood exists that the system will receive toxic, hazardous, or industrial waste. An existing onsite sewage treatment and disposal system may be repaired if a publicly owned or investor-owned sewerage system is not available within 500 feet of the building sewer stub-out and if system construction and operation standards can be met. This paragraph does not require publicly owned or investor-owned sewerage treatment systems to accept anything other than domestic wastewater.

1. A building located in an area zoned or used for industrial or manufacturing purposes, or its equivalent, when such building is served by an onsite sewage treatment and disposal system, must not be occupied until the owner or tenant has obtained written approval from the department. The department may ~~shall~~ not grant approval when the proposed use of the system is to dispose of toxic, hazardous, or industrial wastewater or toxic or hazardous chemicals.

2. Each person who owns or operates a business or facility in an area zoned or used for industrial or manufacturing purposes, or its equivalent, or who owns or operates a business that has the potential to generate toxic, hazardous, or industrial wastewater or toxic or hazardous chemicals, and uses

581 an onsite sewage treatment and disposal system that is installed
582 on or after July 5, 1989, must obtain an annual system operating
583 permit from the department. A person who owns or operates a
584 business that uses an onsite sewage treatment and disposal
585 system that was installed and approved before July 5, 1989, does
586 not need to ~~not~~ obtain a system operating permit. However, upon
587 change of ownership or tenancy, the new owner or operator must
588 notify the department of the change, and the new owner or
589 operator must obtain an annual system operating permit,
590 regardless of the date that the system was installed or
591 approved.
592 3. The department shall periodically review and evaluate
593 the continued use of onsite sewage treatment and disposal
594 systems in areas zoned or used for industrial or manufacturing
595 purposes, or its equivalent, and may require the collection and
596 analyses of samples from within and around such systems. If the
597 department finds that toxic or hazardous chemicals or toxic,
598 hazardous, or industrial wastewater have been or are being
599 disposed of through an onsite sewage treatment and disposal
600 system, the department shall initiate enforcement actions
601 against the owner or tenant to ensure adequate cleanup,
602 treatment, and disposal.
603 (j) An onsite sewage treatment and disposal system designed
604 by a professional engineer registered in the state and certified
605 by such engineer as complying with performance criteria adopted
606 by the department must be approved by the department subject to
607 the following:
608 1. The performance criteria applicable to engineer-designed
609 systems must be limited to those necessary to ensure that such

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610 systems do not adversely affect the public health or
611 significantly degrade the groundwater or surface water. Such
612 performance criteria shall include consideration of the quality
613 of system effluent, the proposed total sewage flow per acre,
614 wastewater treatment capabilities of the natural or replaced
615 soil, water quality classification of the potential surface-
616 water-receiving body, and the structural and maintenance
617 viability of the system for the treatment of domestic
618 wastewater. However, performance criteria shall address only the
619 performance of a system and not a system's design.
620 2. A person electing to use ~~utilize~~ an engineer-designed
621 system shall, upon completion of the system design, submit such
622 design, certified by a registered professional engineer, to the
623 county health department. The county health department may use
624 ~~utilize~~ an outside consultant to review the engineer-designed
625 system, with the actual cost of such review to be borne by the
626 applicant. Within 5 working days after receiving an engineer-
627 designed system permit application, the county health department
628 shall request additional information if the application is not
629 complete. Within 15 working days after receiving a complete
630 application for an engineer-designed system, the county health
631 department either shall issue the permit or, if it determines
632 that the system does not comply with the performance criteria,
633 shall notify the applicant of that determination and refer the
634 application to the department for a determination as to whether
635 the system should be approved, disapproved, or approved with
636 modification. The department engineer's determination shall
637 prevail over the action of the county health department. The
638 applicant shall be notified in writing of the department's

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639 determination and of the applicant’s rights to pursue a variance
640 or seek review under ~~the provisions of~~ chapter 120.
641 3. The owner of an engineer-designed performance-based
642 system must maintain a current maintenance service agreement
643 with a maintenance entity permitted by the department. The
644 maintenance entity shall inspect each system at least twice each
645 year and shall report quarterly to the department on the number
646 of systems inspected and serviced. The reports may be submitted
647 electronically.
648 4. The property owner of an owner-occupied, single-family
649 residence may be approved and permitted by the department as a
650 maintenance entity for his or her own performance-based
651 treatment system upon written certification from the system
652 manufacturer’s approved representative that the property owner
653 has received training on the proper installation and service of
654 the system. The maintenance service agreement must conspicuously
655 disclose that the property owner has the right to maintain his
656 or her own system and is exempt from contractor registration
657 requirements for performing construction, maintenance, or
658 repairs on the system but is subject to all permitting
659 requirements.
660 5. The property owner shall obtain a biennial system
661 operating permit from the department for each system. The
662 department shall inspect the system at least annually, or on
663 such periodic basis as the fee collected permits, and may
664 collect system-effluent samples if appropriate to determine
665 compliance with the performance criteria. The fee for the
666 biennial operating permit shall be collected beginning with the
667 second year of system operation.

668 6. If an engineer-designed system fails to properly
669 function or fails to meet performance standards, the system
670 shall be re-engineered, if necessary, to bring the system into
671 compliance with ~~the provisions of~~ this section.
672 (k) An innovative system may be approved in conjunction
673 with an engineer-designed site-specific system which is
674 certified by the engineer to meet the performance-based criteria
675 adopted by the department.
676 (l) For the Florida Keys, the department shall adopt a
677 special rule for the construction, installation, modification,
678 operation, repair, maintenance, and performance of onsite sewage
679 treatment and disposal systems which considers the unique soil
680 conditions and water table elevations, densities, and setback
681 requirements. On lots where a setback distance of 75 feet from
682 surface waters, saltmarsh, and buttonwood association habitat
683 areas cannot be met, an injection well, approved and permitted
684 by the department, may be used for disposal of effluent from
685 onsite sewage treatment and disposal systems. The following
686 additional requirements apply to onsite sewage treatment and
687 disposal systems in Monroe County:
688 1. The county, each municipality, and those special
689 districts established for the purpose of the collection,
690 transmission, treatment, or disposal of sewage shall ensure, in
691 accordance with the specific schedules adopted by the
692 Administration Commission under s. 380.0552, the completion of
693 onsite sewage treatment and disposal system upgrades to meet the
694 requirements of this paragraph.
695 2. Onsite sewage treatment and disposal systems must cease
696 discharge by December 31, 2015, or must comply with department

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697 rules and provide the level of treatment which, on a permitted
698 annual average basis, produces an effluent that contains no more
699 than the following concentrations:
700 a. Biochemical Oxygen Demand (CBOD5) of 10 mg/l.
701 b. Suspended Solids of 10 mg/l.
702 c. Total Nitrogen, expressed as N, of 10 mg/l or a
703 reduction in nitrogen of at least 70 percent. A system that has
704 been tested and certified to reduce nitrogen concentrations by
705 at least 70 percent shall be deemed to be in compliance with
706 this standard.
707 d. Total Phosphorus, expressed as P, of 1 mg/l.
708
709 In addition, onsite sewage treatment and disposal systems
710 discharging to an injection well must provide basic disinfection
711 as defined by department rule.
712 3. In areas not scheduled to be served by a central sewer,
713 onsite sewage treatment and disposal systems must, by December
714 31, 2015, comply with department rules and provide the level of
715 treatment described in subparagraph 2.
716 4. In areas scheduled to be served by central sewer by
717 December 31, 2015, if the property owner has paid a connection
718 fee or assessment for connection to the central sewer system,
719 the property owner may install a holding tank with a high water
720 alarm or an onsite sewage treatment and disposal system that
721 meets the following minimum standards:
722 a. The existing tanks must be pumped and inspected and
723 certified as being watertight and free of defects in accordance
724 with department rule; and
725 b. A sand-lined drainfield or injection well in accordance

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726 with department rule must be installed.
727 5. Onsite sewage treatment and disposal systems must be
728 monitored for total nitrogen and total phosphorus concentrations
729 as required by department rule.
730 6. The department shall enforce proper installation,
731 operation, and maintenance of onsite sewage treatment and
732 disposal systems pursuant to this chapter, including ensuring
733 that the appropriate level of treatment described in
734 subparagraph 2. is met.
735 7. The authority of a local government, including a special
736 district, to mandate connection of an onsite sewage treatment
737 and disposal system is governed by s. 4, chapter 99-395, Laws of
738 Florida.
739 8. Notwithstanding any other provision of law, an onsite
740 sewage treatment and disposal system installed after July 1,
741 2010, in unincorporated Monroe County, excluding special
742 wastewater districts, that complies with the standards in
743 subparagraph 2. is not required to connect to a central sewer
744 system until December 31, 2020.
745 (m) A ~~No~~ product sold in the state for use in onsite sewage
746 treatment and disposal systems may not contain any substance in
747 concentrations or amounts that would interfere with or prevent
748 the successful operation of such system, or that would cause
749 discharges from such systems to violate applicable water quality
750 standards. The department shall publish criteria for products
751 known or expected to meet the conditions of this paragraph. In
752 the event a product does not meet such criteria, such product
753 may be sold if the manufacturer satisfactorily demonstrates to
754 the department that the conditions of this paragraph are met.

755 (n) Evaluations for determining the seasonal high-water
756 table elevations or the suitability of soils for the use of a
757 new onsite sewage treatment and disposal system shall be
758 performed by department personnel, professional engineers
759 registered in the state, or such other persons with expertise,
760 as defined by rule, in making such evaluations. Evaluations for
761 determining mean annual flood lines shall be performed by those
762 persons identified in paragraph (2)(j). The department shall
763 accept evaluations submitted by professional engineers and such
764 other persons as meet the expertise established by this section
765 or by rule unless the department has a reasonable scientific
766 basis for questioning the accuracy or completeness of the
767 evaluation.
768 (o) The department shall appoint a research review and
769 advisory committee, which shall meet at least semiannually. The
770 committee shall advise the department on directions for new
771 research, review and rank proposals for research contracts, and
772 review draft research reports and make comments. The committee
773 is comprised of:
774 1. A representative of the State Surgeon General, or his or
775 her designee.
776 2. A representative from the septic tank industry.
777 3. A representative from the home building industry.
778 4. A representative from an environmental interest group.
779 5. A representative from the State University System, from
780 a department knowledgeable about onsite sewage treatment and
781 disposal systems.
782 6. A professional engineer registered in this state who has
783 work experience in onsite sewage treatment and disposal systems.

784 7. A representative from local government who is
785 knowledgeable about domestic wastewater treatment.
786 8. A representative from the real estate profession.
787 9. A representative from the restaurant industry.
788 10. A consumer.
789
790 Members shall be appointed for a term of 3 years, with the
791 appointments being staggered so that the terms of no more than
792 four members expire in any one year. Members shall serve without
793 remuneration, but are entitled to reimbursement for per diem and
794 travel expenses as provided in s. 112.061.
795 (p) An application for an onsite sewage treatment and
796 disposal system permit shall be completed in full, signed by the
797 owner or the owner's authorized representative, or by a
798 contractor licensed under chapter 489, and shall be accompanied
799 by all required exhibits and fees. ~~No~~ Specific documentation of
800 property ownership may not ~~shall~~ be required as a prerequisite
801 to the review of an application or the issuance of a permit. The
802 issuance of a permit does not constitute determination by the
803 department of property ownership.
804 (q) The department may not require any form of subdivision
805 analysis of property by an owner, developer, or subdivider
806 before ~~prior to~~ submission of an application for an onsite
807 sewage treatment and disposal system.
808 (r) ~~Nothing in~~ This section does not limit ~~limits~~ the power
809 of a municipality or county to enforce other laws for the
810 protection of the public health and safety.
811 (s) In the siting of onsite sewage treatment and disposal
812 systems, including drainfields, shoulders, and slopes, guttering

may ~~shall~~ not be required on single-family residential dwelling units for systems located greater than 5 feet from the roof drip line of the house. If guttering is used on residential dwelling units, the downspouts shall be directed away from the drainfield.

(t) Notwithstanding ~~the provisions of~~ subparagraph (g)1., onsite sewage treatment and disposal systems located in floodways of the Suwannee and Aucilla Rivers must adhere to the following requirements:

1. The absorption surface of the drainfield must ~~shall~~ not be subject to flooding based on 10-year flood elevations. ~~Provided,~~ However, for lots or parcels created by the subdivision of land in accordance with applicable local government regulations before ~~prior to~~ January 17, 1990, if an applicant cannot construct a drainfield system with the absorption surface of the drainfield at an elevation equal to or above 10-year flood elevation, the department shall issue a permit for an onsite sewage treatment and disposal system within the 10-year floodplain of rivers, streams, and other bodies of flowing water if all of the following criteria are met:

a. The lot is at least one-half acre in size.~~;~~

b. The bottom of the drainfield is at least 36 inches above the 2-year flood elevation.~~; and~~

c. The applicant installs either: a waterless, incinerating, or organic waste composting toilet and a graywater system and drainfield in accordance with department rules; an aerobic treatment unit and drainfield in accordance with department rules; a system approved by the State Health Office that is capable of reducing effluent nitrate by at least 50

percent; or a system approved by the county health department pursuant to department rule other than a system using alternative drainfield materials. The United States Department of Agriculture Soil Conservation Service soil maps, State of Florida Water Management District data, and Federal Emergency Management Agency Flood Insurance maps are resources that shall be used to identify flood-prone areas.

2. The use of fill or mounding to elevate a drainfield system out of the 10-year floodplain of rivers, streams, or other bodies of flowing water must ~~shall~~ not be permitted if such a system lies within a regulatory floodway of the Suwannee and Aucilla Rivers. In cases where the 10-year flood elevation does not coincide with the boundaries of the regulatory floodway, the regulatory floodway will be considered for the purposes of this subsection to extend at a minimum to the 10-year flood elevation.

(u)1. The owner of an aerobic treatment unit system shall maintain a current maintenance service agreement with an aerobic treatment unit maintenance entity permitted by the department. The maintenance entity shall inspect each aerobic treatment unit system at least twice each year and shall report quarterly to the department on the number of aerobic treatment unit systems inspected and serviced. The reports may be submitted electronically.

2. The property owner of an owner-occupied, single-family residence may be approved and permitted by the department as a maintenance entity for his or her own aerobic treatment unit system upon written certification from the system manufacturer’s approved representative that the property owner has received

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871 training on the proper installation and service of the system.
872 The maintenance entity service agreement must conspicuously
873 disclose that the property owner has the right to maintain his
874 or her own system and is exempt from contractor registration
875 requirements for performing construction, maintenance, or
876 repairs on the system but is subject to all permitting
877 requirements.
878 3. A septic tank contractor licensed under part III of
879 chapter 489, if approved by the manufacturer, may not be denied
880 access by the manufacturer to aerobic treatment unit system
881 training or spare parts for maintenance entities. After the
882 original warranty period, component parts for an aerobic
883 treatment unit system may be replaced with parts that meet
884 manufacturer's specifications but are manufactured by others.
885 The maintenance entity shall maintain documentation of the
886 substitute part's equivalency for 2 years and shall provide such
887 documentation to the department upon request.
888 4. The owner of an aerobic treatment unit system shall
889 obtain a system operating permit from the department and allow
890 the department to inspect during reasonable hours each aerobic
891 treatment unit system at least annually, and such inspection may
892 include collection and analysis of system-effluent samples for
893 performance criteria established by rule of the department.
894 (v) The department may require the submission of detailed
895 system construction plans that are prepared by a professional
896 engineer registered in this state. The department shall
897 establish by rule criteria for determining when such a
898 submission is required.
899 (w) Any permit issued and approved by the department for

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900 the installation, modification, or repair of an onsite sewage
901 treatment and disposal system or combined system shall transfer
902 with the title to the property in a real estate transaction. A
903 title may not be encumbered at the time of transfer by new
904 permit requirements by a governmental entity for an onsite
905 sewage treatment and disposal system or combined system which
906 differ from the permitting requirements in effect at the time
907 the system was permitted, modified, or repaired. An inspection
908 of a system may not be mandated by a governmental entity at the
909 point of sale in a real estate transaction. This paragraph does
910 not affect a septic tank phase-out deferral program implemented
911 by a consolidated government as defined in s. 9, Art. VIII of
912 the State Constitution (1885).
913 (x) A governmental entity, including a municipality,
914 county, or statutorily created commission, may not require an
915 engineer-designed performance-based treatment system, excluding
916 a passive engineer-designed performance-based treatment system,
917 before the completion of the Florida Onsite Sewage Nitrogen
918 Reduction Strategies Project. This paragraph does not apply to a
919 governmental entity, including a municipality, county, or
920 statutorily created commission, which adopted a local law,
921 ordinance, or regulation on or before January 31, 2012.
922 Notwithstanding this paragraph, an engineer-designed
923 performance-based treatment system may be used to meet the
924 requirements of the variance review and advisory committee
925 recommendations.
926 (y)1. An onsite sewage treatment and disposal system is not
927 considered abandoned if the system is disconnected from a
928 structure that was made unusable or destroyed following a

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929 disaster and if the system was properly functioning at the time
930 of disconnection and was not adversely affected by the disaster.
931 The onsite sewage treatment and disposal system may be
932 reconnected to a rebuilt structure if:
933 a. The reconnection of the system is to the same type of
934 structure which contains the same number of bedrooms or fewer,
935 if the square footage of the structure is less than or equal to
936 110 percent of the original square footage of the structure that
937 existed before the disaster;
938 b. The system is not a sanitary nuisance; and
939 c. The system has not been altered without prior
940 authorization.
941 2. An onsite sewage treatment and disposal system that
942 serves a property that is foreclosed upon is not considered
943 abandoned.
944 (z) If an onsite sewage treatment and disposal system
945 permittee receives, relies upon, and undertakes construction of
946 a system based upon a validly issued construction permit under
947 rules applicable at the time of construction but a change to a
948 rule occurs within 5 years after the approval of the system for
949 construction but before the final approval of the system, the
950 rules applicable and in effect at the time of construction
951 approval apply at the time of final approval if fundamental site
952 conditions have not changed between the time of construction
953 approval and final approval.
954 (aa) An existing-system inspection or evaluation and
955 assessment, or a modification, replacement, or upgrade of an
956 onsite sewage treatment and disposal system is not required for
957 a remodeling addition or modification to a single-family home if

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

958 a bedroom is not added. However, a remodeling addition or
959 modification to a single-family home may not cover any part of
960 the existing system or encroach upon a required setback or the
961 unobstructed area. To determine if a setback or the unobstructed
962 area is impacted, the local health department shall review and
963 verify a floor plan and site plan of the proposed remodeling
964 addition or modification to the home submitted by a remodeler
965 which shows the location of the system, including the distance
966 of the remodeling addition or modification to the home from the
967 onsite sewage treatment and disposal system. The local health
968 department may visit the site or otherwise determine the best
969 means of verifying the information submitted. A verification of
970 the location of a system is not an inspection or evaluation and
971 assessment of the system. The review and verification must be
972 completed within 7 business days after receipt by the local
973 health department of a floor plan and site plan. If the review
974 and verification is not completed within such time, the
975 remodeling addition or modification to the single-family home,
976 for the purposes of this paragraph, is approved.
977 (5) ENFORCEMENT; RIGHT OF ENTRY; CITATIONS.—
978 (a) Department personnel who have reason to believe
979 noncompliance exists, may at any reasonable time, enter the
980 premises permitted under ss. 381.0065-381.0066, or the business
981 premises of any septic tank contractor or master septic tank
982 contractor registered under part III of chapter 489, or any
983 premises that the department has reason to believe is being
984 operated or maintained not in compliance, to determine
985 compliance with ~~the provisions of~~ this section, part I of
986 chapter 386, or part III of chapter 489 or rules or standards

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

adopted under ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489. As used in this paragraph, the term “premises” does not include a residence or private building. To gain entry to a residence or private building, the department must obtain permission from the owner or occupant or secure an inspection warrant from a court of competent jurisdiction.

(b)1. The department may issue citations that may contain an order of correction or an order to pay a fine, or both, for violations of ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489 or the rules adopted by the department, when a violation of these sections or rules is enforceable by an administrative or civil remedy, or when a violation of these sections or rules is a misdemeanor of the second degree. A citation issued under ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489 constitutes a notice of proposed agency action.

2. A citation must be in writing and must describe the particular nature of the violation, including specific reference to the ~~provisions of~~ law or rule allegedly violated.

3. The fines imposed by a citation issued by the department may not exceed $500 for each violation. Each day the violation exists constitutes a separate violation for which a citation may be issued.

