Committee on Health Policy

CS/SB 56 — Infant Death

by Children, Families, and Elder Affairs Committee and Senator Hays

The bill replaces the concept of Sudden Infant Death Syndrome (SIDS) with Sudden Unexplained Infant Death (SUID). SUID is defined as the sudden, unexpected death of an infant under 1 year of age which remains unexplained after a complete autopsy, death-scene investigation, and review of case history. Accordingly, training requirements for first responders and protocols for medical examiners are revised to show this change in emphasis. The modifications also reflect the current practices of medical examiners and coroners in the identification of the SUID classification for infant death. SIDS remains a component of SUID.

The bill requires the Department of Health to include the child protection teams within the Division of Children's Medical Services in the development of the rule for law enforcement investigations of sudden infant deaths. The bill further requires that the curriculum be based on the federal Centers for Disease Control SUID Initiative.

The bill also deletes the Department of Health's responsibility to coordinate the SIDS hotline and other liaison activities were re-focused from the local alliance to the Florida SIDS Alliance.

The bill requires hospitals with birthing centers to provide information to patients on safe sleep practices for infants and the causes of SUID as part of postpartum care.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 39-0; House 115-0

Committee on Health Policy

CS/CS/HB 239 — Practice of Optometry

by Health and Human Services Committee; Health Quality Subcommittee; Reps. Caldwell, Williams, A., and others (CS/CS/SB 278 by Appropriations Committee; Health Policy Committee; and Senators Richter and Grimsley)

The bill (Chapter 2013-26, L.O.F.) authorizes licensed certified optometrists to administer or prescribe oral ocular pharmaceutical agents, including statutorily specified analgesics which are controlled substances, for the relief of pain due to ocular conditions of the eye and its appendages. The 14 oral ocular pharmaceutical agents that may be administered or prescribed by a certified optometrist are identified in a statutory formulary. The bill repeals the formulary committee and authorizes the Board of Optometry to establish and update the formulary for topical ocular pharmaceutical agents.

Before administering or prescribing oral ocular pharmaceutical agents, the certified optometrist must provide proof to the Department of Health of successful completion of a course and examination on general and ocular pharmaceutical agents and the side effects of those agents. The first course and examination must be presented by October 1, 2013. The 20-hour course and examination may satisfy 20 hours of continuing education for the optometrist.

The bill provides a definition of ocular pharmaceutical agent as a pharmaceutical agent that is administered topically or orally for the diagnosis or treatment of ocular conditions of the human eye and its appendage without the use of surgery or other invasive techniques. Additionally, a definition of surgery is provided and certain procedures under the practice of optometry are excluded from this definition.

A procedure for the co-management of post-operative care by the surgeon and the optometrist is specified in law, which includes certain disclosures to the patient and the patient's consent to the co-management of care. Any adverse incident, as defined in this law, that is attributable to the prescription of an oral ocular pharmaceutical agent by a certified optometrist must be reported to the Department of Health.

The bill prohibits an optometrist from prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug for the purpose of treating a systemic disease. A certified optometrist is authorized to perform eye examinations, including a dilated examination, related to pugilistic exhibitions (boxing, kickboxing, or mixed martial arts matches). The bill also authorizes an optometrist to operate a clinical laboratory to treat his or her own patients and requires other clinical laboratories to accept specimens submitted for examination by an optometrist.

The bill prohibits a certified optometrist from administering or prescribing a controlled substance listed in Schedule I or Schedule II.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 40-0; House 116-0

Committee on Health Policy

CS/SB 248 — Treatment Programs for Impaired Licensees and Applicants

by Health Policy Committee and Senator Thrasher

The bill authorizes an entity that employs a registered nurse as an executive director to serve as a consultant and provides that entities serving as consultants for the impaired practitioner treatment program are not required to be licensed as substance abuse providers or mental health treatment providers for purposes of participating in this program. Consultants are authorized to assist students enrolled in a school or program to become licensed as health care practitioners as defined in ch. 456, F.S., or as veterinarians, and certain health care practitioner schools and veterinary schools are released from liability for referring students to consultants.

The chair or a designee from each board or profession within the Division of Medical Quality Assurance within the Department of Health (DOH), has the authority to ask any licensure applicant to undergo an evaluation for impairment before deciding to certify or not certify the licensure application. If the applicant agrees to undergo such an evaluation, DOH's deadline for certifying or not certifying the application is tolled until the evaluation can be completed and results reported to the appropriate board.