4. The department shall inform the recipient, by written notice pursuant to ss. 120.569 and 120.57, of the right to an administrative hearing to contest the citation within 21 days after the date the citation is received. The citation must contain a conspicuous statement that if the recipient fails to pay the fine within the time allowed, or fails to appear to

contest the citation after having requested a hearing, the recipient has waived the recipient’s right to contest the citation and must pay an amount up to the maximum fine.

5. The department may reduce or waive the fine imposed by the citation. In determining whether to reduce or waive the fine, the department must consider the gravity of the violation, the person’s attempts at correcting the violation, and the person’s history of previous violations including violations for which enforcement actions were taken under ss. 381.0065-381.0067, part I of chapter 386, part III of chapter 489, or other ~~provisions of~~ law or rule.

6. A ~~Any~~ person who willfully refuses to sign and accept a citation issued by the department commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

7. The department, pursuant to ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489, shall deposit any fines it collects in the county health department trust fund for use in providing services specified in those sections.

8. This section provides an alternative means of enforcing ss. 381.0065-381.0067, part I of chapter 386, and part III of chapter 489. This section does not prohibit the department from enforcing ss. 381.0065-381.0067, part I of chapter 386, or part III of chapter 489, or its rules, by any other means. However, the department must elect to use only a single method of enforcement for each violation.

(6) LAND APPLICATION OF SEPTAGE PROHIBITED.—Effective January 1, 2016, the land application of septage from onsite sewage treatment and disposal systems is prohibited.

1045 Section 2. This act shall take effect July 1, 2014.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR THAD ALTMAN
16th District

COMMITTEES:
Military Affairs, Space, and Domestic Security, *Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Finance and Tax
Children, Families, and Elder Affairs
Criminal Justice
Environmental Preservation and Conservation

SELECT COMMITTEE
Indian River Lagoon and Lake Okeechobee

JOINT COMMITTEE:
Joint Administrative Procedures Committee

March 5, 2014

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

Dear Chairman Bean:

I respectfully request that SB 1306, related to *Onsite Sewage Treatment and Disposal Systems,* be placed on the committee agenda at your earliest convenience.

Thank you for your consideration, and please do not hesitate to contact me should you have any questions.

Sincerely,

Thad Altman

Thad Altman

cc: Sandra Stovall, Staff Director, 530 Knott Building
Celia Georgiades, Committee Administrative Assistant

TA/svb

REPLY TO:
☐ 6767 North Wickham Road, Suite 211, Melbourne, Florida 32940 (321) 752-3138
☐ 314 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5016

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

ENTERED

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 690

INTRODUCER: Health Policy Committee and Senator Diaz de la Portilla

SUBJECT: Involuntary Examinations of Minors

DATE: March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall	HP	**Fav/CS**
2.			ED	
3.			AED	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 690 requires public and charter school principals or their designee to notify the parent or guardian of a minor child when the child is removed from school, school transportation, or a school-sponsored activity for involuntary examination under the Baker Act. The bill amends the Baker Act to distinguish between notice related to the whereabouts of an adult patient and notice related to the whereabouts of a minor patient. In both instances, notification may be by telephonic or electronic communication, or in person. Notification related to a minor child must be initiated immediately and continue hourly for the first 12 hours after the child's arrival and once every 24 hours thereafter until notification has been made. The bill also revises the definition of "emergency health services" in the school health services program to include mental illness.

II. Present Situation:

Involuntary Examination

In 1971, the Legislature created part I of ch. 394, F.S., the "Florida Mental Health Act," also known as the Baker Act, to address mental health needs in the state. The Baker Act is a civil commitment law which provides a process for the involuntary examination and subsequent involuntary placement (commitment) of a person for either inpatient or outpatient treatment of a mental, emotional, or behavioral disorder.

The Department of Children and Families (DCF) administers this law through receiving facilities, which are public or private facilities that are designated by the DCF to receive and hold involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment.[1] A patient who requires further treatment may be transported to a treatment facility. Treatment facilities designated by the DCF are state-owned, state-operated, or state-supported hospitals which provide extended treatment and hospitalization beyond what is provided in a receiving facility.[2]

Section 394.463(1), F.S., provides that a person may be taken to a receiving facility for involuntary examination if the person is believed to be mentally ill and because of that mental illness the person has refused voluntary examination or cannot determine for himself or herself whether examination is necessary; and, without care or treatment, the person is either likely to suffer from self-neglect, cause substantial harm to himself or herself, or be a danger to himself or herself or others.[3] An involuntary examination may be initiated in one of the following ways: [4]

- A court may enter an *ex parte* order stating a person appears to meet the criteria for involuntary examination. This order is based on sworn testimony, either written or oral.
- A law enforcement officer may take a person into custody who appears to meet the criteria for involuntary examination and transport him or her to a receiving facility for examination.
- A physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker may execute a certificate stating that he or she examined the person within the preceding 48 hours and the person appears to meet the criteria for involuntary examination.

A receiving facility is required to give prompt notice to the patient's guardian, guardian advocate, attorney, or representative by telephone or in person of the patient's whereabouts, unless the patient requests that no notification be made. Efforts to provide notice must be initiated as soon as reasonably possible after the patient's arrival and be documented in the patient's record and must occur within 24 hours.[5] In addition, the receiving facility must send a copy of the document initiating the examination to the Agency for Health Care Administration by the next working day.[6]

A person accepted by a receiving facility must receive an initial examination by a physician or clinical psychologist without unnecessary delay and may be given emergency treatment if ordered by a physician and necessary to protect the patient or others.[7] The examination must include:[8]

- A thorough review of any observations of the patient's recent behavior;
- A review of the document initiating the involuntary examination and the transportation form; and,

[1] Section 394.455(26), F.S.
[2] Section 394.455(32), F.S.
[3] Section 394.463(1), F.S.
[4] Section 394.463(2)(a), F.S.
[5] Section 394.4599(2), F.S.
[6] Section 394.463(2)(a), F.S.
[7] Section 394.463(2)(f), F.S.
[8] Rule 65E-5.2801(1), F.A.C.

- A face-to-face examination of the patient in a timely manner to determine if the patient meets criteria for release.

Within 72 hours of arriving at the receiving facility, one of the following must occur:[9]
- The patient is released, unless the person has committed a crime;
- The patient is offered the opportunity to consent to voluntary outpatient treatment and released for treatment, unless the person has committed a crime; or,
- A petition for involuntary placement must be filed with the circuit court.

The person cannot be released without the documented approval of a psychiatrist, clinical psychologist, or qualified hospital emergency department physician.[10] Notice of the discharge or transfer of a patient must be given to the patient's guardian, guardian advocate, attorney, or representative; the person who executed the certificate admitting the patient to the receiving facility; and any court that ordered the evaluation.[11]

In 2012, there were 157,352 involuntary examinations initiated in the state. Law enforcement initiated almost half of the involuntary examinations (49.75 percent), followed by mental health professionals (48.14 percent), and then *ex parte* orders by judges (2.10 percent). Overall, the number of involuntary examinations has been increasing annually in a number that exceeds Florida population growth. Between 2007 and 2012, the population of Florida increased by 2.93 percent, while the number of involuntary examinations increased by 28.50 percent.[12]

According to the DCF, of the approximately 150,000 involuntary examinations initiated in 2011, 18,000 were of children. Between 2002 and 2011, there was an overall increase of 50 percent in the number of involuntary examinations and a 35 percent increase in examinations of children.[13]

School Health Services Program

Section 381.0056, F.S., is the "School Health Services Act," which sets forth requirements related to school health. The Department of Health (DOH), in cooperation with the Department of Education, supervises the program and conducts periodic program reviews. However, implementation of program requirements occurs at the local level with the input of the local school health advisory committee.[14] A nonpublic school may request to participate in the school health services program.

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[9] Section 394.463(2)(i), F.S.
[10] Section 394.463(2)(f), F.S.
[11] Section 394.463(3), F.S.
[12] University of South Florida, de la Parte Florida Mental Health Institute, *Annual Report of Baker Act Data, Summary of 2012 Data*, 3 (Feb. 2014) , *available at* http://bakeract.fmhi.usf.edu/document/BA_Annual_2012_Final.pdf (last visited March 13, 2014).
[13] Department of Children and Families, *Florida's Baker Act: 2013 Fact Sheet* (2013), *available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/docs/Baker%20Act%20Overview%202013.pdf (last visited March 13, 2014).
[14] The advisory committee must, at a minimum, represent the eight components of Coordinated School Health as defined by the Centers for Disease Control. These include: health education; healthy school nutrition; physical education; school health services, guidance, counseling, and social service; healthy school environment; staff wellness; and family and community support. (Florida Department of Health, *Coordinated School Health,* http://www.floridahealth.gov/healthy-people-and-families/childrens-health/school-health/coordinated-school-health/index.html (last visited March 13, 2014).

Each county health department must develop, jointly with the local school board and the school advisory committee, a school health services plan that includes, at a minimum, a plan for the delivery of school health services; accountability and outcome indicators; strategies for assessing and blending financial resources (both public and private); and establishment of a data system.[15] Section 381.0056, F.S., requires the plan to contain provisions addressing a wide range of services and health issues, including meeting emergency health needs[16] in each school.

The plan must be reviewed and updated annually and approved biennially by the school district superintendent, chair of the school board, county health department medical director or administrator, and the DOH district administrator.[17]

Student and Parental Rights and Educational Choices

Section 1002.20, F.S., sets forth the right of parents of public school students to receive accurate and timely information regarding their child's academic performance and ways parents can enhance their performance. The section assembles and restates rights afforded K-12 students and their parents in various locations throughout the Florida Statutes.

Section 1002.33, F.S., authorizes charter schools as part of the state's program of public education and establishes minimum standards for their operation.

III. Effect of Proposed Changes:

The bill amends the School Health Services Program by revising the definition of "emergency health needs." The definition is expanded to include evaluation for injury and illness, which is further described as both physical and mental illness, and release to law enforcement.

The bill revises the notification requirements under the Baker Act to distinguish between notice related to the whereabouts of an adult patient and notice related to the whereabouts of a minor patient. The notice related to a minor, which is created by the bill, must be by telephonic or electronic communication or in person and attempts at notification must be initiated immediately and documented in the patient record. If the facility cannot immediately locate the minor patient's guardian, it must repeat notification attempts hourly for the first 12 hours and once every 24 hours thereafter. A facility may request the assistance of law enforcement if notification is not made within the first 24 hours. Notification related to an adult patient is expanded to include notification made by electronic communication. The bill also removes obsolete language related to the local advocacy council.

Finally, the bill adds notification of involuntary examinations to the rights of parents of public school students. Specifically, the school principal or his or her designee must immediately notify a parent or guardian of a student who is removed from school, school transportation, or a school-

[15] Rule 64F-6.002(1), F.A.C.

[16] "Emergency health needs" means onsite management and aid for illness or injury pending the student's return to the classroom or release to a parent, guardian, designated friend, or designated health care provider (s. 381.0056(2)(a), F.S.).

[17] Rule 64F-6.002(3), F.A.C.

sponsored activity and taken to a receiving facility for involuntary examination. The school board must develop a policy and procedure for the required notification. The bill adds nearly identical language to the requirements in ch. 1002, F.S., applicable to charter schools. The language differs only in that it substitutes the term "charter school governing board" for "school board" in describing the entity responsible for developing the notification policy and procedure.

The bill has an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Charter schools will incur an indeterminate cost to develop and adopt the required notification policy and procedure.

The requirement for hourly attempts at notification may require additional staff time at a privately owned receiving facility that does not already attempt repeated notification as a matter of policy and only in those cases when the receiving facility is unable to reach the minor patient's guardian immediately.

C. Government Sector Impact:

School districts will incur an indeterminate cost to develop and adopt the required notification policy and procedure.

The requirement for hourly attempts at notification may require additional staff time at a publicly-owned receiving facility that does not already attempt repeated notification as a matter of policy and only in those cases when the receiving facility is unable to reach the minor patient's guardian immediately.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0056, 394.4599, 1002.20, and 1002.33.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

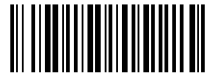
CS by Health Policy on March 19, 2014:
The Committee Substitute:

- Changes the notification requirement for receiving facilities from hourly, to hourly for the first 12 hours after arrival and once per day thereafter.
- Authorizes receiving facilities to seek the assistance of law enforcement in trying to make contact with a child's guardian if notification does not occur within 24 hours.
- Removes the option for the receiving facility or the school principal to delay notification in cases of suspected child abuse, abandonment, and neglect.
- Removes the requirement for the school health services plan to address notification to parents and further revises the definition of "emergency health services," which are an element of the plan, to cover physical and mental illness.
- Conforms language related to a receiving facility's obligation to provide notification to terminology, including defined terms, elsewhere in the Baker Act.

B. Amendments:

None.

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

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Paragraph (a) of subsection (2) of section
6 381.0056, Florida Statutes, is amended to read:
7 381.0056 School health services program.—
8 (2) As used in this section, the term:
9 (a) “Emergency health needs” means onsite evaluation,
10 management, and aid for physical or mental illness or injury

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11 pending the student's return to the classroom or release to a
12 parent, guardian, designated friend, law enforcement officer, or
13 designated health care provider.
14 Section 2. Present paragraphs (c) through (e) of subsection
15 (2) of section 394.4599, Florida Statutes, are redesignated as
16 paragraphs (d) through (f), respectively, paragraphs (a) and (b)
17 of that subsection are amended, and a new paragraph (c) is added
18 to that subsection, to read:
19 394.4599 Notice.—
20 (2) INVOLUNTARY PATIENTS.—
21 (a) Whenever notice is required to be given under this
22 part, such notice shall be given to the patient and the
23 patient's guardian, guardian advocate, attorney, and
24 representative, as applicable.
25 1. When notice is required to be given to a patient, it
26 shall be given both orally and in writing, in the language and
27 terminology that the patient can understand, and, if needed, the
28 facility shall provide an interpreter for the patient.
29 2. Notice to a patient's guardian, guardian advocate,
30 attorney, and representative shall be given by United States
31 mail and by registered or certified mail with the receipts
32 attached to the patient's clinical record. Hand delivery by a
33 facility employee may be used as an alternative, with delivery
34 documented in the clinical record. If notice is given by a state
35 attorney or an attorney for the department, a certificate of
36 service shall be sufficient to document service.
37 (b) A receiving facility shall give prompt notice of the
38 whereabouts of an adult ~~a~~ patient who is being involuntarily
39 held for examination, by telephonic or electronic communication

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40 ~~telephone~~ or in person within 24 hours after the patient’s
41 arrival at the facility, unless the patient requests that no
42 notification be made. Contact attempts shall be documented in
43 the patient’s clinical record and shall begin as soon as
44 reasonably possible after the patient’s arrival. ~~Notice that a~~
45 ~~patient is being admitted as an involuntary patient shall be~~
46 ~~given to the Florida local advocacy council no later than the~~
47 ~~next working day after the patient is admitted.~~
48 (c) A receiving facility shall give notice of the
49 whereabouts of a minor patient who is being held involuntarily
50 for examination, by telephonic or electronic communication or in
51 person immediately after the patient’s arrival at the facility.
52 Notification shall be attempted at least once every hour during
53 the first 12 hours after the patient’s arrival and once every 24
54 hours thereafter until the facility receives confirmation from
55 the guardian that notification has been made. A receiving
56 facility may request the assistance of law enforcement to
57 attempt notification in person if notification is not made
58 within the first 24 hours after the patient’s arrival. Contact
59 attempts shall be documented in the patient’s clinical record.
60 Section 3. Paragraph (l) is added to subsection (3) of
61 section 1002.20, Florida Statutes, to read:
62 1002.20 K-12 student and parent rights.—Parents of public
63 school students must receive accurate and timely information
64 regarding their child’s academic progress and must be informed
65 of ways they can help their child to succeed in school. K-12
66 students and their parents are afforded numerous statutory
67 rights including, but not limited to, the following:
68 (3) HEALTH ISSUES.—

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69 (l) Notification of involuntary examinations.—The public
70 school principal or the principal's designee shall immediately
71 notify the parent or guardian of a student who is removed from
72 school, school transportation, or a school-sponsored activity
73 and taken to a receiving facility for an involuntary examination
74 pursuant to s. 394.463. Each district school board shall develop
75 a policy and procedures for notification under this paragraph.
76 Section 4. Paragraph (q) is added to subsection (9) of
77 section 1002.33, Florida Statutes, to read:
78 1002.33 Charter schools.—
79 (9) CHARTER SCHOOL REQUIREMENTS.—
80 (q) The charter school principal or the principal's
81 designee shall immediately notify the parent or guardian of a
82 student who is removed from school, school transportation, or a
83 school-sponsored activity and taken to a receiving facility for
84 an involuntary examination pursuant to s. 394.463. Each charter
85 school governing board shall develop a policy and procedures for
86 notification under this paragraph.
87 Section 5. This act shall take effect July 1, 2014.
88
89 ================= T I T L E A M E N D M E N T ================
90 And the title is amended as follows:
91 Delete everything before the enacting clause
92 and insert:
93 A bill to be entitled
94 An act relating to involuntary examinations of minors;
95 amending s. 381.0056, F.S.; redefining the term
96 "emergency health needs"; amending s. 394.4599, F.S.;
97 requiring a receiving facility to provide notice of

494910

98 the whereabouts of an adult or minor patient held for
99 involuntary examination; providing minimum
100 requirements for attempts at notification; requiring
101 documentation of contact attempts; amending s.
102 1002.20, F.S.; requiring public schools to provide
103 notice of the whereabouts of a student removed from
104 school, school transportation, or a school-sponsored
105 activity for involuntary examination; requiring
106 district school boards to develop certain policies and
107 procedures for notification; amending s. 1002.33,
108 F.S.; requiring charter schools to provide notice of
109 the whereabouts of a student removed from school,
110 school transportation, or a school-sponsored activity
111 for involuntary examination; requiring charter school
112 governing boards to develop certain notification
113 policies and procedures; providing an effective date.

By Senator Diaz de la Portilla

1 A bill to be entitled
2 An act relating to involuntary examinations of minors;
3 amending s. 381.0056, F.S.; redefining the term
4 “emergency health needs”; requiring school health
5 services plans to include notification requirements
6 when a student is removed from school, school
7 transportation, or a school-sponsored activity for
8 involuntary examination; providing conditions for
9 delay in notification; requiring district school
10 boards to develop certain policies and procedures for
11 notification; amending s. 394.4599, F.S.; requiring a
12 receiving facility to provide notice of the
13 whereabouts of an adult or emancipated minor patient
14 held for involuntary examination; providing conditions
15 for delay in notification; requiring documentation of
16 contact attempts; amending s. 1002.20, F.S.; requiring
17 public schools to provide notice of the whereabouts of
18 a student removed from school, school transportation,
19 or a school-sponsored activity for involuntary
20 examination; providing conditions for delay in
21 notification; requiring district school boards to
22 develop certain policies and procedures for
23 notification; amending s. 1002.33, F.S.; requiring
24 charter schools to provide notice of the whereabouts
25 of a student removed from school, school
26 transportation, or a school-sponsored activity for
27 involuntary examination; providing conditions for
28 delay in notification; requiring charter school
29 governing boards to develop certain notification

30 policies and procedures; providing an effective date.
31
32 Be It Enacted by the Legislature of the State of Florida:
33
34 Section 1. Subsection (2) and paragraph (a) of subsection
35 (4) of section 381.0056, Florida Statutes, are amended to read:
36 381.0056 School health services program.—
37 (2) As used in this section, the term:
38 (a) “Emergency health needs” means onsite evaluation,
39 management, and aid for illness or injury pending the student’s
40 return to the classroom or release to a parent, guardian,
41 designated friend, law enforcement officer, or designated health
42 care provider.
43 (b) “Entity” or “health care entity” means a unit of local
44 government or a political subdivision of the state; a hospital
45 licensed under chapter 395; a health maintenance organization
46 certified under chapter 641; a health insurer authorized under
47 the Florida Insurance Code; a community health center; a migrant
48 health center; a federally qualified health center; an
49 organization that meets the requirements for nonprofit status
50 under s. 501(c)(3) of the Internal Revenue Code; a private
51 industry or business; or a philanthropic foundation that agrees
52 to participate in a public-private partnership with a county
53 health department, local school district, or school in the
54 delivery of school health services, and agrees to the terms and
55 conditions for the delivery of such services as required by this
56 section and as documented in the local school health services
57 plan.
58 (c) “Invasive screening” means any screening procedure in

which the skin or any body orifice is penetrated.