The bill provides guidelines concerning the release and custody of records relating to the impaired practitioner.

The bill also subjects radiologic technologists to the impaired practitioner provisions in s. 456.076, F.S.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 39-0; House 118-0

Committee on Health Policy

CS/CS/HB 365 — Pharmacy

by Health and Human Services Committee; Health Quality Subcommittee; and Reps. Hudson, Jones, and others (CS/CS/SB 732 by Appropriations Committee; Health Policy Committee; and Senator Grimsley)

The bill authorizes a Class II institutional pharmacy (typically a hospital pharmacy) to add biological products, biosimilars, and biosimilar interchangeables to its institutional formulary system.

Under the bill, pharmacists may only dispense biosimilar products to patients in place of prescribed biological products if:

- The federal Food and Drug Administration (FDA) has determined that the substitute biological product is biosimilar to and interchangeable for the prescribed biological product;
- The prescriber does not express any preference against such a substitution;
- The person presenting the prescription is notified of the substitution in a manner consistent with s. 465.025(3), F.S., which includes advising the presenter that he or she may refuse the substitution and request the brand name biological product and that any savings in dispensing the biosimilar will be passed on to the presenter; and
- The pharmacist retains a record of the substitution for at least 2 years.

A pharmacist who practices in a Class II or modified Class II institutional pharmacy must comply with the reporting provisions by entering the substitution into the institution's medical record system. The bill also requires the Board of Pharmacy to maintain on its public website a list of biological products that the FDA has determined to be biosimilar and interchangeable.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 36-1; House 116-1

Committee on Health Policy

CS/CS/CS/HB 375 — Onsite Sewage Treatment and Disposal Systems

by State Affairs Committee; Health Quality Subcommittee; Agriculture and Natural Resources Subcommittee; and Rep. Roberson, K. (CS/CS/CS/SB 1160 by Rules Committee; Environmental Preservation and Conservation Committee; Health Policy Committee; and Senator Bullard)

The bill amends s. 381.0065, F.S., to:

- Authorize inspection reports for engineer-designed onsite sewerage treatment and disposal systems (OSTDS) and aerobic treatment units (ATU) to be submitted electronically to the Department of Health (DOH);

- Remove the requirement that the technical review advisory panel assist the DOH in developing performance criteria applicable to engineer-designed OSTDS;

- Clarify that property owners of owner-occupied single-family residences may be approved and permitted by the DOH as a maintenance entity for their own engineer-designed OSTDS or ATU system upon written certification from the manufacturer that they have received training on the proper installation and maintenance of their own engineer-designed OSTDS or ATU system;

- Clarify that maintenance entity service contracts must conspicuously disclose that property owners of owner-occupied single-family residences have the right to maintain their own engineer-designed OSTDS or ATU system and are exempt from contractor registration requirements for performing construction, maintenance, or repairs on an own engineer-designed OSTDS or ATU system, but are subject to all permitting requirements;

- Provide that a septic tank contractor licensed under ch. 489, part III, F.S., and approved by the ATU manufacturer must not be denied access to ATU training and spare parts by the manufacturer for maintenance entities;

- Allow component parts for ATUs to be replaced with parts that meet the manufacturer's specifications but are manufactured by others after the original warranty period for the ATU expires; and

- With respect to OSTDs in Monroe County:
  - Require property owners who are not scheduled to be served by a central sewer by December 31, 2015, to comply with chemical concentration level standards;
  - Provide that an OSTDS that reduces nitrogen concentrations by at least 70 percent, or if the OSTDS system has been tested and certified to reduce nitrogen concentrations by at least 70 percent, is deemed to be in compliance with current nitrogen standards;
  - Allow property owners who have recently installed OSTDS in areas scheduled to be served by a central sewer system to continue to use the systems until December 31, 2020, except if located in special wastewater districts; and

- Allow property owners who have paid connection fees or assessments for connection to a central sewer system, in an area scheduled to be served by a central sewer by December 31, 2015, the option of installing a holding tank with a high water alarm until they are able to connect to a central sewer system.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 39-0; House 117-0

Committee on Health Policy

CS/CS/SB 398 — Physician Assistants

by Banking and Insurance Committee; Health Policy Committee; and Senator Bean

The bill amends the medical practice act and the osteopathic medical practice act to clarify that a supervising physician may delegate to a physician assistant authority to order medications, including controlled substances, for patients in hospitals, ambulatory surgical centers and mobile surgical facilities. The bill also specifies that an order is not a prescription in these instances.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 35-0; House 118-0

Committee on Health Policy

CS/HB 413 — Physical Therapy

by Health Quality Subcommittee; Reps. Hutson, Campbell, and others (CS/SB 536 by Health Policy Committee and Senator Detert)

The bill amends the definition of the practice of physical therapy to authorize a physical therapist to implement a plan of treatment ordered for a patient by an advanced registered nurse practitioner (ARNP). The bill also makes several technical changes to the definition to improve readability.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 37-0; House 115-0

Committee on Health Policy

SB 452 — OGSR/Joshua Abbot Organ and Tissue Donor Registry/Donor Information

by Health Policy Committee

This bill reenacts the public records exemption for the Joshua Abbott Organ and Tissue Donor Registry.

The Joshua Abbott Organ and Tissue Donor Registry is an interactive web-based organ and tissue donor registry that allows for online organ donor registration. The public records exemption makes information that identifies a donor confidential and exempt from public records requirements except that such information may be disclosed under specified circumstances. The public records exemption was subject to review under the Open Government Sunset Review Act and would have been automatically repealed on October 2, 2013.

If approved by the Governor, these provisions take effect October 1, 2013.
Vote: Senate 40-0; House 117-0

Committee on Health Policy

SB 520 — Emergency Medical Services

by Senator Bradley

The bill updates provisions relating to training and education for emergency medical technicians (EMTs) and paramedics. Specifically the bill:

- Removes emergency personnel certified under ch. 401, F.S., from the instruction requirements on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) contained in s. 381.0034, F.S.;

- Deletes the requirement that any curricula for training EMTs and paramedics include 4 hours of HIV/AIDS instruction;

- Links the definitions of advanced life support and basic life support to the EMT-Paramedic National Standard and the EMT-Basic National Standard, respectively, as well as the National EMS Education Standards of the United States Department of Transportation;

- Adds those National EMS Education Standards approved by the Department of Health to the allowed standards on which emergency medical services trainers may base their curricula; and,

- Increases, from 1 year to 2 years, the period within which an EMT or a paramedic must pass the required certification exam after completing their training program.

The bill also increases, from 2 years to 5 years, the period within which the Department of Health must revise its comprehensive state plan for basic and advanced life support systems.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 117-0

Committee on Health Policy

SB 604 — Practitioners

by Senator Bean

The bill directs certain fees collected by the Department of Health for examinations, certification, and recertification of emergency medical technicians and paramedics to be deposited into the Medical Quality Assurance Trust Fund instead of the Emergency Medical Services Trust Fund.

The bill also adds to the types of proceedings that the Department of Financial Services must defend to include any action for injunctive, affirmative, or declaratory relief against an impaired practitioner consultant involving emergency interventions on behalf of impaired practitioners when the consultant is unable to perform the intervention if the act or omission arises out of and is in the scope of the consultant's contractual duties.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 35-0; House 117-0

Committee on Health Policy

CS/CS/HB 939 — Medicaid Recoveries

by Health and Human Services Committee; Health Innovation Subcommittee; and Rep. Pigman and others (CS/CS/SB 844 by Appropriations Committee; Health Policy Committee; and Senator Grimsley)

The bill modifies existing statutory provisions relating to fraud and abuse, provider controls, and accountability in the Medicaid program. This bill includes the following provisions:

- Requires a Medicaid provider to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) within 30 days after the change occurs;

- Provides a definition for "administrative fines" for purposes of liability for payment of such fines in the event of a change of ownership;

- Authorizes, rather than requires, the AHCA to perform an onsite inspection of a provider before entering a provider agreement to ensure that the entity complies with the Medicaid program and professional regulations;

- Modifies provider's surety bond requirements to provide that the amount of the bond need not exceed $50,000, if the physician or group of physicians licensed under ch. 458, ch. 459 or ch. 460, F.S., has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility under ch. 429, F.S.;

- Provides a definition for principals of a provider with a controlling interest for hospitals and nursing homes, for purposes of conducting criminal background checks to be consistent with the definition for licensure;

- Removes exceptions to the background screenings requirements for hospices or assisted living facilities that are Medicaid providers;

- Permits enrollment of an out-of-state provider if the provider is located within 50 miles of the state line; the provider is a physician actively licensed in the state and interprets diagnostic testing results through telecommunications and information technology from a distance; or the AHCA determines a need for that provider type to ensure adequate access to care;

- Amends the Medicaid Third Party Liability Act with respect to procedures for challenging certain recovered medical expenses to ensure compliance with federal law;