(d) “Physical examination” means a thorough evaluation of the health status of an individual.

(e) “School health services plan” means the document that describes the services to be provided, the responsibility for provision of the services, the anticipated expenditures to provide the services, and evidence of cooperative planning by local school districts and county health departments.

(f) “Screening” means presumptive identification of unknown or unrecognized diseases or defects by the application of tests that can be given with ease and rapidity to apparently healthy persons.

(4)(a) Each county health department shall develop, jointly with the district school board and the local school health advisory committee, a school health services plan.~~; and~~ The plan must include, at a minimum, provisions for:

1. Health appraisal.~~;~~

2. Records review.~~;~~

3. Nurse assessment.~~;~~

4. Nutrition assessment.~~;~~

5. A preventive dental program.~~;~~

6. Vision screening.~~;~~

7. Hearing screening.~~;~~

8. Scoliosis screening.~~;~~

9. Growth and development screening.~~;~~

10. Health counseling.~~;~~

11. Referral and followup of suspected or confirmed health problems by the local county health department.~~;~~

12. Meeting emergency health needs in each school.~~;~~

13. County health department personnel to assist school personnel in health education curriculum development.~~;~~

14. Referral of students to appropriate health treatment, in cooperation with the private health community whenever possible.~~;~~

15. Consultation with a student’s parent or guardian regarding the need for health attention by the family physician, dentist, or other specialist when definitive diagnosis or treatment is indicated.~~;~~

16. Maintenance of records on incidents of health problems, corrective measures taken, and such other information as may be needed to plan and evaluate health programs; except, however, that provisions in the plan for maintenance of health records of individual students must be in accordance with s. 1002.22.~~;~~

17. Health information which will be provided by the school health nurses, when necessary, regarding the placement of students in exceptional student programs and the reevaluation at periodic intervals of students placed in such programs.~~; and~~

18. Notification to the local nonpublic schools of the school health services program and the opportunity for representatives of the local nonpublic schools to participate in the development of the cooperative health services plan.

19. Immediate notification to a student’s parent or guardian if the student is removed from school, school transportation, or a school-sponsored activity and taken to a receiving facility for an involuntary examination pursuant to s. 394.463. The school may delay notification if the school has submitted a report to the Central Abuse Hotline pursuant to s. 39.201 based upon knowledge or suspicion of abuse, abandonment,

117 or neglect, and deems delay in notification to be in the
118 student's best interest. The delay in notification may not
119 exceed 24 hours after the student's removal from school, school
120 transportation, or school-sponsored activity. Each district
121 school board shall develop a policy and procedures for
122 notification under this subsection.
123 Section 2. Present paragraphs (c) through (e) of subsection
124 (2) of section 394.4599, Florida Statutes, are redesignated as
125 paragraphs (d) through (f), respectively, paragraph (b) of that
126 subsection is amended, and a new paragraph (c) is added to that
127 subsection, to read:
128 394.4599 Notice.—
129 (2) INVOLUNTARY PATIENTS.—
130 (b) A receiving facility shall give prompt notice of the
131 whereabouts of an adult or emancipated minor ~~a~~ patient who is
132 being involuntarily held for examination, by telephone or in
133 person within 24 hours after the patient's arrival at the
134 facility, unless the patient requests that no notification be
135 made. Contact attempts shall be documented in the patient's
136 clinical record and shall begin as soon as reasonably possible
137 after the patient's arrival. Notice that a patient is being
138 admitted as an involuntary patient shall be given to the Florida
139 local advocacy council no later than the next working day after
140 the patient is admitted.
141 (c) A receiving facility shall give prompt notice of the
142 whereabouts of a minor patient who is being held involuntarily
143 for examination pursuant to s. 394.463, by telephone or in
144 person immediately after the patient's arrival at the facility.
145 The facility may delay notification if the facility has

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146 submitted a report to the Central Abuse Hotline pursuant to s.
147 39.201 based upon knowledge or suspicion of abuse, abandonment,
148 or neglect and deems delay in notification to be in the minor's
149 best interest. The delay in notification must not exceed 24
150 hours after the minor's arrival at the facility. If the parent,
151 guardian, or guardian advocate cannot be immediately located,
152 attempts to notify must be repeated at least once every hour
153 until notification is made. Contact attempts shall be documented
154 in the patient's clinical record.
155 Section 3. Paragraph (l) is added to subsection (3) of
156 section 1002.20, Florida Statutes, to read:
157 1002.20 K-12 student and parent rights.—Parents of public
158 school students must receive accurate and timely information
159 regarding their child's academic progress and must be informed
160 of ways they can help their child to succeed in school. K-12
161 students and their parents are afforded numerous statutory
162 rights including, but not limited to, the following:
163 (3) HEALTH ISSUES.—
164 (l) *Notification of involuntary examinations.*—The public
165 school principal or the principal's designee shall immediately
166 notify the parent of a student who is removed from school,
167 school transportation, or a school-sponsored activity and taken
168 to a receiving facility for an involuntary examination pursuant
169 to s. 394.463. The school may delay notification if the school
170 has submitted a report to the Central Abuse Hotline pursuant to
171 s. 39.201 based upon knowledge or suspicion of abuse,
172 abandonment, or neglect, and deems delay in notification to be
173 in the student's best interest. The delay in notification must
174 not exceed 24 hours after the student's removal from school,

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175 school transportation, or a school-sponsored activity. Each
176 district school board shall develop a policy and procedures for
177 notification under this paragraph.
178 Section 4. Paragraph (q) is added to subsection (9) of
179 section 1002.33, Florida Statutes, to read:
180 1002.33 Charter schools.—
181 (9) CHARTER SCHOOL REQUIREMENTS.—
182 (q) The charter school principal or the principal's
183 designee shall immediately notify the parent of a student who is
184 removed from school, school transportation, or a school-
185 sponsored activity and taken to a receiving facility for an
186 involuntary examination pursuant to s. 394.463. The school may
187 delay notification if the school has submitted a report to the
188 Central Abuse Hotline pursuant to s. 39.201 based upon knowledge
189 or suspicion of abuse, abandonment, or neglect, and deems delay
190 in notification to be in the student's best interest. The delay
191 in notification must not exceed 24 hours after the student's
192 removal from school, school transportation, or a school-
193 sponsored activity. Each charter school governing board shall
194 develop a policy and procedures for notification under this
195 paragraph.
196 Section 5. This act shall take effect July 1, 2014.

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THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Finance and Tax
Banking and Insurance
Children, Families, and Elder Affairs
Ethics and Elections
Rules
Transportation

JOINT COMMITTEE:
Joint Committee on Administrative Procedures

SENATOR MIGUEL DIAZ de la PORTILLA
40th District

March 10, 2014

The Honorable Aaron Bean
Chair
Health Policy Committee

Via email

RE: SB 690; HB 497

Dear Chairman Bean:

My Senate Bill 690 has been referred to the Health Care committee. I would like to have the bill agendaed at the next available opportunity.

Thank you for your consideration.

Sincerely,

Miguel Diaz de la Portilla
State Senator, Disrict 40

Cc: Ms. Sandra Stovall, Staff Director;
Ms. Celia Georgiades, Community Administrative Assistant

REPLY TO:
☐ 2100 Coral Way, Suite 505, Miami, Florida 33145 (305) 643-7200
☐ 312 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5040

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/2014
Meeting Date

Topic: Involuntary Exams

Bill Number: SB 690 *(if applicable)*

Name: Dana Farmer

Amendment Barcode: 494910 *(if applicable)*

Job Title: Director of Legislative Affairs

Address: 2728 Centerview Dr, Ste. 102
Street

Tallahassee FL 32301
City *State* *Zip*

Phone: 850.617.9709

E-mail: danaf@disabilityrightsflorida.org

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

Representing: Disability ~~[illegible]~~ Rights Florida

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

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

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

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

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 824

INTRODUCER: Health Policy Committee and Senators Joyner and Flores

SUBJECT: Hepatitis C Testing

DATE: March 19, 2014 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 824 creates a Hepatitis C testing program under s. 381.0044, F.S., and requires certain health care practitioners to offer a federally approved Hepatitis C screening test to individuals born between January 1, 1945, and December 31, 1965. Screening is to be offered to persons who receive services as an inpatient in a general hospital or primary care services in a hospital inpatient or outpatient setting or from a specified health care practitioner. For designated individuals, a health care provider is not required to offer the screening test.

If a person accepts a screening test offer and receives a positive result, the bill requires the health care practitioner to forward the results to the patient's primary care health care practitioner for counseling and follow-up care. Follow-up care must include a Hepatitis C diagnostic test.

The Department of Health (DOH) is required to adopt rules to provide procedures for how to offer the tests and to make available a standard information sheet. The State Surgeon General must also submit an evaluation of the effectiveness of the program by January 1, 2016. The report is due to the Governor, President of the Senate, the Speaker of the House of Representatives, and the chairs of the appropriate substantive committees.

II. Present Situation:

"Hepatitis" means inflammation of the liver and is also the name of a family of viral infections that affect the liver. The most common types are Hepatitis A, Hepatitis B, and Hepatitis C.[1] Most people infected with the Hepatitis C virus (HCV) have no symptoms and are unaware that they have the disease until liver damage is discovered years later. The HCV can either be an acute or chronic infection. The virus can last a lifetime and lead to serious liver problems.[2] Hepatitis C-related end-state liver disease is the most common indication for liver transplants among American adults, accounting for more than 30 percent of cases.[3]

The virus is passed through contact with contaminated blood. A person's risk of an infection is increased if the individual has one of the following risk factors:

- Is a health care worker who has been exposed to infected blood, such as through an infected needle that pierced the skin;
- Injects or previously injected illicit drugs;
- Has HIV;
- Receives a piercing or tattoo in an unclean environment using unsterile equipment;
- Received a blood transfusion or organ transplant before 1992;
- Received clotting factor concentrates before 1987;
- Received hemodialysis treatments for a long period of time; or,
- Was born to a woman with a Hepatitis C infection.[4]

It is estimated that at least 3.2 million persons in the United States, including more than 310,000 Floridians, have the Hepatitis C virus infection, and most of those have chronic infections.[5,6] Approximately 23,000 chronic cases of the HCV infection is reported each year in Florida[7]. However, because the initial stages of the HCV infection are either asymptomatic or associated only with mild symptoms, most new infections are undiagnosed.

The Centers for Disease Control and Prevention (CDC) estimates that although persons born during the 1945 - 1965 period, the "baby boomers," comprise an estimated 27 percent of the population, they account for approximately 75 percent of all HCV infections in the United States, 73 percent of HCV-associated mortality, and are at the greatest risk for HCV-related disease.[8] In 2012, the CDC issued new recommendations that all adults born during this time period should

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[1] Centers for Disease Control and Prevention, *Hepatitis C Information for the Public*, http://www.cdc.gov/hepatitis/C/cFAQ.htm#statistics (last visited Mar. 14, 2014).
[2] *Id.*
[3] United States Preventive Services Task Force, *Screening for Hepatitis C Virus Infection in Adults, U.S. Preventive Services Task Force Recommendation Statement* (June 25, 2013), http://www.uspreventiveservicestaskforce.org/uspstf12/hepc/hepcfinalrs.htm (last visited Mar. 14, 2014).
[4] Mayo Clinic, *Diseases and Conditions - Hepatitis C*, http://www.mayoclinic.org/diseases-conditions/hepatitis-c/basics/risk-factors/con-20030618 (last visited Mar. 14, 2014).
[5] Centers for Disease Control and Prevention, *Supra,* note 1.
[6] Department of Health, 2014 Agency Legislative Bill Analysis - SB 824 (January 7, 2014), on file with Senate Health Policy Committee.
[7] *Id.*
[8] Department of Health, *Supra* note 6 at 2.

undergo one-time testing regardless of their risk status.[9] Estimates indicate that as many as five million Floridians fall into the baby boomer cohort.

The United States Preventive Services Task Force (USPSTF) in June 2013 added, as a B-rating, a recommendation that a one-time screening for HCV infection be offered for adults born between 1945 and 1965.[10] The USPSTF in its recommendation statement concluded that persons born during this time period are more likely to be diagnosed with HCV infection because they received blood transfusions before screening was introduced or have a history of other risk factors.[11] A one-time screening may lead to earlier detection of the infection and result in increased diagnosis and treatment.[12]

New treatments for HCV have been estimated to cost at least $66,000 to $84,000.[13]

Florida's Hepatitis C Programs and Coverage

Department of Health

Currently, adult Floridians, aged 18 years and older, who test positive for HCV are offered the Hepatitis B vaccine and counseling on nutrition; exercise; stopping drug, alcohol and tobacco use; and other health messages by county health departments (CHD) through the statewide Hepatitis Prevention Program. (HPP). All of these interventions slow the progress of the HCV, but there is no vaccine for HCV. While HPP testing and vaccine are provided to CHDs at no charge, some CHDs charge a small administrative fee for the vaccines, usually not more than $20.[14] A CHD will waive the cost if the client cannot afford the fee.

Funding for specific hepatitis prevention programs is provided to 15 CHDs: Alachua, Bay, Broward, Collier, Duval, Escambia, Lee, Miami-Dade, Monroe, Okeechobee, Orange, Palm Beach, Pinellas, Polk, and Seminole. All CHDs are eligible to participate.[15] In fiscal year 2013-2014, the HPP received $1,413,745 in General Revenue funding. Other annual funding supports the HPP from the HIV Prevention Program for viral hepatitis testing; HIV Patient Care Program for Hepatitis A and B vaccines and funds from the CDC for a hepatitis prevention coordinator and associated expenses.[16] The Department of Health's, Bureau of Epidemiology also funds and provides hepatitis surveillance and epidemiologic services.

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[9] United States Preventive Services Task Force, *Supra,* note 3.
[10] United States Preventive Services Task Force, *Supra,* note 3. A B rating means the Task Force recommends the service and that there is a high certainty that the net benefit is moderate or that the net benefit is moderate to substantial. The practice suggestion is to offer this service. The Task Force recommends that services be offered for A and B rated services, without further qualification.
[11] *Id.*
[12] *Id.*
[13] Julie Appleby, *Should Healthier Patients Be Asked to Wait to Use Costlier Hepatitis C Drugs?,* KAISER HEALTH NEWS, Mar. 11, 2014 at http://capsules.kaiserhealthnews.org/index.php/2014/03/cost-of-new-hepatitis-c-drugs-ignites-debate-about-who-needs-them-now/.
[14] Department of Health, *Supra,* note 6 at 2.
[15] Department of Health, *Supra* note 6 at 2.
[16] *Id.*

The state laboratory processes all viral hepatitis tests for the HPP. In 2012, the laboratory performed 22,826 tests and of those, 9 percent were positive.[17] The HPP does not provide treatment for HCV.

Medicaid

Medicaid is a joint federal and state funded program that provides health care to low income Floridians. The program is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Over 3.3 million Floridians are currently enrolled in Medicaid and the program's estimated expenditures for fiscal year 2012-2013 were approximately $21 billion.[18] The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Florida Medicaid covers medically necessary laboratory services for screening and diagnosis of Hepatitis C. Florida Medicaid also covers all medically necessary treatments for active Hepatitis C related illness for its recipients.

Medicaid recipients who test positive for the virus would likely have the confirming test and one or more other procedures to determine if the recipient has an active viral disease and to determine the quantity and characteristics of the virus. The estimated number of current Medicaid recipients within the "baby boomer" cohort is 301,776.[19]

III. Effect of Proposed Changes:

Section 1 creates s. 381.0044, F.S., relating to new Hepatitis C testing standards for certain health care practitioners and any person born between January 1, 1945, and December 31, 1965. The bill creates definitions specific to this section for:

- Health care practitioner;
- Hepatitis C diagnostic test; and,
- Hepatitis C screening test.

A person who falls within the designated age cohort and who receives health care services as an inpatient at a general hospital, primary care services in a hospital inpatient or outpatient setting, or primary care services from a physician, physician assistant or an advanced registered nurse practitioner, must be offered a Hepatitis C screening test.

A health care practitioner is not required to offer a test if the health care practitioner reasonably believes the person:

- Is being treated for a life-threatening emergency;
- Has previously been offered a Hepatitis C test or has received a screening test; however, if the person's medical condition indicates the need for additional testing, a test should be offered; or,

[17] *Id,* at 3.
[18] Agency for Health Care Administration, *Florida Medicaid,* http://ahca.myflorida.com/Medicaid/index.shtml (last visited Mar. 14, 2014).
[19] Agency for Health Care Administration, *2014 Agency Legislative Bill Analysis - SB 824* (January 2, 2014), on file with Senate Health Policy Committee.

- Lacks the capacity to consent to the test.

If a person receives a positive test result, the practitioner shall forward the results to the person's primary care health care practitioner for counseling and follow-up care. The follow-up health care must include a Hepatitis C diagnostic test.

The DOH is directed to adopt rules for linguistically and culturally appropriate procedures for offering the Hepatitis C test. The DOH must also provide health care practitioners a standard information sheet on HCV for use with patients.

The bill provides that its provisions do not impact the scope of practice of a health care practitioner or diminish the authority or professional obligation of a health care practitioner to offer a Hepatitis C screening or diagnostic test or to provide services or follow-up treatment.

The State Surgeon General is required to provide an evaluation on the effectiveness of the Hepatitis C testing program by January 1, 2016. The State Surgeon General must submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the appropriate substantive committees of the Legislature.

Section 2 provides an effective date of the act of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Currently, the CHDs charge only a small administrative fee for the test and will waive the fee if the patient is unable to pay.

B. Private Sector Impact:

Certain health care practitioners are required to offer certain individuals a Hepatitis C screening when they receive health care services in a general hospital or primary care services. The screening is voluntary, but unless the patient is being treated for an

emergency or has already been screened or tested, the health care practitioner is required to offer the screening.

CS/SB 824 requires the test to be offered; however, it does not mandate that the patient's insurance carrier provide coverage for the test or treatment. However, non-grandfathered health plans and other health insurance coverage are already required to cover any preventive services that receive an "A" or "B" grade from the USPSTF.[20]

C. Government Sector Impact:

Hospitals or facilities owned or operated by local government that treat patients in the age cohort, are required to offer the Hepatitis C screening except in limited circumstances. The bill does not address who would incur the cost of the test should the patient not have the means to cover the fees.

The DOH reports that the bill could increase demand for its services. During the last calendar year, the CHDs saw 131,821 people born between 1945 and1968.[21] The DOH projects that 70 percent of these individuals had incomes below 100 percent of the federal poverty level, placing them in the "no pay" category of the CHD's fee scale. The DOH was unable to determine the total fiscal impact but stated it may exceed their current resources.[22]

The DOH is also required to adopt rules, report on the effectiveness of the Hepatitis C testing program by January 1, 2016, and make available to practitioners a standard information sheet on Hepatitis C for use with patients. The DOH is responsible for the development and dissemination of this information. The DOH indicates that development of rules and a report can be accomplished within existing resources; no information is available on any fiscal impact for the standard information sheet.

The AHCA reports that the potential fiscal impact caused by the possible treatment of additional Medicaid recipients between 49 and 69 years of age is minimal and indeterminate for the following reasons:[23]

- In persons without symptoms, Hepatitis C is often detected through routine blood tests to measure liver function and that treatment is already covered by Medicaid;
- The AHCA cites a World Health Organization report[24] that Hepatitis C does not always require treatment, so it is difficult to predict whether an increase in the number of tests will automatically result in treatment with a variety of medications; and,
- Early detection of asymptomatic patients may result in lower treatment costs in the long-term.

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[20] *See Sec. 2713;* Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010) and 29 CFR Section 2590.715-2713.
[21] Department of Health, *Supra,* note 6 at 5.
[22] Department of Health, *Supra,* note 6 at 5.
[23] Agency for Health Care Administration, *Supra,* note 19 at 3.
[24] World Health Organization, *Hepatitis C - Fact Sheet*, (July 2013), http://www.who.int/mediacentre/factsheets/fs164/en/ (last visited Mar. 14, 2014).

For year one, the AHCA estimates an overall fiscal impact of $2,180,621, of which $1,288,747 represents the federal share and the remaining $891,874 the state costs. The cost impact is based on 50 percent of the eligible population receiving the test and 1.6 percent percentage of those that tested having follow-up tests.

For year two, the recurring impact estimate is $1,090,311 ($647,536 federal share; $442,775 state share).