- Expands the list of criminal offenses for which the AHCA may terminate the participation of a Medicaid provider;

- Requires the AHCA to impose the sanction of termination for cause against providers that voluntarily relinquish their Medicaid provider numbers after being notified that an audit, survey, or inspection that could result in the sanction of suspension or termination is underway or has been conducted;

- Requires that when the AHCA determines that an overpayment has been made, the AHCA must base its determination solely on the information available before the issuance of an audit report and upon contemporaneous records. The AHCA may consider addenda and modifications to a note made contemporaneously with the patient care episode if the addenda is germane to the care;

- Requires overpayments or fines to be paid to the AHCA within 30 days after the date of the final order;

- Clarifies the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts;

- Amends the membership of the Medicaid and Public Assistance Fraud Strike Force to allow members to utilize designees and repeals the Strike Force effective June 30, 2014; and,

- Repeals s. 624.352, F.S., relating to interagency agreements to detect and deter Medicaid and public assistance fraud effective June 30, 2014.

The AHCA will primarily oversee the implementation of the bill relating to Medicaid in coordination with the Chief Financial Officer and other state agencies involved in Medicaid and public assistance fraud activities.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 116-0

Committee on Health Policy

CS/HB 969 — Recreational Vehicle Parks

by Health Quality Subcommittee; and Rep. Raburn and others (CS/SB 938 by Health Policy Committee and Senator Dean)

The bill, to be cited as "The Jim Tillman Act":

- Creates a definition for the term "occupancy" from language already present in the definition of the term "recreational vehicle" (RV);

- Fixes setback and separation distances for RV sites at the time of initial approval of an RV park; and,

- Repeals s. 513.111, F.S., which regulates site rates, the posting of signs, and advertising in and for RV parks and establishes penalties for violating those regulations.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 37-0; House 119-0

Committee on Health Policy

CS/HB 1071 — Health Care Accrediting Organizations

by Health Innovation Subcommittee and Rep. Antone (CS/CS/SB 594 by Rules Committee; Banking and Insurance Committee; and Senator Bean)

The bill amends ss. 154.11, 394.741, 397.403, 400.925, 400.9935, 402.7306, 408.05, 430.80, 440.13, 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015, F.S., to replace requirements that health care entities be accredited by specific accreditation organizations with general provisions requiring health care entities to be accredited by an accrediting organization whose standards incorporate comparable licensure regulations required by this state and, where appropriate, is approved by the Centers for Medicare and Medicaid Services.

The bill amends s. 395.3038, F.S., to delete an outdated provision requiring the Agency for Health Care Administration to notify hospitals that it is creating a registry of primary and comprehensive stroke centers.

The bill also amends s. 486.102, F.S., to specify that any regional or national institutional accrediting agency recognized by the United State Department of Education, as well as the Commission on Accreditation for Physical Therapy Education, are appropriate accrediting agencies for the purpose of approving courses for the preparation of physical therapist assistants.

If approved by the Governor, these provisions take effect July 1, 2013
Vote: Senate 33-0; House 115-1

Committee on Health Policy

CS/CS/HB 1093 — Volunteer Health Services

by Health and Human Services Committee; Health Quality Subcommittee; Rep. Hudson and others (CS/CS/SB 1690 by Appropriations Committee; Health Policy Committee; and Senator Bean)

The bill amends the Medical Practice Act and the Osteopathic Medical Practice Act to revise the criteria for limited licensure for physicians. Limited licenses are typically issued to physicians providing volunteer, uncompensated services for low-income Floridians or services in areas of critical medical need. The bill provides greater flexibility for the Department of Health to issue the limited licenses.

The bill also amends s. 766.115, F.S., the Access to Health Care Act (the Act), to:

- Revise the contractual requirements for patient referrals and care under the Act. The contract between the governmental contractor and the provider may authorize the provider to determine patient selection and initial referral. The Department is required to retain review and oversight authority of this process;

- Eliminate the requirement that patient care, including follow-up or hospital care, is subject to approval by the government contractor;

- Require the Department of Health to post online volunteers, volunteer providers' hours, and the number of patient visits for each volunteer. However, a provider may request in writing to be excluded from the online listing;

- Permit volunteer providers to earn continuing education credit for participating in the program. The bill allows each hour of volunteer services to count as a continuing education hour for up to eight hours per licensure period.

If approved by the Governor, these provisions take effect July 1, 2013
Vote: Senate 36-0; House 116-0

Committee on Health Policy

CS/CS/SB 1094 — Home Health Agencies

by Appropriations Committee; Health Policy Committee; and Senator Flores

The bill reduces the mandatory fine amount levied against home health agencies that fail to file a quarterly report which includes several indicators of potential Medicaid fraud with the Agency for Health Care Administration. The bill reduces the current fine of $5,000 to a fine of $200 per day up to a maximum of $5,000 per quarter. The bill also exempts home health agencies that do not bill Medicare or Medicaid, and are not owned by a health care entity which bills Medicare or Medicaid, from submitting the report and from the fine for failing to file the report.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 34-0; House 115-0

Committee on Health Policy

CS/CS/CS/HB 1129 — Infants Born Alive

by Health and Human Services Committee; Civil Justice Subcommittee; Health Quality Subcommittee; and Reps. Pigman, Rodrigues, and others (CS/CS/SB 1636 by Judiciary Committee; Health Policy Committee and Senator Flores)

The bill provides protections for an infant born alive during an attempted abortion. Specifically, he bill:

- Defines "born alive" as the complete expulsion or extraction from the mother of a human infant, at any stage of development, who, after such expulsion or extraction, breathes or has a beating heart, or definite and voluntary movement of muscles, regardless of whether the umbilical cord has been cut and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, Cesarean section, induced abortion, or other method;

- Grants an infant who is born alive during or immediately after an attempted abortion the same rights as infants born naturally;

- Requires healthcare professionals to apply the same level of care towards an infant born alive as they would for an infant born naturally of the same gestational age;

- Requires that an infant born alive as part of an attempted abortion be immediately transported and admitted to a hospital;

- Requires health care practitioners to report violations of these provisions to the Department of Health;

- Causes violations of these provisions to be punishable as a first degree misdemeanor;

- Specifies that these provisions do not preclude the prosecution for a more general offense, regardless of penalty;

- Specifies that these provisions do not affirm, deny, expand, or contract any legal status or right of a fetus or infant prior to being born alive; and

- Requires facilities that perform abortions to report monthly the number of infants born alive to the Agency for Health Care Administration.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 119-0

Committee on Health Policy

HB 1157 — Health Flex Plans

by Rep. Powell and others (CS/CS/SB 1128 by Community Affairs Committee; Banking and Insurance Committee; and Health Policy Committee)

The bill amends s. 408.909, F.S., relating to the Health Flex Plans program. The bill eliminates the statute's repeal date of July 1, 2013, extending the Health Flex Plan program indefinitely. Health Flex plans were designed to provide affordable, alternative health care coverage for low-income individuals.

The bill also modifies the definition of "health care coverage" or "health flex plan coverage" to allow Health Flex plans coverage to include excepted benefits, such as hospital indemnity or other fixed indemnity insurance, and limited scope dental or vision. This change will bring the Health Flex plans, as an excepted benefits plan, into conformity with the provisions of the federal Patient Protection and Affordable Care Act.

The Agency for Health Care Administration and the Office of Insurance Regulation will continue to jointly regulate and monitor the operation of the Health Flex Plan program.

If approved by the Governor, these provisions take effect June 30, 2013.
Vote: Senate 39-0; House 116-1

Committee on Health Policy

CS/CS/HB 1159 — Health Care

by Health and Human Services Committee; Health Innovation Subcommittee; and Rep. O'Toole (CS/CS/SB 1482 by Judiciary Committee; Health Policy Committee; and Senator Hays)

The bill amends various sections of law relating to the provision of health care. Specifically, the bill amends sections relating to:

Obstetrical Services in Specialty Licensed Children's Hospitals

The bill allows a specialty licensed children's hospital located in a county with a population of 1,750,000 or more to provide obstetrical services, in accordance with the guidelines with the American College of Obstetricians and Gynecologists, to up to 10 beds. These services are restricted to the diagnosis, care, and treatment of pregnant women who have documentation by an examining physician that their fetus has at least one fetal characteristic or condition diagnosed intra-utero that would characterize the pregnancy or delivery as high risk or who have medical advice or a diagnosis indicating that the fetus may require at least one perinatal intervention.