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill requires the health care practitioner to forward the results of the screening test to the person's primary care practitioner who can provide appropriate counseling and follow up care. The provision also requires that the follow-up care include a Hepatitis C diagnostic test. All activities are mandatory on the part of the health care practitioner and does not address whether the patient can afford the follow-up care or the required diagnostic test, including whether the primary care health care practitioner might later determine that the diagnostic test is not necessary.

VIII. Statutes Affected:

This bill creates the following section of the Florida Statutes: 381.0044.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS/SB 824 by Health Policy Committee on March 19, 2014:
The CS modifies the definition of "health care practitioner" to mean a person licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner certified under part I of chapter 464. References to health care practitioner or the types of health care practitioners that may perform testing is also standardized. The definition of "Hepatitis C screening test" is narrowed to specify those with federal Food and Drug Administration approval. If a person accepts the offer of a Hepatitis C screening test and receives a positive result, the CS requires the result to be forwarded to the person's primary care practitioner for counseling and follow-up care. The CS also creates an additional responsibility for the DOH to make available to health care practitioners a standard information sheet on Hepatitis C for use when discussing the screening test.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 381.0044, Florida Statutes, is created
6 to read:
7 381.0044 Hepatitis C testing.—
8 (1) As used in this section, the term:
9 (a) “Health care practitioner” means a person licensed
10 under chapter 458 or chapter 459, or an advanced registered

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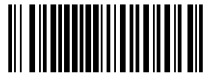
11 nurse practitioner certified under part I of chapter 464.
12 (b) “Hepatitis C diagnostic test” means a laboratory test
13 that detects the presence of the hepatitis C virus in the blood
14 and provides confirmation of a hepatitis C virus infection.
15 (c) “Hepatitis C screening test” means a federal Food and
16 Drug Administration (FDA)-approved laboratory screening test,
17 FDA-approved rapid point-of-care test, or other FDA-approved
18 test that detects the presence of hepatitis C antibodies in the
19 blood.
20 (2) A person born between January 1, 1945, and December 31,
21 1965, who receives health care services as an inpatient in a
22 general hospital as defined in s. 395.002, primary care services
23 in a hospital inpatient or outpatient setting, or primary care
24 services from a health care practitioner shall be offered a
25 hepatitis C screening test unless the health care practitioner
26 providing these services reasonably believes that the person:
27 (a) Is being treated for a life-threatening emergency;
28 (b) Has previously been offered or has been the subject of
29 a hepatitis C screening test; however, if the person’s medical
30 condition indicates the need for additional testing, a test
31 shall be offered; or
32 (c) Lacks the capacity to consent to a hepatitis C
33 screening test.
34 (3) If a person accepts the offer of a hepatitis C
35 screening test and receives a positive test result, the health
36 care practitioner shall forward the results to the person's
37 primary care health care practitioner who can provide the
38 appropriate counseling and followup health care. The followup
39 health care must include a hepatitis C diagnostic test.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40 (4) The Department of Health shall:
41 (a) Adopt rules that provide procedures for culturally and
42 linguistically offering hepatitis C screening in accordance with
43 this section; and
44 (b) Make available to health care practitioners a standard
45 hepatitis C information sheet to use when discussing and
46 offering the screening test to patients.
47 (5) This section does not affect the scope of practice of a
48 health care practitioner or diminish the authority or legal or
49 professional obligation of a health care practitioner to offer a
50 hepatitis C screening test or hepatitis C diagnostic test or to
51 provide services or followup health care to the subject of a
52 hepatitis C screening test or hepatitis C diagnostic test.
53 (6) The State Surgeon General shall submit a status report
54 evaluating the effectiveness of the hepatitis C testing program
55 established in this section by January 1, 2016. The State
56 Surgeon General shall submit the report to the Governor, the
57 President of the Senate, the Speaker of the House of
58 Representatives, and the chairs of the appropriate substantive
59 committees of the Legislature.
60 Section 2. This act shall take effect July 1, 2014.
61
62 ================= T I T L E A M E N D M E N T ================
63 And the title is amended as follows:
64 Delete everything before the enacting clause
65 and insert:
66 A bill to be entitled
67 An act relating to hepatitis C testing; creating s.
68 381.0044, F.S.; providing definitions; requiring

977812

69 specified persons to be offered hepatitis C testing;
70 requiring a health care practitioner to provide
71 followup health care to persons who receive a positive
72 test result; requiring the Department of Health to
73 adopt rules and make standard hepatitis C information
74 sheets available to health care practitioners;
75 providing applicability with respect to hepatitis C
76 testing by health care practitioners; requiring a
77 report to the Governor and the Legislature; providing
78 an effective date.

By Senator Joyner

19-01236-14 2014824__

1 A bill to be entitled
2 An act relating to Hepatitis C testing; creating s.
3 381.0044, F.S.; providing definitions; requiring
4 specified persons to be offered Hepatitis C testing;
5 providing followup health care for persons with a
6 positive test result; requiring the Department of
7 Health to adopt rules; providing applicability with
8 respect to Hepatitis C testing by health care
9 practitioners; requiring a report to the Governor and
10 Legislature; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Section 381.0044, Florida Statutes, is created
15 to read:
16 381.0044 Hepatitis C testing.—
17 (1) As used in this section, the term:
18 (a) "Health care practitioner" means a physician licensed
19 under chapter 458; an osteopathic physician licensed under
20 chapter 459; or an advanced registered nurse practitioner,
21 registered nurse, or licensed practical nurse licensed under
22 part I of chapter 464.
23 (b) "Hepatitis C diagnostic test" means a laboratory test
24 that detects the presence of the Hepatitis C virus in the blood
25 and provides confirmation of a Hepatitis C virus infection.
26 (c) "Hepatitis C screening test" means a laboratory test
27 that detects the presence of Hepatitis C virus antibodies in the
28 blood.
29 (2) A person born between January 1, 1945, and December 31,

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

30 1965, who receives health care services as an inpatient in a
31 general hospital as defined in s. 395.002, primary care services
32 in a hospital inpatient or outpatient setting, or primary care
33 services from a physician, physician assistant, or nurse
34 practitioner shall be offered a Hepatitis C screening test
35 unless the health care practitioner providing those services
36 reasonably believes that the person:
37 (a) Is being treated for a life-threatening emergency;
38 (b) Has previously been offered or has been the subject of
39 a Hepatitis C screening test; however, if the person's medical
40 condition indicates the need for additional testing, a test
41 shall be offered; or
42 (c) Lacks the capacity to consent to a Hepatitis C
43 screening test.
44 (3) If a person accepts the offer of a Hepatitis C
45 screening test and receives a positive test result, the health
46 care practitioner shall offer the person followup health care or
47 refer the person to a health care provider who can provide
48 followup health care. The followup health care must include a
49 Hepatitis C diagnostic test.
50 (4) The Department of Health shall adopt rules that provide
51 procedures for culturally and linguistically offering Hepatitis
52 C screening in accordance with this section.
53 (5) This section does not affect the scope of practice of a
54 health care practitioner or diminish the authority or legal or
55 professional obligation of any health care practitioner to offer
56 a Hepatitis C screening test or Hepatitis C diagnostic test or
57 to provide services or followup health care to the subject of a
58 Hepatitis C screening test or Hepatitis C diagnostic test.

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

19-01236-14 2014824__

59 (6) The State Surgeon General shall submit a report
60 evaluating the effectiveness of the Hepatitis C testing program
61 established in this section by January 1, 2016. The State
62 Surgeon General shall submit the report to the Governor, the
63 President of the Senate, the Speaker of the House of
64 Representatives, and the chairs of the appropriate substantive
65 committees of the Legislature.
66 Section 2. This act shall take effect July 1, 2014.

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

SENATOR ARTHENIA L. JOYNER
19th District

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Criminal and Civil Justice, *Vice Chair*
Appropriations
Appropriations Subcommittee on General Government
Ethics and Elections
Health Policy
Judiciary
Transportation

SELECT COMMITTEE:
Select Committee on Indian River Lagoon and Lake Okeechobee Basin

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

February 6, 2014

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

Dear Chairman Bean:

This is to request that Senate Bill 824, Hepatitis C Testing, be placed on the agenda for the Committee on Health Policy. Your consideration of this request is greatly appreciated.

Sincerely,

Arthenia L. Joyner
State Senator, District 19

REPLY TO:
☐ 508 W. Dr. Martin Luther King, Jr. Blvd., Suite C, Tampa, Florida 33603-3415 (813) 233-4277
☐ 202 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5019 FAX: (813) 233-4280

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

Written Copy of Oral Testimony
Health Policy, March 19, 2014
Michael Ruppal, Executive Director, The AIDS Institute

Good Morning (Afternoon), Mr. Chairman and Members:

My name is Michael Ruppal and I am the Executive Director of The AIDS Institute. Founded in 1985, our mission is to promote action for social change through public policy, advocacy, research and education.

The AIDS Institute has gradually expanded its mission and vision, and today, is a leading national HIV/AIDS and Hepatitis organization.

We are raising our voice, for awareness and hope, for the over 300,000 Floridians infected with Hepatitis C. We will help and support these people to understand whether they are infected with Hepatitis C, and then how to best manage their illness.

We know how to do this but can only succeed with YOUR help. You see, over 150,000 of the 300,000 infected do not know they have the disease. There is only one way they can learn their status – by being tested. That is why we are asking you today to support Senate bill 824. It will make a critical difference in people's lives.

With Hepatitis C, we have arrived at a unique moment in time. Thanks to intensive research, new treatments have just become available for Hepatitis C – and more are on the way later this year and next. These treatments only work if patients know they carry the Hepatitis C virus and seek care and treatment.

So, why is this a unique moment? Two reasons:

First, as I said, you have the ability to assure that people will get tested and know their status by passing this bill.

Second, the new treatments make it highly likely that when a patient decides to be treated, she or he will be able to start and complete their treatment. Unlike, HIV/AIDS which still cannot be cured; these new Hepatitis C treatments result in a 90% or better effective cure rate.

Before the new treatments, less than half of patients who started treatment were able to finish. The duration of treatment – typically 48 weeks and/or the toxicities of the treatments – resulted in this unacceptably high rate of failure.

Best of all, by testing those at risk – especially Baby Boomers – we can dramatically influence the course of this infection and prevent the inevitable complications of liver failure, liver cancer and premature death suffered by so many who go untreated.

Today, testing for Hepatitis C and effectively treating it just makes good sense. It constitutes sound public health policy and is consistent with national guidelines. It represents sound medical management. And it represents sound fiscal policy; early intervention and treatment will be less burdensome than continuing to manage the end stages of untreated infection.

Many peoples' lives will be saved or improved as a result of increased testing and subsequent referral to care.

On behalf of The AIDS Institute, and HepInfoNow.org, I thank you for the opportunity to share these remarks. And thank you for supporting Senate bill 824.

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic ______________________ Bill Number 824 *(if applicable)*

Name Chris Nuland Amendment Barcode ______________________ *(if applicable)*

Job Title ______________________

Address 1000 Riverside Ave #115
Street

Phone 904-233-3051

Jacksonville, FL 32204
City *State* *Zip*

E-mail nulandlaw@aol.com

Speaking: [x] For [ ] Against [ ] Information

Representing Florida Public Health Association

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

3-19-14
Meeting Date

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

Topic: Hepatitis C Testing

Bill Number: 824 *(if applicable)*

Name: Michael Ruppal

Amendment Barcode: *(if applicable)*

Job Title: Executive Director

Address: 17 Davis Blvd. Suite 403
Street

Tampa, FL 33606
City, State, Zip

Phone: 813-258-5929

E-mail: mruppal@theaidsinstitute.org

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

Representing: The AIDS Institute

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

3/19/2014 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic: HEPATITIS "C" testing

Bill Number: 824 *(if applicable)*

Name: Jesse Fry

Amendment Barcode: ________ *(if applicable)*

Job Title: Advocacy Committee Co-Chairman

Address: 641 E College Ave #2 (*Street*)

Tallahassee (*City*) FL (*State*) 32301 (*Zip*)

Phone: (850) 339-6395

E-mail: jesse_fry@comcast.net

Speaking: ☐ For ☐ Against ☐ Information

Representing: Florida HIV/AIDS Advocacy Network

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic: Hepatitis C

Bill Number: 824 *(if applicable)*

Name: Jack McRay

Amendment Barcode: 977812 *(if applicable)*

Job Title: Advocacy Manager

Address: 200 W College A, Suite 804 (*Street*)

Tallahassee (*City*) FL (*State*) 32301 (*Zip*)

Phone: 850-228-7295

E-mail: jmcray@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

Representing: AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic ____________________ Bill Number 824 *(if applicable)*

Name Jason Goldman, M.D. Amendment Barcode ____________________ *(if applicable)*

Job Title ____________________

Address 3001 Coral Hills Drive Phone 954-227-1234
Street

Coral Springs, FL 33065 E-mail goldmanmd@bellsouth.net
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information

Representing Florida Chapter, American College of Physicians

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

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

This form is part of the public record for this meeting. S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 1014

INTRODUCER: Health Policy Committee and Senator Garcia

SUBJECT: Pharmacy Benefit Managers

DATE: March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall	HP	**Fav/CS**
2.			BI	
3.			AGG	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1014 creates a new section of law titled "Pharmacy benefit managers." The bill creates definitions of "maximum allowable cost," "plan sponsor," and "pharmacy benefit manager." The bill sets out required provisions and conditions for contracts entered into between a pharmacy benefit manager (PBM) and a pharmacy and between a PBM and a plan sponsor related to drug pricing and claims adjudication.

II. Present Situation:

Pharmacy Regulation

Pharmacies and pharmacists are regulated under the Florida Pharmacy Act (the Act) found in ch. 465, F.S.[1] The Board of Pharmacy (the board) is created within the Department of Health (DOH) to adopt rules to implement provisions of the Act and take other actions according to duties conferred on it in the Act.[2]

Several pharmacy types are specified in law and are required to be permitted or registered under the Act:

[1] Other pharmacy paraprofessionals, including pharmacy interns and pharmacy technicians, are also regulated under the Act.
[2] Section 465.005, F.S.

- Community pharmacy – a location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.
- Institutional pharmacy – a location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility where medical drugs are compounded, dispensed, stored, or sold. The Act further classifies institutional pharmacies according to the type of facility or activities with respect to the handling of drugs within the facility.
- Nuclear pharmacy – a location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold, excluding hospitals or the nuclear medicine facilities of such hospitals.
- Internet pharmacy – a location not otherwise permitted under the Act, whether within or outside the state, which uses the internet to communicate with or obtain information from consumers in this state in order to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state.
- Non-resident pharmacy – a location outside this state which ships, mails, or delivers, in any manner, a dispensed drug into this state.
- Special pharmacy – a location where medicinal drugs are compounded, dispensed, stored, or sold if such location is not otherwise defined which provides miscellaneous specialized pharmacy service functions.

Each pharmacy is subject to inspection by the DOH and discipline for violations of applicable state or federal law relating to pharmacy. Any pharmacy located outside this state which ships, mails, or delivers, in any manner, a dispensed drug into this state is considered a nonresident pharmacy, and must register with the board as a nonresident pharmacy.[3,4]

Pharmacy Benefit Managers

Advances in pharmaceuticals have transformed health care over the last several decades. Many health care problems are prevented, cured, or managed effectively for years through the use of prescription drugs. As a result, national expenditures for retail prescription drugs have grown from $120.9 billion in 2000 to 263.3 billion in 2012.[5] Health plan sponsors, which include commercial insurers, private employers, and government plans, such as Medicaid and Medicare, spent $216.5 billion on prescription drugs in 2012 and consumers paid $46.8 billion out of pocket for prescription drugs that year.[6]

As expenditures for drugs have increased, health plan sponsors have looked for ways to control that spending. Among other things, they have turned to pharmacy benefit managers (PBMs), which are third party administrators of prescription drug programs. PBMs initially emerged in the 1980s as prescription drug claims processors. PBMs now provide a range of services including developing and managing pharmacy networks, developing drug formularies, providing

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[3] Section 465.0156, F.S.

[4] However, the board may grant an exemption from the registration requirements to any nonresident pharmacy which confines its dispensing activity to isolated transactions. *See* s. 465.0156(2), F.S.

[5] Centers for Medicare and Medicaid Services, *National Health Expenditures Web Tables, Table 16, Retail Prescription Drugs Aggregate, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2012*, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf (last visited March 17, 2014).

[6] *Id.*

mail order and specialty pharmacy services, rebate negotiation, therapeutic substitution, disease management, utilization review, support services for physicians and beneficiaries, and processing and auditing claims.

Health plan sponsors contract with PBMs to provide specified services, which may include some or all of the services described. Payments for the services are established in contracts between health plan sponsors and PBMs. For example, contracts will specify how much health plan sponsors will pay PBMs for brand-name and generic drugs. These prices are typically set as a discount off the Average Wholesale Price (AWP)[7] for brand-name drugs and at a Maximum Allowable Cost (MAC)[8] for generic drugs, plus a dispensing fee. Contracts also generally include fees for processing claims submitted by pharmacies (usually based on a rate per claim) and fees for providing services such as disease management or utilization review.[9] In addition, contracts generally specify whether and how the PBM will pass manufacturer rebates on to the health plan sponsors.[10] The contracts can also include performance guarantees, such as claims processing accuracy or amount of rebates received.[11]

In 2007, there were approximately 70 PBMs operating in the United States and managing prescription drug benefits for an estimated 95 percent of health beneficiaries nationwide.[12] Industry mergers in recent years have cut the number of large PBMs to two which together control 60 percent of the market and provide benefits for approximately 240 million people.[13]

Office of Program Policy Analysis and Government Accountability (OPPAGA) Report on Pharmacy Benefit Managers

Pursuant to a legislative request, the OPPAGA reviewed pharmacy benefit managers in a report released in 2007. This report addresses four questions.

- What role do PBMs play in the prescription drug industry?
- What concerns exist related to PBM business practices?
- How have states, PBMs, and health plan sponsors addressed these concerns?
- What options could the Legislature consider to address PBM business practices?

Relevant portions of the report are excerpted below.[14]

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[7] AWP is the retail list price (sticker price) or the average price that manufacturers recommend wholesalers sell to physicians, pharmacies and others, such as hospitals.
[8] MAC is a price set for generic drugs and is the maximum amount that the health plan will pay for a specific drug.
[9] If the PBM owns the mail-order or specialty pharmacy, claims processing fees may not be applied.
[10] Contracts may specify a fixed amount per prescription or a percentage of the total rebates received by a PBM.
[11] Information contained in this analysis has been excerpted in detail from a February 2007 report prepared by the Office of Program Policy Analysis & Government Accountability. (Office of Program Policy Analysis & Government Accountability, *Legislature Could Consider Options to Address Pharmacy Benefit Manager Business Practices*, Report No. 07-08 (Feb. 2007), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0708rpt.pdf (last visited March 17, 2014).
[12] *Id.*
[13] Office of Program Policy Analysis & Government Accountability, *Research memorandum: Pharmacy Benefit Managers* (December 2, 2013) (on file with the Senate Health Policy Committee).
[14] Office of Program Policy Analysis & Government Accountability, *supra* note 11.

What role do PBMs play in the prescription drug industry?

Pharmacy Benefit Managers are sometimes referred to as the middlemen in the prescription drug market because they act as intermediaries between health plan sponsors and drug manufacturers and pharmacies. PBMs negotiate with drug manufacturers and pharmacies on behalf of plan sponsors. These negotiations include provisions for cash rebates that drug manufacturers pay for drugs placed on health plan sponsor formularies (lists of approved drugs for prescribing) and the volume of these drugs that are used by health plan beneficiaries. PBMs also contract with pharmacies on behalf of plan sponsors to establish how pharmacies will be reimbursed for prescriptions they dispense to health plan sponsor beneficiaries.

What concerns exist related to PBM business practices?

In recent years, federal and state litigation as well as various stakeholders in the prescription drug industry have alleged that PBMs sometimes engage in unfair business practices that may not be in health plan sponsors' or their beneficiaries' best interests. These allegations cite unfair business practices that have resulted in excessive profits at the expense of health plan sponsors or pharmacies. The confidential and proprietary nature of PBM contracts and financial arrangements with drug manufacturers and pharmacies creates the opportunity for PBMs to engage in unfair business practices.