The Cancer Treatment Fairness Act

The bill creates the "Cancer Treatment Fairness Act" which requires an individual or group insurance policy, or a health maintenance organization contract, that provides medical, major medical, or similar comprehensive coverage and includes coverage for cancer treatment to also cover prescribed, orally administered cancer treatment medications. The Act restricts such policies and contracts from applying cost-sharing requirements for orally administered cancer treatment medications that are less favorable than cost-sharing requirements for other cancer treatment medications covered under the policy or contract except that if the cost sharing requirements for intravenous or injected cancer medications are less than $50 per month the cost-sharing requirements for orally administered cancer treatment medications may be up to $50 a month. The Act also restricts insurers offering such policies and contracts from:

- Varying the terms of the policy or contract after July 1, 2014 to avoid compliance with these provisions;
- Providing any incentive or imposing any treatment limitation to encourage a covered person to accept less than the minimum protections available under these provisions;
- Penalizing a health care practitioner for recommending or providing services or care to a covered person as required under these provisions;
- Providing any incentive to induce a health care practitioner to not comply with these provisions; or,

- Changing the classification of any intravenous or injected cancer treatment medication or increasing the amount of cost sharing applicable to any intravenous or injected cancer treatment medication in order to achieve compliance with this section.

Grandfathered health plans, Medicare supplement, dental, vision, long-term care, disability, accident only, and specified disease policies, or other supplemental limited-benefit plans are exempted from the provisions of the act.

The Prescription Drug Monitoring Program

The bill appropriates $500,000 of nonrecurring funds to the Department of Health for the general administration of the prescription drug monitoring program.

Level II Trauma Center Designation

The bill requires the Department of Health to designate a hospital as a Level II trauma center if the hospital has a valid certificate of trauma center verification from the American College of Surgeons and is located in an area with limited access to trauma center services. A hospital is located within an area with limited access to trauma center services when it is located:

- In a trauma service area with a population of greater than 600,000 persons and a density of less than 225 persons per square mile;

- In a county with no verified trauma center; and,

- At least 15 miles or 20 minutes travel time by ground transport from the nearest verified trauma center.

Clinics

The bill exempts pediatric cardiology and perinatology clinical facilities, anesthesia clinical facilities that are not otherwise exempt, and entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners where one or more of the persons responsible for the operations of the entity are a health care practitioner from the definition of "clinic" under s. 400.9905, F.S.

Expedited Review for Certain Nursing Home Certificates of Need

The bill allows for an expedited review for the certificate of need application for the construction of a new nursing home, regardless of the moratorium on nursing home certificates of need established by s. 408.0435, F.S., in a retirement community:

- Where the residential use area is deed-restricted as housing for older persons as defined in s. 790.29(4)(b), F.S.;

- That is located in a county with 25 percent or more of its population aged 65 and older;
- That is located in a county that has a rate of no more than 16.1 nursing home beds per 1,000 people age 65 or older;
- That has a population of at least 8,000 residents; and,
- Where the number of proposed nursing home beds does not exceed 16.1 beds per 1,000 persons aged 65 or older for the county projected 3 years into the future.

The bill authorizes the expedited review process for up to 120 new beds per application and for a total of 240 beds per community regardless of whether the community spans multiple counties. Each community may make a second request for an expedited review of a certificate of need application 2 years after the construction of the first nursing home facility has commenced or 1 year after the initial beds have been licensed. Also, each nursing home approved for the expedited review process must be dually certified for participation in the Medicare and Medicaid programs.

After verifying that a retirement community meets the criteria for the expedited review, the Agency for Health Care Administration (Agency) must publish a notice of the request in the Florida Administrative Weekly which includes the information specified in the bill. The retirement community must determine what requirements applicants for the certificate of need must meet and make land available to applicants it deems to have met the requirements. However, the retirement community only must sell or lease land to the applicant that is issued the certificate of need by the Agency. Within the certificate of need application, the applicant must identify the intended site for the project and show written evidence that the retirement community's requirements are met. If there are multiple applicants that meet the requirements specified by the retirement community, the community may notify the Agency of which applicant it prefers.

If approved by the Governor, and except as specified in the act, these provisions take effect upon becoming law.
Vote: Senate 37-2; House 103-13

Committee on Health Policy

CS/SB 1302 — Temporary Certificates for Visiting Physicians

by Banking and Insurance Committee and Senator Garcia

The bill amends s. 458.3137. F.S., relating to temporary certificates for visiting physicians to obtain medical privileges for instructional purposes. The types of training programs and educational symposiums for which visiting faculty may seek a temporary certificate are expanded beyond the current single subject matter of plastic surgery to include other medical or surgical training programs affiliated with a medical school or educational symposium sponsored in conjunction with a medical school or teaching hospital.

In addition, the bill expands the types of entities that may sponsor the training programs to include any other medical or surgical training program that is affiliated with a medical school accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or is part of a teaching hospital as defined in s. 408.07, F.S.

The temporary certificates are capped on a per symposium basis of 12 per event instead of the existing limit of 6 per year. Each certificate is valid for 5 days, an increase from the current limit of 3 days.

The bill also modifies the requirements for proof of financial responsibility for medical malpractice for physicians seeking a temporary certificate by providing as an additional option for physicians not licensed in this country proof that the physician is covered under the medical malpractice insurance of a teaching hospital or medical school. The amount of the bond, certificate of deposit, or guaranteed letter of credit continues to be at least $250,000.

The Department of Health is responsible for issuing the temporary certificates and updating any rules and procedures to accommodate these modifications.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 37-0; House 117-0

Committee on Health Policy

CS/SB 1420 — Mental Health Treatment

by Health Policy Committee and Senator Sobel

The bill authorizes the admitting physician at a civil or forensic facility operated by the Department of Children and Families to continue psychotherapeutic medications for a client who has been receiving these medications at the jail prior to transfer based on certain conditions. These conditions include the client lacking the capacity to make an informed decision regarding treatment at the time of admission and the physician's clinical judgment that abrupt cessation of the medication could pose a risk to the health or safety of the client while a court order to medicate is pursued. The administrator or designee of the civil or forensic facility must petition the court for an order authorizing the continued treatment of the client within 5 business days after admission. The jail physician must 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.

The bill requires the court to hold a commitment hearing within 30 days after receiving notification that a defendant, who has been adjudicated not guilty by reason of insanity, no longer meets the criteria for continued commitment. Current law is silent with respect to the timeframe within which the proceeding must be heard.

The bill provides for the dismissal of charges against any defendant, who is adjudicated mentally incompetent to proceed, if he or she remains incompetent 3 (rather than 5) years after the initial competency decision was made, 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 specified crimes of a violent nature, the period before charge dismissal remains 5 years. The bill preserves the state's ability to refile dismissed charges should the defendant be declared competent to proceed in the future.

The bill also provides additional details for how incompetency is determined in juvenile delinquency cases. It provides a definition for when a child is considered competent and specifies certain components which must be included in a competency evaluation report. 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.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 37-0; House 117-0

Committee on Health Policy

CS/CS/SB 1660 — Quality Cancer Care and Research

by Appropriations Committee; Children, Families, and Elder Affairs Committee; and Senators Flores and Sobel

Cancer Center of Excellence Award

This bill creates the Cancer Center of Excellence Award to recognize hospitals, treatment centers, and other providers in the state which demonstrate excellence in cancer care.

The Florida Cancer Control and Research Advisory Council (the Council) and the Biomedical Research Advisory Council (BRAC) will appoint members to a joint committee for purposes of creating selection criteria and application forms for the award. The committee will be administratively housed under the Department of Health (the department), and the department is given rulemaking authority related to application cycles and the submission of the application form. The committee will consist of 13 members, seven chosen by majority vote of the Council and six chosen by majority vote of the BRAC. Members of the committee shall serve without compensation but may be reimbursed for travel and other necessary expenses.

Specific duties of the committee include:

- By January 1, 2014, develop performance measures, a rating system, and a rating standard that must be achieved for consideration for the award;
- Review these criteria at least every 3 years to ensure providers are continually enhancing their programs to reflect advances in cancer treatment from the perspective of quality, comprehensive, and patient-centered coordinated care;
- Submit the proposed criteria to the Council and BRAC for approval by both entities prior to their use for award evaluation; and,
- Develop an application form for the award which requires, among other things, submission of documentation which demonstrates that the selection criteria have been met.

The criteria developed by the committee must require, at minimum, that each award applicant:

- Maintain a license in good standing in this state which authorizes the health care services to be provided;
- Be accredited by the Commission on Cancer of the American College of Surgeons;
- Actively participate in at least one regional cancer control collaborative operating pursuant to the Florida Comprehensive Cancer Control Program's cooperative agreement

with the Centers for Disease Control and Prevention's National Comprehensive Care Control Program;

- Demonstrate excellence in and dissemination of scientifically rigorous cancer research;

- Integrate training and education of biomedical researchers and health care professionals; and,

- Meet enhanced cancer care coordination standards which, at a minimum, focus on:
  - Coordination of care by cancer specialists and nursing and allied health professionals;
  - Psychosocial assessment and services;
  - Suitable and timely referrals and follow-up;
  - Providing accurate and complete information on treatment options, including clinical trials, which consider each person's needs, preferences, and resources, whether provided by that center or available through other health care providers;
  - Participation in a network of cancer specialists of multiple disciplines;
  - Family services and support;
  - Aftercare and survivor services; and
  - Patient and family satisfaction survey results.