Although PBMs save health plan sponsors money by managing prescription drug costs, litigation, as well as stakeholders representing health plan sponsors, allege that PBMs have excessively profited by illegally accepting secret monetary incentives from drug manufacturers that are not shared with health plan sponsors. To manage prescription drug costs, PBMs negotiate rebates with manufacturers for drugs placed on health plan formularies as well as on the volume of drugs used by beneficiaries of the health plan sponsor. PBMs also manage costs by substituting, when clinically appropriate, a beneficiary's prescription for a more cost-effective drug, i.e., a less expensive but therapeutically equivalent brand-name or generic drug.

However, lawsuits assert that some PBMs have illegally accepted secret rebates or payments from manufacturers that are not shared with health plan sponsors, such as incentives for increasing a manufacturer's drug sales. Also, some stakeholders allege that PBMs have illegally increased rebates by changing patient prescriptions to drugs that receive higher rebates. These business practices are not only illegal but can also increase health plan sponsor costs if PBMs switch beneficiaries to higher cost drugs.[15] Drug switching, for non-clinical reasons, also may not be in the best interest of patients as changed prescriptions can potentially cause them harm or result in higher out-of-pocket payments.

Lawsuits and stakeholders also allege that PBMs have excessively profited from the price spread created by the difference between pharmacy reimbursements and health plan sponsor drug prices. Ideally, health plan sponsors should pay drug prices to the PBMs that are comparable to the prices that PBMs reimburse pharmacies. However, some stakeholders allege that PBMs have realized high profits by charging health plan sponsors significantly higher drug prices than prices at which they reimburse pharmacies. For example, in 2002 one PBM made a profit of $200 for each prescription of a generic version of Zantac, a drug for acid reflux, it sold on behalf of a

[15] Federal and state anti-kickback laws classify payments in exchange for favorable treatment as illegal kickbacks.

health plan sponsor. It did this by charging the health plan sponsor $215 per prescription while only reimbursing network pharmacies $15.

Many of these issues arise because historically, PBM contracts with health plan sponsors have not provided sponsors access to information on PBM transactions or negotiations with manufacturers and pharmacies. PBMs consider this information to be confidential and proprietary. However, this lack of transparency increases the potential that PBMs may engage in unfair business practices that can prevent health plan sponsors and pharmacies from receiving a fair share of the profits realized by PBMs in their negotiations with drug manufacturers.

How have states, PBMs, and health plan sponsors addressed these concerns?

As of December 2006, three states and the District of Columbia had passed legislation that addresses these issues by requiring contract transparency.[16] Another 28 states, including Florida, had considered but not passed similar legislation. In addition, two states had passed legislation to regulate PBMs by requiring licensure or oversight by state insurance departments or pharmacy boards. PBMs, health plans sponsors, and other stakeholders have also taken steps to change business practices and increase transparency.

To create more transparency in their business practices, PBMs have begun to offer health plan sponsors contracts that provide more transparency than traditional contracts. These contracts give health plan sponsors access to information about contractual and financial arrangements with drug manufacturers and pharmacies. Some PBMs also will negotiate contracts that establish drug prices for health plan sponsors equal to the price at which PBMs reimburse pharmacies. In addition to these voluntary steps, the provisions of settled lawsuits require defendant PBMs to adhere to specific transparency practices.[17]

Some stakeholders claim that over time voluntary efforts[18] combined with the effect of litigation will reduce the need for regulation. However, because the more transparent contracts generally require PBMs to pass on more rebates to health plan sponsors, potentially reducing profits, PBMs have increased their administrative fees for transparent contracts. In addition, the more transparent contracts require health plan sponsors to accept greater risk because these contracts do not guarantee specific amounts of drug rebates. Health plan sponsors could also experience greater administrative costs because of the increased monitoring needed to ensure transparency.

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[16] At least twenty-one states and the District of Columbia have now enacted laws imposing some form of regulation on pharmacy benefit managers, including: Arkansas, Connecticut, Florida (Medicaid audits), Georgia, Indiana, Iowa, Kansas, Kentucky, Maryland, Mississippi, Missouri, New Mexico, North Carolina, North Dakota, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, and the District of Columbia. (National Community Pharmacy Association, *Laws that Provide Regulation of the Business Practices of Pharmacy Benefit Managers*, *available at* http://www.ncpanet.org/pdf/leg/leg_pbm_business_practice_regulation.pdf (last visited March 17, 2014).

[17] For example, the settlement agreement between 20 state attorneys general against Medco arising from litigation in 2003 prohibits Medco from soliciting drug switches when the net drug cost of the proposed drug exceeds the cost of the prescribed drug. It also requires Medco to disclose financial incentives for switching drugs.

[18] For example, URAC, an independent accrediting organization that promotes health care quality now accredits PBMs. According to its website, URAC's PBM Accreditation standards cover the organization's contract terms and pricing structures; ensure access to drugs and pharmacies; provide for drug utilization management, formulary management, patient safety and customer service; and create a process for PBM outcomes measurement and quality improvement. (URAC, *Pharmacy Benefit Management*, https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/pharmacy-benefit-management/ (last visited March 17, 2014).

As such, some health plan sponsors are reluctant to negotiate more transparent contracts, in part, because they prefer contracts with lower fixed costs and guaranteed rebates.

What options could the Legislature consider to address PBM business practices?

In 2007, the OPPAGA suggested that prior to considering statutory actions, the Legislature may wish to give market forces time to further influence efforts by PBMs, health plan sponsors, and other stakeholders to change PBM business practices and establish more transparent contracts. If the Legislature wishes to enact statutory provisions to regulate PBMs, the OPPAGA suggested it could consider options adopted in other states, which include establishing transparency guidelines or licensing or certifying PBMs.

III. Effect of Proposed Changes:

CS/SB 1014 creates a new section of law titled "Pharmacy benefit managers." The bill defines terms used in the law as follows:

- "Maximum allowable cost" means the upper limit or maximum amount that an insurance or managed care plan will pay for generic, or brand-name drugs that have generic versions available, which are included on a PBM-generated list of products.
- "Plan sponsor" means an employer, insurer, managed care organization, prepaid limited health service organization, third-party administrator, or other entity contracting for pharmacy benefit manager services.
- "Pharmacy benefit manager" means a person, business, or other entity that provides administrative services related to processing and paying prescription claims for pharmacy benefit and coverage programs. Such services may include contracting with a pharmacy or network of pharmacies; establishing payment levels for provider pharmacies; negotiating discounts and rebate arrangements with drug manufacturers; developing and managing prescription formularies, preferred drug lists, and prior authorization programs; assuring audit compliance; and providing management reports.

The bill requires a contract between a PBM and a pharmacy which includes MAC pricing to require the PBM to update pricing information weekly and provide notice of updates, and maintain a procedure for eliminating products from the list or modifying the MAC pricing timely so pricing remains consistent with pricing changes in the marketplace.

In order to put a prescription drug on the MAC list, the PBM must ensure a drug has at least three or more nationally available, therapeutically equivalent, multiple-source generic drugs that:

- Have a significant cost difference;
- Are listed as therapeutically and pharmaceutically equivalent or "A" rated in the United States Food and Drug Administration's most recent version of the Orange Book;
- Are available for purchase without limitations by all pharmacies in the state from national or regional wholesalers; and
- Are not obsolete or temporarily unavailable.

The bill requires a PBM to disclose to the plan sponsor:

- The methodology and sources used to determine MAC pricing between the PBM and the plan sponsor. The plan sponsor must be notified as updates occur.

- Whether the PBM uses a MAC list for drugs dispensed at retail but not for drugs dispensed by mail order.
- Whether the PBM is using the identical MAC lists to bill the plan sponsor that it uses to reimburse network pharmacies and, if not, to disclose the pricing differences.

The bill requires that contracts between PBMs and pharmacies contain:

- A process for appealing, investigating, and resolving disputes regarding MAC pricing, which limits the right to appeal to 90 calendar days following the initial claim; requires the dispute to be resolved within 7 days; and requires the PBM to provide contact information of the person who is responsible for processing the appeal.
- A requirement that if the appeal is denied, the PBM must provide the reason and identify the national drug code of an alternative that may be purchased at a price at or below the MAC.
- A requirement that if the appeal is upheld, the PBM must make an adjustment retroactive to the date the claim was adjudicated and make the adjustment effective for all similarly situated network pharmacies.

The bill has an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The new contracting requirements could be an impairment of contracts if any contracts between a PBM and plan sponsor or a PBM and a pharmacy are multi-year contracts.

The United States Constitution and the Florida Constitution prohibit the state from passing any law impairing the obligation of contracts.[19] The courts will subject state actions that impact state-held contracts to an elevated form of scrutiny when the Legislature passes laws that impact such contracts. *Cf. Chiles v. United Faculty of Fla.,* 615 So.2d 671 (Fla. 1993). "[T]he first inquiry must be whether the state law has, in fact,

[19] U.S. Const. art. I, § 10; art. I, s. 10, Fla. Const.

operated as a substantial impairment of a contractual relationship. The severity of the impairment measures the height of the hurdle the state legislation must clear."[20]

If a law does impair contracts, the courts will assess whether the law is deemed reasonable and necessary to serve an important public purpose.[21] The court will also consider three factors when balancing the impairment of contracts with the important public purpose:

- Whether the law was enacted to deal with a broad economic or social problem;
- Whether the law operates in an area that was already subject to state regulation at the time the contract was entered into; and,
- Whether the effect on the contractual relationship is temporary; not severe, permanent, immediate, and retroactive.[22]

A law that is deemed to be an impairment of contract will be deemed to be invalid as it applies to any contracts entered into prior to the effective date of the Act.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Indeterminate.

C. Government Sector Impact:

Indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 465.1862 of the Florida Statutes.

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[20] *Pomponio v. Claridge of Pompano Condominium, Inc.,* 378 So. 2d 774 (Fla. 1980). *See also General Motors Corp. v. Romein,* 503 U.S. 181 (1992).

[21] *Park Benzinger & Co. v. Southern Wine & Spirits, Inc.,* 391 So. 2d 681 (Fla. 1980); *Yellow Cab C., v. Dade County,* 412 So. 2d 395 (Fla. 3rd DCA 1982). *See also Exxon Corp. v. Eagerton,* 462 U.S. 176 (1983).

[22] *Pomponio v. Cladridge of Pompanio Condo., Inc.,* 378 So. 2d 774 (Fla. 1980).

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Policy on March 19, 2014:

- Deletes the requirement for contracts between PBMs and pharmacies to be executed by January 1 annually.
- Deletes the contract requirement for PBMs to provide pharmacies with the basis and sources used to determine MAC pricing.
- Deletes the requirement for a PBM to contractually commit to providing a specified reimbursement rate for generic drugs.
- Deletes the definitions of "average wholesale price" and "AWP Discount."
- Makes a technical change to the definition of "plan sponsor," by replacing the word "administration" with "administrator."
- Reorganizes, without changing content, language related to conditions under which a PBM can place a drug on a MAC list.
- Clarifies the date for retroactive adjustment of payment when a pharmacy wins an appeal of a claim, as retroactive to the date the claim was adjudicated.

B. Amendments:

None.

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

960356

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 22 - 121

4 and insert:

5 (a) “Maximum allowable cost” (MAC) means the upper limit or

6 maximum amount that an insurance or managed care plan will pay

7 for generic, or brand-name drugs that have generic versions

8 available, which are included on a PBM-generated list of

9 products.

10 (b) “Plan sponsor” means an employer, insurer, managed care

960356

11 organization, prepaid limited health service organization,
12 third-party administrator, or other entity contracting for
13 pharmacy benefit manager services.
14 (c) "Pharmacy benefit manager" (PBM) means a person,
15 business, or other entity that provides administrative services
16 related to processing and paying prescription claims for
17 pharmacy benefit and coverage programs. Such services may
18 include contracting with a pharmacy or network of pharmacies;
19 establishing payment levels for provider pharmacies; negotiating
20 discounts and rebate arrangements with drug manufacturers;
21 developing and managing prescription formularies, preferred drug
22 lists, and prior authorization programs; assuring audit
23 compliance; and providing management reports.
24 (2) A contract between a pharmacy benefit manager and a
25 pharmacy must:
26 (a) Include the basis of the methodology and sources used
27 to determine the MAC pricing administered by the pharmacy
28 benefit manager, update the pricing information on such a list
29 at least every 7 calendar days, and establish a reasonable
30 process for the prompt notification of such pricing updates to
31 network pharmacies; and
32 (b) Maintain a procedure to eliminate products from the
33 list or modify the MAC pricing in a timely fashion in order to
34 remain consistent with pricing changes in the marketplace.
35 (3) In order to place a particular prescription drug on a
36 MAC list, the pharmacy benefit manager must, at a minimum,
37 ensure that the drug has at least three or more nationally
38 available, therapeutically equivalent, multiple-source generic
39 drugs which:

960356

40 (a) Have a significant cost difference;
41 (b) Are listed as therapeutically and pharmaceutically
42 equivalent or “A” rated in the United States Food and Drug
43 Administration’s most recent version of the Orange Book;
44 (c) Are available for purchase without limitations by all
45 pharmacies in the state from national or regional wholesalers;
46 and
47 (d) Are not obsolete or temporarily unavailable.
48 (4) The pharmacy benefit manager must disclose the
49 following to the plan sponsor:
50 (a) The basis of the methodology and sources used to
51 establish applicable MAC pricing in the contract between the
52 pharmacy benefit manager and the plan sponsor. Applicable MAC
53 lists must be updated and provided to the plan sponsor whenever
54 there is a change.
55 (b) Whether the pharmacy benefit manager uses a MAC list
56 for drugs dispensed at retail but does not use a MAC list for
57 drugs dispensed by mail order in the contract between the
58 pharmacy benefit manager and the plan sponsor or within 21
59 business days after implementation of the practice.
60 (c) Whether the pharmacy benefit manager is using the
61 identical MAC list with respect to billing the plan sponsor as
62 it does when reimbursing all network pharmacies. If multiple MAC
63 lists are used, the pharmacy benefit manager must disclose any
64 difference between the amount paid to a pharmacy and the amount
65 charged to the plan sponsor.
66 (5) All contracts between a pharmacy benefit manager and a
67 contracted pharmacy must include:
68 (a) A process for appealing, investigating, and resolving

960356

69 disputes regarding MAC pricing. The process must:
70 1. Limit the right to appeal to 90 calendar days following
71 the initial claim;
72 2. Investigate and resolve the dispute within 7 days; and
73 3. Provide the telephone number at which a network pharmacy
74 may contact the pharmacy benefit manager and speak with an
75 individual who is responsible for processing appeals.
76 (b) If the appeal is denied, the pharmacy benefit manager
77 shall provide the reason for the denial and identify the
78 national drug code of a drug product that may be purchased by a
79 contracted pharmacy at a price at or below the MAC.
80 (c) If an appeal is upheld, the pharmacy benefit manager
81 shall make an adjustment retroactive to the date the claim was
82 adjudicated. The pharmacy benefit manager shall make the
83 adjustment effective for all similarly situated pharmacies in
84 this state which are within the network.
85
86 ================ T I T L E A M E N D M E N T ================
87 And the title is amended as follows:
88 Delete lines 12 - 14
89 and insert:
90 providing an effective date.

128416

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
	.	
	.	
	.	

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

1 **Senate Amendment to Amendment (960356)**

2

3 Delete lines 24 - 29

4 and insert:

5 (2) A contract between a pharmacy benefit manager and a

6 pharmacy that includes MAC pricing must require the pharmacy

7 benefit manager to:

8 (a) Update the MAC pricing information at least every 7

9 calendar days and establish a reasonable

By Senator Garcia

38-00556-14 20141014__

1 A bill to be entitled
2 An act relating to pharmacy benefit managers; creating
3 s. 465.1862, F.S.; defining terms; specifying contract
4 terms that must be included in a contract between a
5 pharmacy benefit manager and a pharmacy; providing
6 restrictions on the inclusion of prescriptions drugs
7 on a list that specifies the maximum allowable cost
8 for such drugs; requiring the pharmacy benefit manager
9 to disclose certain information to a plan sponsor;
10 requiring a contract between a pharmacy benefit
11 manager and a pharmacy to include an appeal process;
12 requiring a pharmacy benefit manager to contractually
13 commit to providing a certain reimbursement rate for
14 generic drugs; providing an effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Section 465.1862, Florida Statutes, is created
19 to read:
20 465.1862 Pharmacy benefit managers.—
21 (1) As used in this section, the term:
22 (a) "Average wholesale price" (AWP) means the published or
23 suggested cost of pharmaceuticals charged to a pharmacy by a
24 large group of pharmaceutical wholesalers.
25 (b) "AWP Discount," also known as the generic effective
26 rate, means the negotiated amount a plan sponsor pays to
27 pharmacies for the ingredient cost of a prescription and
28 commonly expressed as a percentage of AWP.
29 (c) "Maximum allowable cost" (MAC) means the upper limit or

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

38-00556-14 20141014__

30 maximum amount that an insurance or managed care plan will pay
31 for generic, or brand-name drugs that have generic versions
32 available, which are included on a PBM-generated list of
33 products.
34 (e) "Plan sponsor" means an employer, insurer, managed care
35 organization, prepaid limited health service organization,
36 third-party administration, or other entity contracting for
37 pharmacy benefit manager services.
38 (d) "Pharmacy benefit manager" (PBM) means a person,
39 business, or other entity that provides administrative services
40 related to processing and paying prescription claims for
41 pharmacy benefit and coverage programs. Such services may
42 include contracting with a pharmacy or network of pharmacies;
43 establishing payment levels for provider pharmacies; negotiating
44 discounts and rebate arrangements with drug manufacturers;
45 developing and managing prescription formularies, preferred drug
46 lists, and prior authorization programs; assuring audit
47 compliance; and providing management reports.
48 (2) A pharmacy benefit manager contracting with pharmacies
49 in this state shall annually contract with a pharmacy on or
50 before January 1 of the contract year. Such contract must:
51 (a) Include the basis of the methodology and sources used
52 to determine the MAC pricing administered by the pharmacy
53 benefit manager, update the pricing information on such a list
54 at least every 7 calendar days, and establish a reasonable
55 process for the prompt notification of such pricing updates to
56 network pharmacies; and
57 (b) Maintain a procedure to eliminate products from the
58 list or modify the MAC pricing in a timely fashion in order to

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

59 remain consistent with pricing changes in the marketplace.
60 (3) In order to place a particular prescription drug on a
61 MAC list, the pharmacy benefit manager must, at a minimum,
62 ensure that:
63 (a) The drug has at least three or more nationally
64 available, therapeutically equivalent, multiple-source generic
65 drugs that have a significant cost difference;
66 (b) The products are listed as therapeutically and
67 pharmaceutically equivalent or "A" rated in the United States
68 Food and Drug Administration's most recent version of the Orange
69 Book; and
70 (c) The product is available for purchase without
71 limitations by all pharmacies in the state from national or
72 regional wholesalers and may not be obsolete or temporarily
73 unavailable.
74 (4) The pharmacy benefit manager must disclose the
75 following to the plan sponsor:
76 (a) The basis of the methodology and sources used to
77 establish applicable MAC pricing in the contract between the
78 pharmacy benefit manager and the plan sponsor. Applicable MAC
79 lists must be updated and provided to the plan sponsor whenever
80 there is a change.
81 (b) Whether the pharmacy benefit manager uses a MAC list
82 for drugs dispensed at retail but does not use a MAC list for
83 drugs dispensed by mail order in the contract between the
84 pharmacy benefit manager and the plan sponsor or within 21
85 business days after implementation of the practice.
86 (c) Whether the pharmacy benefit manager is using the
87 identical MAC list with respect to billing the plan sponsor as

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

88 it does when reimbursing all network pharmacies. If multiple MAC
89 lists are used, the pharmacy benefit manager must disclose any
90 difference between the amount paid to a pharmacy and the amount
91 charged to the plan sponsor.
92 (5) All contracts between a pharmacy benefit manager and a
93 contracted pharmacy must include:
94 (a) A process for appealing, investigating, and resolving
95 disputes regarding MAC pricing. The process must:
96 1. Limit the right to appeal to 90 calendar days following
97 the initial claim;
98 2. Investigate and resolve the dispute within 7 days; and
99 3. Provide the telephone number at which a network pharmacy
100 may contact the pharmacy benefit manager and speak with an
101 individual who is responsible for processing appeals.
102 (b) If the appeal is denied, the pharmacy benefit manager
103 shall provide the reason for the denial and identify the
104 national drug code of a drug product that may be purchased by a
105 contracted pharmacy at a price at or below the MAC.
106 (c) If an appeal is upheld, the pharmacy benefit manager
107 shall make an adjustment retroactive to the date of
108 adjudication. The pharmacy benefit manager shall make the
109 adjustment effective for all similarly situated pharmacies in
110 this state which are within the network.
111 (6) A pharmacy benefit manager shall contractually commit
112 to providing a particular aggregate average reimbursement rate
113 for generics or a maximum average AWP discount on multi-source
114 generics as a whole. For the purposes of the AWP discount
115 amount, a pharmacy benefit manager must use an AWP published by
116 a nationally available compendia. The aggregate average rate for

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

38-00556-14 20141014__

117 reimbursement shall be calculated using the actual amount paid
118 to the pharmacy, excluding the dispensing fee. The reimbursement
119 rate may not be calculated solely according to the amount
120 allowed by the plan and must include all generics dispensed,
121 regardless of whether they are subject to MAC pricing.
122 Section 2. This act shall take effect July 1, 2014.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Communications, Energy, and Public Utilities, Vice Chair
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Health and Human Services
Transportation
Health Policy
Agriculture
Transportation

JOINT COMMITTEE:
Joint Committee on Administrative Procedures, Chair

SENATOR RENE GARCIA
38th District

February 21, 2014

The Honorable Aaron Bean
Chair, Health Policy Committee
302 Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Bean:

This letter should serve as a request to have my bill *SB 1014 Pharmacy Benefit Managers* heard at the next possible committee meeting. If there is any other information needed please do not hesitate to contact me. Thank you.