The department will conduct semiannual application cycles for this award, starting after January 1, 2014. A team of five evaluators will be selected by the State Surgeon General to assess applicants for award eligibility. Each evaluator must sign a conflict of interest form stating his or her lack of connection with any health care provider or facility licensed in this state. The evaluators may be chosen from any of the following groups:

- No more than five health care practitioners or health care facilities not licensed in this state which provide cancer diagnosis or treatment services;

- No more than three members of the Council;

- No more than two members of the BRAC; and,

- No more than one layperson who has experience as a cancer patient or as the family member of a cancer patient, as long as that patient did not receive care from the applicant being evaluated.

The evaluation team will present to the State Surgeon General those applications which have met or exceeded selection criteria, employing the rating system developed by the joint committee. The State Surgeon General will then notify the Governor of those providers eligible to receive the award. The grant of the award by the State Surgeon General is not final agency action, and the award program is not subject to the provisions of ch. 120, F.S., the Administrative Procedure Act.

The Cancer Center of Excellence Award is good for 3 years, and the recipient may use the designation in its advertising and marketing during this time and may receive preference in competitive state solicitations related to cancer care or research. Previous award recipients are eligible for subsequent awards.

By January 31, 2014, and by December 15 thereafter, the State Surgeon General must provide a report to the President of the Senate and the Speaker of the House of Representatives detailing implementation status of the award program and recommendations for improvement.

Reporting Requirements for Recipients of Cancer-Related Appropriations

Any entity associated with cancer research or care which receives a specific appropriation in the General Appropriations Act and does not have statutory reporting requirements for the receipt of such funds must submit an annual fiscal-year progress report to the President of the Senate and the Speaker of the House of Representatives by December 15. The report must describe the general use of the funds, specify the research (if any) funded by the appropriation, describe any fixed capital outlay project funded by the appropriation, and identify any federal or private sources of funding generated as a result of the appropriation (if traceable).

State-Endowed Research Chairs at Cancer Institutions

To attract and retain talented cancer researchers to the state, the department will award endowments to integrated cancer research and care institutions for establishment of funded research chair positions. Funding must be specified in the General Appropriations Act and are independent of funds appropriated for the James and Esther King Biomedical Research Program. The endowment aims to provide 7 years' of funding, not tied to time-limited grant awards, for a cancer scientist to facilitate coordination among Florida research institutions and to attract other promising researchers and funding to the state.

Each institution which has received an endowment must notify the chairs of the appropriations committees in the Senate and the House of Representatives upon selection of its research chair. Each institution must also provide an annual progress report describing the performance of the chair and use of the endowment funds to the President of the Senate, the Speaker of the House of Representatives, and the Governor by December 15.

If an institution needs to replace a research chair, the endowment will cease funding all expenses except those related to recruitment until a new chair is found. During the interim, the endowment will continue to earn interest, and all earnings must be added to the balance of the endowment. A vacancy tolls the 7-year timeframe for the research chair.

The General Appropriations Act for state FY 2013–2014 (SB 1500) includes total funding in the amount of $10 million to be allocated equally to Shands Cancer Hospital at the University of Florida, H. Lee Moffitt Cancer Center and Research Institute, and Sylvester Cancer Center at the University of Miami for an endowed chair.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 36-0; House 117-0

Committee on Health Policy

CS/SB 1844 — Florida Health Choices Program

by Appropriations Committee and Health Policy Committee

The bill amends s. 408.910, F.S., and expands the current Florida Health Choices Program (FHCP) eligibility guidelines by modifying the participation criteria for individuals and employers as long as other program criteria are met. The bill also clarifies that products sold in the FHCP marketplace are not limited to those specifically listed or to risk-bearing products.

The bill provides Florida Health Choices Corporation (FHCC) more flexibility in setting open enrollment periods and removes product pricing guidelines that are in conflict with the provisions of the federal Patient Protection and Affordable Care Act.

The bill provides that any standard forms, website design, or marketing communication developed by the FHCC and used by the FHCC or any vendor is not subject to the Florida Insurance Code, as established under s. 624.01, F.S.

The bill provides the FHCC with an appropriation of $900,000 of non-recurring general revenue for FY 2013-2014.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 36-0; House 73-41