Sincerely,

State Senator René García
District 38
RG:dm

CC: Sandra Stovall, Staff Director

REPLY TO:
☐ 1490 West 68 St., Suite 201 Hialeah, FL 33014 (305) 364-3100
☐ 310 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5038

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

ENTERED

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-19
Meeting Date

Topic: Pharmacy PBM Price

Bill Number: SB 1014 *(if applicable)*

Name: Bill Napier

Amendment Barcode: ______ *(if applicable)*

Job Title: Pharmacist

Address: 4369 St. Albans Dr.
Street

Jacksonville, FL 32257
City, State, Zip

Phone: 904-571-5730

E-mail: PanamaRx@AOL.Com

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

Representing: Panama Pharmacy

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

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

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

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

S-001 (10/20/11)

✓

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19
Meeting Date

Topic: MAC Legislation

Bill Number: SB 1014 (if applicable)

Name: Allen Horne

Amendment Barcode: ______ (if applicable)

Job Title: V.P. Gov't Affairs CVS Caremark

Address: 12004 Uplands Ridge
Street

Austin TX 78738
City State Zip

Phone: 512-351-8488

E-mail: allen.horne@cvscaremark.com

Speaking: ☐ For ☑ Against ☐ Information

Representing: CVS Caremark

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-19-2014
Meeting Date

Topic: Pharmacy Benefit Managers

Bill Number: SB1014 *(if applicable)*

Name: Joy Ryan

Amendment Barcode: *(if applicable)*

Job Title: Meenan PA

Address: 310 W College St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone: 425-4000

E-mail: joy@meenanlawfirm.com

Speaking: ☐ For ☒ Against ☐ Information

Representing: Prime Therapeutics

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

____
Meeting Date

Topic: Hospital Pricing

Bill Number: 1014 *(if applicable)*

Name: J. Roger Accardi / PharmD

Amendment Barcode: ______ *(if applicable)*

Job Title: Pharmacy Owner

Address: 449 Hightower Rd
Street

DeBary FL 32713
City *State* *Zip*

Phone: 386 801 4011

E-mail: ACCARDICLINICAL@EARTHLINK.NET

Speaking: [x] For [ ] Against [ ] Information

Representing: Self

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

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19
Meeting Date

Topic: Generic Pricing

Bill Number: 1074 (if applicable)

Name: DAN FUCARINO

Amendment Barcode: (if applicable)

Job Title: pharmacist/owner

Address: 3019 Peacock Lane
Street

Tampa, FL 33618
City, State, Zip

Phone: 813 391 3009

E-mail: dan@carrollwoodpharmacy.com

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

Representing: Self

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

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/19/14
Meeting Date

Topic: Generic DRUG PRICING

Bill Number: SB 1014 *(if applicable)*

Name: JIM POWERS

Amendment Barcode: ______ *(if applicable)*

Job Title: PHARMACIST

Address: 1349 OLD VILLAGE ROAD
Street

Phone: 850-422-0079

TALLAHASSEE FL. 32312
City *State* *Zip*

E-mail: THEPOWERS@NETTALLY.COM

Speaking: [x] For [ ] Against [ ] Information

Representing: FLORIDA INDEPENDENT PHARMACY NETWORK

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

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

4/19/14
Meeting Date

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

Topic: Generic Drug Pricing

Bill Number: SB 1014 (if applicable)

Name: Bill Miniy

Amendment Barcode: ______ (if applicable)

Job Title: VP

Address: 2648 Bantry Bay Drive
Street

Tallahassee, FL 32309
City, State, Zip

Phone: ______

E-mail: ______

Speaking: [✓] For [ ] Against [ ] Information

Representing: PPSC independent pharmacy owners

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

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/2014
Meeting Date

Topic: PHARMACY BENEFIT MANAGERS

Bill Number: 1014 *(if applicable)*

Name: MICHAEL JACKSON

Amendment Barcode: *(if applicable)*

Job Title: EXECUTIVE VICE PRESIDENT & CEO

Address: 610 N. ADAMS STREET
Street

TALLAHASSEE, FL 32301
City, State, Zip

Phone: 850 222-2400

E-mail: MJACKSON@PHARMVIEW.COM

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

Representing: FLORIDA PHARMACY ASSOCIATION

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

3/19/2014
Meeting Date

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

Topic Pharmacy Benefit Managers

Bill Number 1014 (if applicable)

Name Sally West

Amendment Barcode ______ (if applicable)

Job Title Director, Government Affairs

Address ______
Street

______
City State Zip

Phone 224-723-2650

E-mail sally.west@walgreens.com

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

Representing Walgreens

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

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/2014
Meeting Date

Topic MAC Pricing

Bill Number 1014 (if applicable)

Name Jorge Chamizo

Amendment Barcode ________ (if applicable)

Job Title Attorney

Address 108 South Monroe Street
Street

Tallahassee, FL 32301
City State Zip

Phone (850)681-0024

E-mail jorge@flapartners.com

Speaking: [✓] For [ ] Against [ ] Information

Representing Independent Pharmacy Cooperative

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic Pharmacy Benefit Managers

Bill Number SB 1014 (if applicable)

Name Larry Gonzalez

Amendment Barcode (if applicable)

Job Title General Counsel, FSHP*

Address 223 S. Gadsden St
Street

Tallahassee FL 32301
City State Zip

Phone 222-0465

E-mail lawgonz@earthlink.net

Speaking: [x] For [ ] Against [ ] Information

Representing * Florida Society of Health-System Pharmacists

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

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

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

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

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 944

INTRODUCER: Health Policy Committee and Senator Sobel

SUBJECT: Mental Health Treatment

DATE: March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			CJ	
3.			JU	
4.			CA	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 944 amends certain statutes that govern mental health issues for criminal defendants and juveniles charged with delinquent acts.

The bill:

- Permits the continuation of treatment with psychotropic drugs, under limited circumstances, by the Department of Children and Families (DCF) for defendants and forensic clients that have received such treatment in jail prior to relocation to a DCF facility;
- Provides the court with discretion to reduce the period of time under which certain charges against a defendant adjudicated incompetent due to mental illness will be dismissed, under specified conditions and exceptions, from 5 years to between 3 and 5 years; and,
- Provides additional parameters for how incompetency is determined in juvenile cases.

The bill has no fiscal impact on the DCF and may reduce the workload on the state courts system by an indeterminate amount.

II. Present Situation:

The Due Process Clause of the 14th Amendment prohibits the states from trying and convicting defendants who are incompetent to stand trial.[1] The states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[2] Defendants (including juveniles charged with having committed felony-level delinquent acts) must be able to appreciate the range and nature of the charges and penalties that may be imposed, and must be able to understand the adversarial nature of the legal process and disclose to counsel facts pertinent to the proceedings. Defendants also must manifest appropriate courtroom behavior and be able to testify relevantly.[3]

If a defendant is suspected of being incompetent, the court or counsel for the defendant or the state may file a motion for examination to have the defendant's cognitive state assessed. If the motion is well-founded the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing. If the defendant is found to be competent, the criminal proceeding resumes. If the defendant is found to be incompetent to proceed, the proceeding may not resume unless competency is restored.[4]

Restoration of Competency

Competency restoration is designed to help defendants meaningfully participate in their own defense. In Florida, the DCF has oversight of felony defendants who are found incompetent to proceed due to mental illness, while the Agency for Persons with Disabilities (APD) is charged with oversight of felony defendants who are incompetent to proceed due to developmental disabilities.[5] Competency restoration training and mental health services are provided in four state forensic facilities that have forensic step-down beds, The four secure facilities have a capacity of 1,108 beds and the civil facilities have 435 designated, forensic, non-secure step-down beds.[6] Of the four forensic facilities, two are publicly-operated and two are privately contracted.[7] During fiscal year 2012-2013, 1,537 adult forensic individuals were committed to the care of the DCF. Of those, 1,473 were adjudicated incompetent to proceed and needed competency restoration services.[8]

The DCF is directed by statute to provide competency training for juveniles who have been found incompetent to proceed to trial as a result of mental illness, mental retardation or autism.[9] The DCF has outsourced competency restoration training by contract in both the community and

---

[1] See *Pate v. Robinson,* 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); *Bishop v. U.S.*, 350 U.S.961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); *Jones v. State*, 740 So.2d 520 (Fla. 1999).
[2] *Id.* See also Rule 3.210(a)(1), Fla.R.Crim.P., Rule 8.095(d)(1), Fla.R.Juv.P.
[3] *Id.* See also s. 916.12, 916.3012, and 985.19, F.S.
[4] Rule 3.210(b), 3.211, 3.212, Fla.R.Crim.P.; Rule 8.095(a)(1)-(6), Fla.R.Juv.P.
[5] Ch. 916, F.S.
[6] E-Mail Correspondence with Department of Children and Families (Mar. 14, 2014), on file with Senate Health Policy Committee.
[7] *Id.*
[8] *Id.*
[9] s. 985.19(4), F.S.

secure residential settings. The DCF served 407 incompetent-to-proceed children in fiscal year 2012-2013.[10]

If a court determines that the defendant is a danger to himself or others, the court may commit the defendant to a secure forensic facility.[11] Defendants may be placed on conditional release to receive competency restoration training in the community if the court finds they do not pose a risk to public safety.[12]

Once a defendant is determined to have regained his or her competence to proceed, the court is notified and a hearing is set for the judge to determine the defendant's competency.[13] If the court finds the defendant to be competent, the criminal proceeding resumes. If, however, the court finds the defendant incompetent to proceed, the defendant is returned to a forensic facility or community restoration on conditional release until competency is restored.[14]

Qualifications of Competency Experts

Section 916.115 (1)(a), F.S., provides that experts appointed by the court to conduct competency evaluations shall, to the extent possible, have completed forensic evaluator training approved by the DCF and each shall be a psychiatrist, licensed psychologist, or physician. The DCF is required by s. 916.115 (1)(b), F.S., to maintain and annually provide the courts with a list of available mental health professionals who have completed the approved training as experts.

In the juvenile system, the court appoints mental health experts to conduct competency evaluations although there does not appear to be a specific requirement in the juvenile competency statute that the expert be a psychiatrist, licensed psychologist, or physician as is the case in the adult system.[15] As in the adult system, the DCF provides the court a list of experts who have completed a DCF-approved program.

The APD conducts evaluations and makes reports to the court regarding juveniles who meet the definition of "retardation" or "autism."[16] Although there is a requirement in s. 916.301(2)(b)1., F.S., that the expert appointed to examine adult defendants who are intellectually disabled or autistic be a psychologist, the juvenile statute does not make such a specification.

Hearing to Determine Restoration of Competency or Need for Continued Commitment

When the court adjudicates a defendant incompetent to proceed and the defendant is committed to the DCF to be restored to competency, or if the defendant has been found not guilty by reason

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[10] Department of Children and Families, *2014 Agency Legislative Bill Analysis - SB 944* (Feb. 13, 2014), 2, on file with the Senate Health Policy Committee.
[11] s. 916.13, F.S.
[12] s. 916.17, F.S.
[13] Rule 3.212, Fla.R.Crim.P.
[14] *Id.*
[15] s. 985.19(1)(b), F.S.
[16] s. 985.19(1)(e), F.S.

of insanity and committed to the DCF, the defendant is returned to court periodically for a review and report on his or her condition.[17] Generally, a review is conducted:

- No later than 6 months after the date of admission;
- At the end of any extended period of commitment;
- At any time the facility administrator's communication to the court that the defendant no longer meets commitment criteria; or
- Upon counsel's motion for review having been granted.

Rules of Criminal and Juvenile Procedure require that a hearing be held within 30 days of the court's receiving the administrator's pre-hearing report.[18] There is no corresponding statutory time constraint on the court conducting a hearing.

The court also retains jurisdiction for purposes of dismissing charges if a defendant has not become competent within 5 years.[19] However, the charges will not be dropped if the court specifies in its order reasons for believing that the defendant will become competent to proceed in the foreseeable future and specifies a timeframe in which the defendant is expected to become competent to proceed.[20] The DCF data shows that for the past 15 years (fiscal year 1998-1999 through fiscal year 2012-2013, encompassing 15,610 individuals), 99.6 percent of the individuals restored to competency were restored in 3 years or less.[21]

Psychotropic Medication

The DCF is responsible for providing treatment deemed necessary to fulfill its obligation under the statutes governing competency restoration and mental illness. Forensic clients of the DCF, which includes defendants who have been committed to the DCF for competency restoration or because they have been found not guilty by reason of insanity, must be treated with dignity and respect.

When treatment is needed, forensic clients are asked to give express and informed consent.[22] When treatment is refused, treatment may nonetheless be provided in an emergency situation for periods of up to 48 hours (excluding weekends and holidays, subject to review in 48-hour increments by a physician until a court rules) unless or until the DCF obtains a court order authorizing continued treatment.[23]

III. Effect of Proposed Changes:

Section 1 amends s. 916.107, F.S., concerning administration of psychotherapeutic medications to forensic clients. If a client has been receiving psychotherapeutic medications in jail at the time of transfer to the forensic or civil facility and lacks informed decision-making capacity with

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[17] ss. 916.13(2), 916.15(3) and 916.302(2)(a), F.S. See also s. 985.19(4)(e), (5) and (6), F.S., related to the court's jurisdiction and reporting requirements in juvenile cases.

[18] Rules 3.212 and 3.218, Fla.R.Crim.P.; Rule 8.095(a)(5), Fla.R.Juv.P. See also Rule 8.095(e), Fla.R.Juv.P.

[19] ss. 916.145 and 916.303, F.S. Regarding dismissal of charges of juvenile delinquency, see s. 985.19(5)(c), F.S.

[20] s. 916.145, F.S.

[21] Department of Children and Families, *2014 Agency Legislative Bill Analysis - SB 944* (Feb. 13, 2014), on file with the Senate Health Policy Committee.

[22] s. 916.107(3), F.S.

[23] *Id.*

respect to mental health treatment, the admitting physician at the facility may order continued administration of these medications if the physician judges that abrupt cessation could jeopardize the health or safety of the client during the period before acquisition of a court order for medication administration.

To continue the psychotherapeutic medication, the facility administrator or his or her designee must petition the committing court or the local circuit court for an authorization order. This petition must be made within 5 business days after admission of the client. The jail physician must also have a current therapeutic medication order for the client at the admitting physician's request or at the time of transfer to the facility. The bill does not provide a timeframe for when a hearing on the petition must be held.

The bill also makes some technical changes to s. 916.107(3)(a), F.S.

Section 2 amends s. 916.13, F.S., to require the court to hold a competency hearing within 30 days after receiving notification that any facility client adjudicated mentally incompetent no longer meets the criteria for continued commitment.

Section 3 substantially rewords s. 916.145, F.S., to state that charges against any defendant adjudicated mentally incompetent may be dismissed if he or she remains incompetent between 3 and 5 years after such determination, rather than to require dismissal after 5 years which is current law, unless the court believes that he or she will become competent in the future.

If the defendant was committed in relation to an allegation of certain crimes, the period before charge dismissal is 5 years. Such crimes or situations that would exclude the defendant from the reduced time period include:

- Arson;
- Sexual battery;
- Robbery;
- Kidnapping;
- Aggravated child abuse;
- Aggravated abuse of an elderly person or disabled adult;
- Aggravated assault with a deadly weapon;
- Murder;
- Manslaughter;
- Aggravated manslaughter of an elderly person or disabled adult;
- Aggravated manslaughter of a child;
- Unlawful throwing, placing, or discharging of a destructive device or bomb;
- Armed burglary;
- Aggravated battery;
- Aggravated stalking;
- Any forcible felony as defined in s. 766.08, F.S., not listed above;
- Any offense involving the possession, use, or discharge of a firearm;
- An attempt to commit any of the offenses listed above;

- The charge was committed by a defendant who has had a forcible or violent felony conviction within the 5 years preceding the date of arrest for the non-violent felony sought to be dismissed;
- The charge was committed by a defendant who, after having been found incompetent and under court supervision in a community based program, is formally charged by a state attorney with a new felony offense; or,
- Where there is an identifiable victim and such victim has not consented.

The state is not prohibited from refiling dismissed charges if the defendant is declared to be competent to proceed in the future.

Section 4 amends s. 916.15, F.S., to require the court to hold a competency hearing within 30 days after receiving notification that any facility client adjudicated not guilty by reason of insanity no longer meets the criteria for continued commitment.

Section 5 amends s. 985.19, F.S., to provide additional details for how incompetency is determined in juvenile delinquency cases. A child is considered competent to proceed if he or she has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and has a rational and factual understanding of the proceedings.[24]

A child's competency evaluation report must specifically state the basis for the determination of his or her mental condition and must also include written findings that:
- Identify the specific matters referred for evaluation;
- Identify the sources of information used by the expert;
- Describe the procedures, techniques, and diagnostic tests used in the examination to determine the basis of the child's mental condition;
- Assess the child's capacity to:
  - Appreciate the charges or allegations against him or her;
  - Appreciate the range and nature of possible penalties that may be imposed in proceedings against him or her, if applicable;
  - Understand the adversarial nature of the legal process;
  - Disclose to counsel facts pertinent to the proceedings at issue;
  - Display appropriate courtroom behavior; and,
  - Testify relevantly.

The evaluation report must also include a summary of findings which presents the factual basis for the expert's clinical findings and opinions of the child's mental condition; this factual basis must be supported by the diagnostic criteria found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The summary of findings must include:
- The day, month, year, and length of time of the face-to-face diagnostic clinical interview to determine the child's mental condition;
- A statement that identifies the DSM clinical name and associated diagnostic code for the specific mental disorder that forms the basis of the child's incompetency;

[24] This definition is very similar to how competency and incompetency are described in s. 916.12(1), F.S., governing adults.

- A statement of how the child would benefit from competency restoration services in the community or in a secure residential treatment facility;
- An assessment of the probable duration of the treatment to restore competence and the probability that the child will attain competence to proceed in the foreseeable future; and,
- A description of recommended treatment or education appropriate for the mental disorder.

If the evaluator finds the child to be incompetent to proceed to trial, he or she must report on the mental disorder that forms the basis of the incompetency.

The bill also changes the term "incompetency evaluations" to "competency evaluations" in this section.

Concerning competency evaluations related to mental retardation or autism, the bill requires the evaluator to provide a clinical opinion as to whether the child is competent to proceed with delinquency hearings.

Section 6 provides an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Adults and children with mental illness will be evaluated and treated differently in the justice system. Some adults with mental illness may be released from facilities earlier.

C. Government Sector Impact:

The Office of the State Courts Administrator reports that the bill is likely to reduce the workload of the judiciary and the state court system, as the criminal courts have to monitor and hold status hearings for these defendants until their charges are dismissed or

competency is restored.[25] The majority of these defendants are non-violent and on conditional release in community placements. Reducing the period to between 3 and 5 years would eliminate up to 2 years of monitoring and status hearings by the criminal courts.

Requiring the courts to hold competency and commitment hearings within 30 days after the court receives the notice that the defendant is competent to proceed or no longer meets the criteria for continued commitment will have no impact as this is the current standard under the Florida Rules of Criminal Procedure.[26]

The DCF reports no fiscal impact.

VI. Technical Deficiencies:

None.

VII. Related Issues:

During the 2013 Session, CS/SB 1420 passed the Legislature using similar language as CS/SB 944. The Governor vetoed the bill stating:

> While the bill maintains the current 5-year requirement for defendants charged with most violent crimes, it does not maintain this requirement for attempted violent crimes or other serious crimes. The additional time provides an opportunity for the defendant to regain competency under state supervision in order to stand trial. Dismissal of criminal charges for individuals deemed incompetent after only 3 years who have been charged with attempting to commit violent crimes, could pose a serious public safety risk.[27]

CS/SB 944 provides the court with discretion on the dismissal of charges rather than require dismissal, expands the types of crimes excluded from consideration, and adds situations for which the 5-year period would continue to apply.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 916.107, 916.13, 916.145, 916.15, and 985.19.

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[25] Office of the State Courts Administrator, *2014 Judicial Impact Statement - SB 944* (Mar. 3, 2014), on file with the Senate Health Policy Committee.

[26] *Id.*

[27] Governor Rick Scott, *Veto Message -CS/SB 1420* (June 12, 2013), http://www.flgov.com/wp-content/uploads/2013/06/Veto-Letter-SB-1420.pdf (last visited: Mar. 14, 2014).

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Policy on March 19, 2014:
The CS removes the mandatory dismissal of charges in certain situations after 3 years and provides the court discretion to dismiss limited charges against a defendant adjudicated incompetent to proceed due to mental illness without prejudice if the defendant remains incompetent 3 to 5 years after such determination.

The CS also expands the list of specific charges and situations for which the reduced time period for dismissal of charges against a defendant adjudicated incompetent to proceed due to mental illness would not be an option. The expanded circumstances where the reduced time would not be applicable include:

- Commission of any of the additional non-violent felonies;
- An attempt to commit any of the listed crimes;
- If the defendant had been previously charged with a forcible felony in the preceding 5 years,
- If the defendant is formally charged with a new felony while under court supervision in a community based program; or
- If an identifiable victim does not consent to such dismissal.

B. Amendments:

None.

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

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/19/2014	.	
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	.	

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

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Paragraph (a) of subsection (3) of section
6 916.107, Florida Statutes, is amended to read:
7 916.107 Rights of forensic clients.—
8 (3) RIGHT TO EXPRESS AND INFORMED CONSENT.—
9 (a) A forensic client shall be asked to give express and
10 informed written consent for treatment. If a client refuses such

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11 treatment as is deemed necessary and essential by the client’s
12 multidisciplinary treatment team for the appropriate care of the
13 client, such treatment may be provided under the following
14 circumstances:
15 1. In an emergency situation in which there is immediate
16 danger to the safety of the client or others, such treatment may
17 be provided upon the written order of a physician for a period
18 not to exceed 48 hours, excluding weekends and legal holidays.
19 If, after the 48-hour period, the client has not given express
20 and informed consent to the treatment initially refused, the
21 administrator or designee of the civil or forensic facility
22 shall, within 48 hours, excluding weekends and legal holidays,
23 petition the committing court or the circuit court serving the
24 county in which the facility is located, at the option of the
25 facility administrator or designee, for an order authorizing the
26 continued treatment of the client. In the interim, the need for
27 treatment shall be reviewed every 48 hours and may be continued
28 without the consent of the client upon the continued written
29 order of a physician who has determined that the emergency
30 situation continues to present a danger to the safety of the
31 client or others.
32 2. In a situation other than an emergency situation, the
33 administrator or designee of the facility shall petition the
34 court for an order authorizing necessary and essential treatment
35 for the client.
36 a. If the client has been receiving psychotherapeutic
37 medications at the jail at the time of transfer to the forensic
38 or civil facility and lacks the capacity to make an informed
39 decision regarding mental health treatment at the time of

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40 admission, the admitting physician may order continued
41 administration of psychotherapeutic medications if, in the
42 clinical judgment of the physician, abrupt cessation of
43 psychotherapeutic medications could pose a risk to the health or
44 safety of the client during the time a court order to medicate
45 is pursued. The administrator or designee of the civil or
46 forensic facility shall, within 5 days after admission,
47 excluding weekends and legal holidays, petition the committing
48 court or the circuit court serving the county in which the
49 facility is located, at the option of the facility administrator
50 or designee, for an order authorizing the continued treatment of
51 a client. The jail physician shall provide a current
52 psychotherapeutic medication order at the time of transfer to
53 the forensic or civil facility or upon request of the admitting
54 physician after the client is evaluated.
55 b. The court order shall allow such treatment for up to ~~a~~
56 ~~period not to exceed~~ 90 days after ~~following~~ the date of the
57 entry of the order. Unless the court is notified in writing that
58 the client has provided express and informed consent in writing
59 or that the client has been discharged by the committing court,
60 the administrator or designee shall, before ~~the~~ expiration of
61 the initial 90-day order, petition the court for an order
62 authorizing the continuation of treatment for another 90 days
63 ~~90-day period~~. This procedure shall be repeated until the client
64 provides consent or is discharged by the committing court.
65 3. At the hearing on the issue of whether the court should
66 enter an order authorizing treatment for which a client was
67 unable to or refused to give express and informed consent, the
68 court shall determine by clear and convincing evidence that the

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69 client has mental illness, intellectual disability, or autism,
70 that the treatment not consented to is essential to the care of
71 the client, and that the treatment not consented to is not
72 experimental and does not present an unreasonable risk of
73 serious, hazardous, or irreversible side effects. In arriving at
74 the substitute judgment decision, the court must consider at
75 least the following factors:
76 a. The client's expressed preference regarding treatment;
77 b. The probability of adverse side effects;
78 c. The prognosis without treatment; and
79 d. The prognosis with treatment.
80
81 The hearing shall be as convenient to the client as may be
82 consistent with orderly procedure and shall be conducted in
83 physical settings not likely to be injurious to the client's
84 condition. The court may appoint a general or special magistrate
85 to preside at the hearing. The client or the client's guardian,
86 and the representative, shall be provided with a copy of the
87 petition and the date, time, and location of the hearing. The
88 client has the right to have an attorney represent him or her at
89 the hearing, and, if the client is indigent, the court shall
90 appoint the office of the public defender to represent the
91 client at the hearing. The client may testify or not, as he or
92 she chooses, and has the right to cross-examine witnesses and
93 may present his or her own witnesses.
94 Section 2. Subsection (2) of section 916.13, Florida
95 Statutes, is amended to read:
96 916.13 Involuntary commitment of defendant adjudicated
97 incompetent.—

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98 (2) A defendant who has been charged with a felony and who
99 has been adjudicated incompetent to proceed due to mental
100 illness, and who meets the criteria for involuntary commitment
101 ~~to the department~~ under ~~the provisions of~~ this chapter, may be
102 committed to the department, and the department shall retain and
103 treat the defendant.
104 (a) Within ~~No later than~~ 6 months after the date of
105 admission and at the end of any period of extended commitment,
106 or at any time the administrator or designee has ~~shall have~~
107 determined that the defendant has regained competency to proceed
108 or no longer meets the criteria for continued commitment, the
109 administrator or designee shall file a report with the court
110 pursuant to the applicable Florida Rules of Criminal Procedure.
111 (b) A competency hearing must be held within 30 days after
112 the court receives notification that the defendant is competent
113 to proceed or no longer meets the criteria for continued
114 commitment.
115 Section 3. Section 916.145, Florida Statutes, is amended to
116 read:
117 (Substantial rewording of section. See
118 s. 916.145, F.S., for present text.)
119 916.145 Dismissal of charges.—
120 (1) The charges against a defendant adjudicated incompetent
121 to proceed due to mental illness shall be dismissed without
122 prejudice to the state if the defendant remains incompetent to
123 proceed 5 years after such determination, unless the court in
124 its order specifies its reasons for believing that the defendant
125 will become competent to proceed within the foreseeable future
126 and specifies the time within which the defendant is expected to

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127 become competent to proceed. The court may dismiss these charges
128 between 3 and 5 years after such determination, unless the
129 charge is:
130 (a) Arson;
131 (b) Sexual battery;
132 (c) Robbery;
133 (d) Kidnapping;
134 (e) Aggravated child abuse;
135 (f) Aggravated abuse of an elderly person or disabled
136 adult;
137 (g) Aggravated assault with a deadly weapon;
138 (h) Murder;
139 (i) Manslaughter;
140 (j) Aggravated manslaughter of an elderly person or
141 disabled adult;
142 (k) Aggravated manslaughter of a child;
143 (l) Unlawful throwing, projecting, placing, or discharging
144 of a destructive device or bomb;
145 (m) Armed burglary;
146 (n) Aggravated battery; or
147 (o) Aggravated stalking;
148 (p) Any forcible felony as defined in s. 776.08, not listed
149 in paragraphs (a)-(o);
150 (q) Any offense involving the possession, use, or discharge
151 of a firearm;
152 (r) An attempt to commit any of the offenses listed in
153 paragraphs (a)-(q);
154 (s) Committed by a defendant who has had a forcible or
155 violent felony conviction within the 5 years preceding the date

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156 of arrest for the nonviolent felony sought to be dismissed;
157 (t) Committed by a defendant who, after having been found
158 incompetent and under court supervision in a community based
159 program, is formally charged by a state attorney with a new
160 felony offense; or
161 (u) Where there is an identifiable victim and such victim
162 has not consented.
163 (2) This section does not prohibit the state from refiling
164 dismissed charges if the defendant is declared to be competent
165 to proceed in the future.
166 Section 4. Subsection (5) is added to section 916.15,
167 Florida Statutes, to read:
168 916.15 Involuntary commitment of defendant adjudicated not
169 guilty by reason of insanity.—
170 (5) The commitment hearing must be held within 30 days
171 after the court receives notification that the defendant no
172 longer meets the criteria for continued commitment.
173 Section 5. Subsection (1) of section 985.19, Florida
174 Statutes, is amended to read:
175 985.19 Incompetency in juvenile delinquency cases.—
176 (1) If, at any time prior to or during a delinquency case,
177 the court has reason to believe that the child named in the
178 petition may be incompetent to proceed with the hearing, the
179 court on its own motion may, or on the motion of the child's
180 attorney or state attorney must, stay all proceedings and order
181 an evaluation of the child's mental condition.
182 (a) Any motion questioning the child's competency to
183 proceed must be served upon the child's attorney, the state
184 attorney, the attorneys representing the Department of Juvenile

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185 Justice, and the attorneys representing the Department of
186 Children and Families ~~Family Services~~. Thereafter, any motion,
187 notice of hearing, order, or other legal pleading relating to
188 the child's competency to proceed with the hearing must be
189 served upon the child's attorney, the state attorney, the
190 attorneys representing the Department of Juvenile Justice, and
191 the attorneys representing the Department of Children and
192 Families ~~Family Services~~.
193 (b) All determinations of competency must ~~shall~~ be made at
194 a hearing, with findings of fact based on an evaluation of the
195 child's mental condition made by at least ~~not less than~~ two but
196 not ~~nor~~ more than three experts appointed by the court. ~~The~~
197 ~~basis for the determination of incompetency must be specifically~~
198 ~~stated in the evaluation. In addition, a recommendation as to~~
199 ~~whether residential or nonresidential treatment or training is~~
200 ~~required must be included in the evaluation.~~ Experts appointed
201 by the court to determine the mental condition of a child shall
202 be allowed reasonable fees for services rendered. State
203 employees may be paid expenses pursuant to s. 112.061. The fees
204 shall be taxed as costs in the case.
205 (c) A child is competent to proceed if the child has
206 sufficient present ability to consult with counsel with a
207 reasonable degree of rational understanding and the child has a
208 rational and factual understanding of the present proceedings.
209 The expert's competency evaluation report must specifically
210 state the basis for the determination of the child's mental
211 condition and must include written findings that:
212 1. Identify the specific matters referred for evaluation.
213 2. Identify the sources of information used by the expert.

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214 3. Describe the procedures, techniques, and diagnostic
215 tests used in the examination to determine the basis of the
216 child's mental condition.
217 4. Address the child's capacity to:
218 a. Appreciate the charges or allegations against the child.
219 b. Appreciate the range and nature of possible penalties
220 that may be imposed in the proceedings against the child, if
221 applicable.
222 c. Understand the adversarial nature of the legal process.
223 d. Disclose to counsel facts pertinent to the proceedings
224 at issue.
225 e. Display appropriate courtroom behavior.
226 f. Testify relevantly.
227 5. Present the factual basis for the expert's clinical
228 findings and opinions of the child's mental condition. The
229 expert's factual basis of his or her clinical findings and
230 opinions must be supported by the diagnostic criteria found in
231 the most recent edition of the Diagnostic and Statistical Manual
232 of Mental Disorders (DSM) published by the American Psychiatric
233 Association and must be presented in a separate section of the
234 report entitled "summary of findings." This section must
235 include:
236 a. The day, month, year, and length of time of the face-to-
237 face diagnostic clinical interview to determine the child's
238 mental condition.
239 b. A statement that identifies the DSM clinical name and
240 associated diagnostic code for the specific mental disorder that
241 forms the basis of the child's incompetency.
242 c. A statement of how the child would benefit from

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243 competency restoration services in the community or in a secure
244 residential treatment facility.
245 d. An assessment of the probable duration of the treatment
246 to restore competence and the probability that the child will
247 attain competence to proceed in the foreseeable future.
248 e. A description of recommended treatment or education
249 appropriate for the mental disorder.
250 6. If the evaluator determines the child to be incompetent
251 to proceed to trial, the evaluator must report on the mental
252 disorder that forms the basis of the incompetency.
253 (d)(c) All court orders determining incompetency must
254 include specific written findings by the court as to the nature
255 of the incompetency and whether the child requires secure or
256 nonsecure treatment or training environment environments.
257 (e)(d) For competency incompetency evaluations related to
258 mental illness, the Department of Children and Families Family
259 Services shall maintain and annually provide the courts with a
260 list of available mental health professionals who have completed
261 a training program approved by the Department of Children and
262 Families Family Services to perform the evaluations.
263 (f)(e) For competency incompetency evaluations related to
264 intellectual disability or autism, the court shall order the
265 Agency for Persons with Disabilities to examine the child to
266 determine if the child meets the definition of "intellectual
267 disability" or "autism" in s. 393.063 and, provide a clinical
268 opinion as to if so, whether the child is competent to proceed
269 with delinquency proceedings.
270 (f) A child is competent to proceed if the child has
271 sufficient present ability to consult with counsel with a

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272 ~~reasonable degree of rational understanding and the child has a~~
273 ~~rational and factual understanding of the present proceedings.~~
274 ~~The report must address the child’s capacity to:~~
275 ~~1. Appreciate the charges or allegations against the child.~~
276 ~~2. Appreciate the range and nature of possible penalties~~
277 ~~that may be imposed in the proceedings against the child, if~~
278 ~~applicable.~~
279 ~~3. Understand the adversarial nature of the legal process.~~
280 ~~4. Disclose to counsel facts pertinent to the proceedings~~
281 ~~at issue.~~
282 ~~5. Display appropriate courtroom behavior.~~
283 ~~6. Testify relevantly.~~
284 (g) Immediately upon the filing of the court order finding
285 a child incompetent to proceed, the clerk of the court shall
286 notify the Department of Children and Families ~~Family Services~~
287 and the Agency for Persons with Disabilities and fax or hand
288 deliver to the department and to the agency a referral packet
289 that includes, at a minimum, the court order, the charging
290 documents, the petition, and the court-appointed evaluator’s
291 reports.
292 (h) After placement of the child in the appropriate
293 setting, the Department of Children and Families ~~Family Services~~
294 in consultation with the Agency for Persons with Disabilities,
295 as appropriate, must, within 30 days after placement of the
296 child, prepare and submit to the court a treatment or training
297 plan for the child’s restoration of competency. A copy of the
298 plan must be served upon the child’s attorney, the state
299 attorney, and the attorneys representing the Department of
300 Juvenile Justice.

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301 Section 6. This act shall take effect July 1, 2014.
302
303 ================= T I T L E A M E N D M E N T ================
304 And the title is amended as follows:
305 Delete everything before the enacting clause
306 and insert:
307 A bill to be entitled
308 An act relating to mental health treatment; amending
309 s. 916.107, F.S.; authorizing forensic and civil
310 facilities to order the continuation of
311 psychotherapeutics for individuals receiving such
312 medications in the jail before admission; amending s.
313 916.13, F.S.; providing timeframes within which
314 competency hearings must be held; amending s. 916.145,
315 F.S.; revising the time for dismissal of certain
316 charges for defendants that remain incompetent to
317 proceed to trial; providing exceptions; amending s.
318 916.15, F.S.; providing a timeframe within which
319 commitment hearings must be held; amending s. 985.19,
320 F.S.; standardizing the protocols, procedures,
321 diagnostic criteria, and information and findings that
322 must be included in an expert’s competency evaluation
323 report; providing an effective date.

By Senator Sobel

1 A bill to be entitled
2 An act relating to mental health treatment; amending
3 s. 916.107, F.S.; authorizing forensic and civil
4 facilities to order the continuation of
5 psychotherapeutics for individuals receiving such
6 medications in the jail before admission; amending s.
7 916.13, F.S.; providing timeframes within which
8 competency hearings must be held; amending s. 916.145,
9 F.S.; revising the time for dismissal of certain
10 charges for defendants that remain incompetent to
11 proceed to trial; providing exceptions; amending s.
12 916.15, F.S.; providing a timeframe within which
13 commitment hearings must be held; amending s. 985.19,
14 F.S.; standardizing the protocols, procedures,
15 diagnostic criteria, and information and findings that
16 must be included in an expert's competency evaluation
17 report; providing an effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Paragraph (a) of subsection (3) of section
22 916.107, Florida Statutes, is amended to read:
23 916.107 Rights of forensic clients.—
24 (3) RIGHT TO EXPRESS AND INFORMED CONSENT.—
25 (a) A forensic client shall be asked to give express and
26 informed written consent for treatment. If a client refuses such
27 treatment as is deemed necessary and essential by the client's
28 multidisciplinary treatment team for the appropriate care of the
29 client, such treatment may be provided under the following

30 circumstances:
31 1. In an emergency situation in which there is immediate
32 danger to the safety of the client or others, such treatment may
33 be provided upon the written order of a physician for a period
34 not to exceed 48 hours, excluding weekends and legal holidays.
35 If, after the 48-hour period, the client has not given express
36 and informed consent to the treatment initially refused, the
37 administrator or designee of the civil or forensic facility
38 shall, within 48 hours, excluding weekends and legal holidays,
39 petition the committing court or the circuit court serving the
40 county in which the facility is located, at the option of the
41 facility administrator or designee, for an order authorizing the
42 continued treatment of the client. In the interim, the need for
43 treatment shall be reviewed every 48 hours and may be continued
44 without the consent of the client upon the continued written
45 order of a physician who has determined that the emergency
46 situation continues to present a danger to the safety of the
47 client or others.
48 2. In a situation other than an emergency situation, the
49 administrator or designee of the facility shall petition the
50 court for an order authorizing necessary and essential treatment
51 for the client.
52 a. If the client has been receiving psychotherapeutic
53 medications at the jail at the time of transfer to the forensic
54 or civil facility and lacks the capacity to make an informed
55 decision regarding mental health treatment at the time of
56 admission, the admitting physician may order continued
57 administration of psychotherapeutic medications if, in the
58 clinical judgment of the physician, abrupt cessation of

psychotherapeutic medications could pose a risk to the health or safety of the client during the time a court order to medicate is pursued. The administrator or designee of the civil or forensic facility shall, within 5 days after admission, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of a client. The jail physician shall provide a current psychotherapeutic medication order at the time of transfer to the forensic or civil facility or upon request of the admitting physician after the client is evaluated.

b. The court order shall allow such treatment for up to ~~a period not to exceed~~ 90 days after ~~following~~ the date of the entry of the order. Unless the court is notified in writing that the client has provided express and informed consent in writing or that the client has been discharged by the committing court, the administrator or designee shall, before ~~the~~ expiration of the initial 90-day order, petition the court for an order authorizing the continuation of treatment for another 90 days ~~90-day period~~. This procedure shall be repeated until the client provides consent or is discharged by the committing court.

3. At the hearing on the issue of whether the court should enter an order authorizing treatment for which a client was unable to or refused to give express and informed consent, the court shall determine by clear and convincing evidence that the client has mental illness, intellectual disability, or autism, that the treatment not consented to is essential to the care of the client, and that the treatment not consented to is not

experimental and does not present an unreasonable risk of serious, hazardous, or irreversible side effects. In arriving at the substitute judgment decision, the court must consider at least the following factors:

a. The client’s expressed preference regarding treatment;

b. The probability of adverse side effects;

c. The prognosis without treatment; and

d. The prognosis with treatment.

The hearing shall be as convenient to the client as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the client’s condition. The court may appoint a general or special magistrate to preside at the hearing. The client or the client’s guardian, and the representative, shall be provided with a copy of the petition and the date, time, and location of the hearing. The client has the right to have an attorney represent him or her at the hearing, and, if the client is indigent, the court shall appoint the office of the public defender to represent the client at the hearing. The client may testify or not, as he or she chooses, and has the right to cross-examine witnesses and may present his or her own witnesses.

Section 2. Subsection (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment

~~to the department~~ under ~~the provisions of~~ this chapter, may be committed to the department, and the department shall retain and treat the defendant.

(a) Within ~~No later than~~ 6 months after the date of admission and at the end of any period of extended commitment, or at any time the administrator or designee has ~~shall have~~ determined that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

(b) A competency hearing must be held within 30 days after the court receives notification that the defendant is competent to proceed or no longer meets the criteria for continued commitment.

Section 3. Section 916.145, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 916.145, F.S., for present text.)

916.145 Dismissal of charges.—

(1) The charges against a defendant adjudicated incompetent to proceed due to mental illness shall be dismissed without prejudice to the state if the defendant remains incompetent to proceed:

(a) Three years after such determination; or

(b) Five years after such determination if the charge related to commitment is:

1. Arson;

2. Sexual battery;

3. Robbery;

4. Kidnapping;

5. Aggravated child abuse;

6. Aggravated abuse of an elderly person or disabled adult;

7. Aggravated assault with a deadly weapon;

8. Murder;

9. Manslaughter;

10. Aggravated manslaughter of an elderly person or disabled adult;

11. Aggravated manslaughter of a child;

12. Unlawful throwing, projecting, placing, or discharging of a destructive device or bomb;

13. Armed burglary;

14. Aggravated battery; or

15. Aggravated stalking,

unless the court, in an order, specifies reasons for believing that the defendant will become competent to proceed, and specifies a reasonable time within which the defendant is expected to become competent.

(2) This section does not prohibit the state from refiling dismissed charges if the defendant is declared to be competent to proceed in the future.

Section 4. Subsection (5) is added to section 916.15, Florida Statutes, to read:

916.15 Involuntary commitment of defendant adjudicated not guilty by reason of insanity.—

(5) The commitment hearing must be held within 30 days after the court receives notification that the defendant no

175 longer meets the criteria for continued commitment.
176 Section 5. Subsection (1) of section 985.19, Florida
177 Statutes, is amended to read:
178 985.19 Incompetency in juvenile delinquency cases.—
179 (1) If, at any time prior to or during a delinquency case,
180 the court has reason to believe that the child named in the
181 petition may be incompetent to proceed with the hearing, the
182 court on its own motion may, or on the motion of the child's
183 attorney or state attorney must, stay all proceedings and order
184 an evaluation of the child's mental condition.
185 (a) Any motion questioning the child's competency to
186 proceed must be served upon the child's attorney, the state
187 attorney, the attorneys representing the Department of Juvenile
188 Justice, and the attorneys representing the Department of
189 Children and Families ~~Family Services~~. Thereafter, any motion,
190 notice of hearing, order, or other legal pleading relating to
191 the child's competency to proceed with the hearing must be
192 served upon the child's attorney, the state attorney, the
193 attorneys representing the Department of Juvenile Justice, and
194 the attorneys representing the Department of Children and
195 Families ~~Family Services~~.
196 (b) All determinations of competency must ~~shall~~ be made at
197 a hearing, with findings of fact based on an evaluation of the
198 child's mental condition made by at least ~~not less than~~ two but
199 not ~~nor~~ more than three experts appointed by the court. ~~The~~
200 ~~basis for the determination of incompetency must be specifically~~
201 ~~stated in the evaluation. In addition, a recommendation as to~~
202 ~~whether residential or nonresidential treatment or training is~~
203 ~~required must be included in the evaluation.~~ Experts appointed

204 by the court to determine the mental condition of a child shall
205 be allowed reasonable fees for services rendered. State
206 employees may be paid expenses pursuant to s. 112.061. The fees
207 shall be taxed as costs in the case.
208 (c) A child is competent to proceed if the child has
209 sufficient present ability to consult with counsel with a
210 reasonable degree of rational understanding and the child has a
211 rational and factual understanding of the present proceedings.
212 The expert's competency evaluation report must specifically
213 state the basis for the determination of the child's mental
214 condition and must include written findings that:
215 1. Identify the specific matters referred for evaluation.
216 2. Identify the sources of information used by the expert.
217 3. Describe the procedures, techniques, and diagnostic
218 tests used in the examination to determine the basis of the
219 child's mental condition.
220 4. Address the child's capacity to:
221 a. Appreciate the charges or allegations against the child.
222 b. Appreciate the range and nature of possible penalties
223 that may be imposed in the proceedings against the child, if
224 applicable.
225 c. Understand the adversarial nature of the legal process.
226 d. Disclose to counsel facts pertinent to the proceedings
227 at issue.
228 e. Display appropriate courtroom behavior.
229 f. Testify relevantly.
230 5. Present the factual basis for the expert's clinical
231 findings and opinions of the child's mental condition. The
232 expert's factual basis of his or her clinical findings and

233 opinions must be supported by the diagnostic criteria found in
234 the most recent edition of the Diagnostic and Statistical Manual
235 of Mental Disorders (DSM) published by the American Psychiatric
236 Association and must be presented in a separate section of the
237 report entitled "summary of findings." This section must
238 include:
239 a. The day, month, year, and length of time of the face-to-
240 face diagnostic clinical interview to determine the child's
241 mental condition.
242 b. A statement that identifies the DSM clinical name and
243 associated diagnostic code for the specific mental disorder that
244 forms the basis of the child's incompetency.
245 c. A statement of how the child would benefit from
246 competency restoration services in the community or in a secure
247 residential treatment facility.
248 d. An assessment of the probable duration of the treatment
249 to restore competence and the probability that the child will
250 attain competence to proceed in the foreseeable future.
251 e. A description of recommended treatment or education
252 appropriate for the mental disorder.
253 6. If the evaluator determines the child to be incompetent
254 to proceed to trial, the evaluator must report on the mental
255 disorder that forms the basis of the incompetency.
256 (d) ~~(c)~~ All court orders determining incompetency must
257 include specific written findings by the court as to the nature
258 of the incompetency and whether the child requires secure or
259 nonsecure treatment or training environment ~~environments~~.
260 (e) ~~(d)~~ For competency ~~incompetency~~ evaluations related to
261 mental illness, the Department of Children and Families ~~Family~~

262 ~~Services~~ shall maintain and annually provide the courts with a
263 list of available mental health professionals who have completed
264 a training program approved by the Department of Children and
265 Families ~~Family Services~~ to perform the evaluations.
266 (f) ~~(e)~~ For competency ~~incompetency~~ evaluations related to
267 intellectual disability or autism, the court shall order the
268 Agency for Persons with Disabilities to examine the child to
269 determine if the child meets the definition of "intellectual
270 disability" or "autism" in s. 393.063 and, provide a clinical
271 opinion as to ~~if so~~, whether the child is competent to proceed
272 with delinquency proceedings.
273 ~~(f) A child is competent to proceed if the child has~~
274 ~~sufficient present ability to consult with counsel with a~~
275 ~~reasonable degree of rational understanding and the child has a~~
276 ~~rational and factual understanding of the present proceedings.~~
277 ~~The report must address the child's capacity to:~~
278 ~~1. Appreciate the charges or allegations against the child.~~
279 ~~2. Appreciate the range and nature of possible penalties~~
280 ~~that may be imposed in the proceedings against the child, if~~
281 ~~applicable.~~
282 ~~3. Understand the adversarial nature of the legal process.~~
283 ~~4. Disclose to counsel facts pertinent to the proceedings~~
284 ~~at issue.~~
285 ~~5. Display appropriate courtroom behavior.~~
286 ~~6. Testify relevantly.~~
287 (g) Immediately upon the filing of the court order finding
288 a child incompetent to proceed, the clerk of the court shall
289 notify the Department of Children and Families ~~Family Services~~
290 and the Agency for Persons with Disabilities and fax or hand

291 deliver to the department and to the agency a referral packet
292 that includes, at a minimum, the court order, the charging
293 documents, the petition, and the court-appointed evaluator's
294 reports.
295 (h) After placement of the child in the appropriate
296 setting, the Department of Children and Families ~~Family Services~~
297 in consultation with the Agency for Persons with Disabilities,
298 as appropriate, must, within 30 days after placement of the
299 child, prepare and submit to the court a treatment or training
300 plan for the child's restoration of competency. A copy of the
301 plan must be served upon the child's attorney, the state
302 attorney, and the attorneys representing the Department of
303 Juvenile Justice.
304 Section 6. This act shall take effect July 1, 2014.

February 28, 2014

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

Dear Chair Bean:

This letter is to request that **SB 944** relating to Mental Health Treatment be placed on the agenda of the next scheduled meeting of the committee.

The proposed legislation would authorize forensic and civil facilities to order the continuation of psychotherapeutics for individuals receiving such medications in jail before admission and provide timeframes within which competency hearings must be held. It would also revise the time for dismissal of certain charges for defendants that remain incompetent to proceed to trial and provide a timeframe within which commitment hearings must be held.

Thank you for your consideration of this request.

Respectfully,

Eleanor Sobel
State Senator, 33rd District

Cc: Celia Georgiades, Committee Administrative Assistant

ENTERED

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/19/14
Meeting Date

Topic: Mental Health Treatment

Bill Number: 944 *(if applicable)*

Name: Dana Farmer

Amendment Barcode: 605394 *(if applicable)*

Job Title: Director of Legislative Affairs

Address: 2728 Centerview Dr., Ste 102
Street

Tallahassee FL 32301
City *State* *Zip*

Phone: 850.617.9709

E-mail: danaf@disabilityrightsflorida.org

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

Representing: Disability Rights Florida

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

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

Topic AMENDMENT TO SECTION 916.145 "DISMISSAL OF CHARGES" Bill Number 944 *(if applicable)*

Name MARK SPEISER Amendment Barcode *(if applicable)*

Job Title CIRCUIT COURT JUDGE

Address BROWARD COUNTY COURTHOUSE Phone
Street

FORT LAUDERDALE FLA 33306 E-mail
City State Zip

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

Representing

Appearing at request of Chair: [ ] Yes [ ] No Lobbyist registered with Legislature: [ ] Yes [ ] No

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

This form is part of the public record for this meeting. S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

3-19-14
Meeting Date

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

Topic: MENTAL HEALTH

Bill Number: 944 *(if applicable)*

Name: MONICA HOFHEINZ

Amendment Barcode: ______ *(if applicable)*

Job Title: ASSISTANT STATE ATTORNEY 17th JUDICIAL CIRC

Address: 201 SE 6th St
Street

FTL
City *State* *Zip*

Phone: 954-831-8543

E-mail: ______

Speaking: ☐ For ☐ Against ☑ Information 'STRIKE ALL'

Representing: ______

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Transportation, *Chair*
Agriculture
Appropriations Subcommittee on Finance and Tax
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Education
Health Policy

SELECT COMMITTEE:
Select Committee on Patient Protection and Affordable Care Act

SENATOR JEFF BRANDES
22nd District

March 19, 2014

Senator Aaron Bean, Chair
Committee on Health Policy
302 Senator Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Chair Bean:

Please excuse my absence from the Committee on Health Policy, today, March, 19, 2014. I have bills to present in other committees.

Thank you for your consideration in this matter.

Sincerely,

Senator Jeff Brandes
District 22

Cc: Sandra Stovall, Staff Director

X

REPLY TO:
☐ 3637 Fourth Street North, Suite 101, St. Petersburg, Florida 33704-1300 (727) 552-2745
☐ 318 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5022

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Health Policy **Judge:**

Started: 3/19/2014 11:04:53 AM
Ends: 3/19/2014 12:26:43 PM Length: 01:21:51

11:04:55 AM Meeting Called to Order
11:06:41 AM Roll Call
11:07:00 AM (Tab 1) SB 872- Alzheimer's Disease
11:07:21 AM Bill is explained by Sen. Richter
11:08:31 AM Barcode 616350 by Sen. Grimsley is explained
11:08:45 AM AM is adopted
11:08:48 AM Barcode 902302 by Sen. Grimsley is explained
11:09:11 AM Chair Bean asks for questions/debate/objections
11:09:23 AM AM is adopted
11:09:56 AM Testimony by Eve Rainey, FL Emergency Preparedness Assoc.
11:10:46 AM Layne Smith, Mayo Clinic, waives in support
11:10:58 AM Dana Farmer, Disability Rights FL, waives in support
11:11:24 AM Testimony by Natalie Kelly, Alzheimer's Assoc
11:11:41 AM Laura Cantwell, AARP, waives in support
11:11:54 AM Chair Bean asks for debate
11:12:07 AM Sen. Richter waives close
11:12:17 AM Sen. Grimsley moves SB 872 as committee substitute
11:12:30 AM Roll Call
11:12:41 AM Bill Recorded Favorably
11:12:47 AM (Tab 2) SB 840- Public Records and Meetings
11:12:59 AM Bill is explained by Sen. Richter
11:13:19 AM Barcode 209838 by Sen. Grimsley is explained
11:13:48 AM Sen. Richter comments
11:14:03 AM Chair Bean asks for questions/debate/objection
11:14:15 AM Barcode 20983 is adopted
11:15:04 AM Sen. Richter waives close
11:15:09 AM Sen. Galvano moves to consider SB 840 as committee substitute
11:15:24 AM Roll call
11:15:34 AM Bill recorded favorably
11:15:40 AM (Tab 5) SB 690- Involuntary Examinations of Minors
11:15:58 AM Sen. Diaz de la Portilla explains bill
11:16:09 AM Barcode 494910 is explained
11:17:27 AM Dana Farmer, Disability Rights FL, waives in support
11:18:15 AM Strike-all is adopted
11:18:25 AM Sen. Joyner asks a question
11:18:59 AM Sen. Diaz de la Portilla waives close
11:19:07 AM Sen. Braynon moves to consider bill as committee substitute
11:19:15 AM Roll Call
11:19:35 AM Show bill recorded favorably
11:20:07 AM (Tab 6) SB 824- Hepatitis C Testing
11:20:22 AM Sen. Joyner explains the bill
11:20:49 AM Barcode 977812 is explained
11:21:05 AM Testimony by Jason Goldman, FL Chapter, American College of Physicians
11:22:24 AM Chair Bean comments and asks question about mandate
11:22:38 AM Sen. Joyner comments
11:23:07 AM Chair Bean asks follow-up question
11:23:15 AM Sen. Joyner responds
11:24:48 AM Chair Bean comments
11:25:17 AM Dr. Goldman responds with regard to mandate
11:26:56 AM Sen. Garcia asks a question
11:27:57 AM Dr. Goldman responds
11:28:37 AM Sen. Garcia asks follow-up question

11:30:02 AM Sen. Braynon comments
11:30:52 AM Sen. Grimsley asks a question
11:32:27 AM Dr. Goldman responds
11:32:31 AM Sen. Grimsley asks follow-up question
11:32:38 AM Dr. Goldman responds
11:32:52 AM Sen. Grimsley asks follow-up question
11:32:58 AM Dr. Goldman responds
11:33:01 AM Sen. Sobel asks a question
11:33:39 AM Dr. Goldman responds
11:33:53 AM Sen. Sobel saks follow-up question
11:34:45 AM Dr. Goldman responds
11:36:09 AM Chris Nuland, FL Public Health Assoc. waives in support
11:36:28 AM Testimony by Michael Ruppal, The AIDS Institute
11:37:33 AM Jesse Fry, FL HIV/AIDS Advocacy Network, waives in support
11:38:08 AM Jack McRay, AARP, waives in support
11:38:28 AM Chair Bean asks for questions/debate
11:38:59 AM Sen. Garcia comments in debate
11:40:00 AM Sen. Sobel comments
11:41:01 AM Chair Bean comments
11:42:19 AM Sen. Joyner closes on bill
11:46:41 AM Show AM adopted
11:46:48 AM Roll Call on SB 824
11:46:55 AM Sen. Braynon moves that we consider SB 824 a committee substitute
11:47:20 AM Bill reported favorably
11:47:31 AM Sen. Galvano votes affirmatively on SB 872
11:47:57 AM (Tab 3) CS/SB 1208- Fraudulent Controlled Substance Prescriptions
11:48:25 AM The bill is explained by Tracy Cadell
11:48:45 AM Sen. Joyner asks a question
11:49:01 AM Ms. Cadell responds
11:49:11 AM Sen. Sobel explains late-filed amendment
11:50:47 AM Sen. Galvano asks a question
11:50:58 AM Ms. Cadell responds
11:51:09 AM Sen. Joyner asks question
11:51:28 AM Sen. Sobel responds
11:52:56 AM Show the Sobel amendment adopted
11:53:03 AM Larry Gonzaloz, FL Society of Health, waives in support
11:53:21 AM Holly Miller, FMA, waives in support
11:53:49 AM Sen. Joyner asks a question
11:54:32 AM Sen. Joyner asks a follow-up question
11:54:43 AM Ms. Cadell responds
11:55:29 AM Sen. Sobel comments
11:56:10 AM Sen. Garcia moves to consider SB 1208 as a committee substitute
11:56:25 AM Roll Call
11:56:43 AM Bill recorded favorably
11:56:50 AM (Tab 7) SB 1014- Pharmacy Benefit Managers
11:57:20 AM Sen. Garcia explains the amendment and amendment to amendment
11:57:50 AM Barcode 128416 is adopted
11:58:07 AM Barcode 960356 is explained by Sen. Garcia
12:00:30 PM Chair Bean asks for questions/debate/objections
12:00:41 PM Barcode 960356 is adopted
12:01:03 PM Testimony by Joy Ryan, Prime Therapeutics
12:02:31 PM Sen. Garcia asks a question
12:03:05 PM Ms. Ryan responds
12:03:33 PM Testimony by allen Horne, CVS Caremark
12:06:22 PM Sen. Garcia comments
12:07:16 PM Larry Gonzalez, Florida Society of Health, waives in support
12:07:44 PM Testimony by Bill Napier, Panama Pharmacy
12:11:02 PM Testimony by Roger Accardi, Pharmacy Owner
12:14:08 PM Dan Fucarino, Pharmacist, waives in favor
12:14:29 PM Jim Powers, Pharmacist, waives in favor
12:14:31 PM Bill Mincy, PPSC Indepdendent Pharmacy Owners, waives in support
12:14:32 PM Michael Jackson, Florida Pharmacy Assoc. waives in support

12:14:39 PM Sally West, Director of Government Affairs, waives in support
12:14:50 PM Jorge Chamizo, Independent Pharmacy Cooperative, waives in support
12:14:53 PM Chair closes on bill
12:15:29 PM Sen. Galvano motions to consider SB 1014 as committee substitute
12:15:41 PM Roll Call
12:15:49 PM Bill recorded favorably
12:15:56 PM (Tab 8) SB 944 Mental Health Treatment
12:16:07 PM Sen. Sobel explains Barcode 605394
12:17:15 PM Chair Bean asks question
12:17:27 PM Sen. Sobel comments
12:17:39 PM Barcode 605394 is adopted
12:17:54 PM Dana Farmer, Disability Rights Florida, waives in support
12:18:18 PM Testimony by Monica Hofheinz, Assistant State Attorney
12:19:44 PM Testimony by Mark Speiser, Circuit Court Judge
12:22:49 PM Sen. Flores moves to consider SB 944 as committee substitute
12:23:03 PM Roll Call
12:23:18 PM Bill recorded favorably
12:23:35 PM (Tab 4) SB 1306- Onsite Sewage Treatment
12:23:49 PM Bill is explained
12:24:38 PM Barcode 219978 is explained
12:24:47 PM Chair Bean asks for questions/debate/objections
12:24:58 PM Strike-all is adopted
12:25:14 PM Celine waives close
12:25:21 PM Sen. Garcia motions to consider bill as committee substitute
12:25:33 PM Roll call
12:25:49 PM Bill recorded favorably
12:26:03 PM Sen. Flores asks to be shown favorably on SB 872, 840, 690, 824
12:26:32 PM Sen. Grimsley moves to rise