The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, January 19, 2016
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 204** Clemens (Compare CS/H 571)	Music Therapists; Establishing the music therapist profession within the Division of Medical Quality Assurance; creating the Music Therapy Advisory Committee; establishing requirements for licensure as a music therapist; providing for disciplinary grounds and actions, etc. HP 01/19/2016 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0
2	**SB 212** Gaetz (Similar H 85)	Recovery Care Services; Providing legislative intent regarding recovery care centers; authorizing the agency to establish separate standards for the care and treatment of patients in recovery care centers; directing the agency to enforce special-occupancy provisions of the Florida Building Code applicable to recovery care centers; providing applicability of the Health Care Licensing Procedures Act to recovery care centers; exempting recovery care centers from specified minimum licensure requirements, etc. HP 01/19/2016 Fav/CS AHS AP	Fav/CS Yeas 7 Nays 2
3	**SB 526** Grimsley (Identical H 421)	Reimbursement of Medicaid Providers; Defining the term “usual and customary charge” for purposes of Medicaid billing, etc. HP 01/19/2016 Temporarily Postponed AHS AP	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 938** Benacquisto (Similar CS/H 691)	Retail Sale of Dextromethorphan; Prohibiting a retail entity from knowingly or willfully selling a finished drug product containing dextromethorphan to a person younger than 18 years of age; requiring a person making a retail sale of a finished drug product containing any quantity of dextromethorphan to obtain certain proof of age from the purchaser; preempting local government regulation of dextromethorphan, etc. HP 01/19/2016 Fav/CS CM FP	Fav/CS Yeas 9 Nays 0
5	**SB 998** Ring (Similar H 1381)	Treatment Programs; Providing purposes of residential treatment programs and outdoor youth programs;requiring licensure by the Agency for Health Care Administration; requiring the Department of Children and Families to adopt rules for the licensure, administration, and operation of programs; providing requirements for programs that provide services to residents with substance abuse problems, children and youth, and residents with disabilities; requiring programs to have an educational component approved by the Department of Education, etc. HP 01/19/2016 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0
6	**SB 1034** Simmons (Similar H 1431, Compare CS/S 178)	Health Care Providers; Revising the definitions of the terms “contract” and “health care provider”; extending sovereign immunity to employees or agents of a health care provider that executes a contract with a governmental contractor; requiring the posting of notice that a specified health care provider is an agent of a governmental contractor; revising the definition of the term “officer, employee, or agent” to include employees or agents of a health care provider, etc. HP 01/19/2016 Favorable JU RC	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1496** Bradley (Compare H 1175)	Transparency in Health Care; Requiring a facility licensed under ch. 395, F.S., to provide timely and accurate financial information and quality of service measures to certain individuals; requiring a health care practitioner to provide a patient upon his or her request a written, good faith estimate of anticipated charges within a certain timeframe; requiring a health insurer to make available on its website certain methods that a policyholder can use to make estimates of certain costs and charges, etc. HP 01/19/2016 Favorable AHS AP	Favorable 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 204
INTRODUCER:	Health Policy Committee and Senator Clemens
SUBJECT:	Music Therapists
DATE:	January 20, 2016
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 204 creates a new regulated profession, Music Therapists, in ch. 491, F.S., relating to Clinical, Counseling and Psychotherapy Services. Music therapists will be regulated by the Department of Health (DOH) through a registration process in order to practice music therapy or hold oneself out as a music therapist, with certain exceptions. The bill requires biennial renewal of a music therapist's registration and authorizes the DOH to deny or revoke the registration or renewal for violations of s. 491.017, F.S.

II. Present Situation:

The Sunrise Act and Sunrise Questionnaire

The Sunrise Act (the act), codified in s. 11.62, F.S., requires the Legislature to consider specific factors in determining whether to regulate a new profession or occupation. The legislative intent in the act provides that:

- No profession or occupation be subject to regulation unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the state's police power be exercised only to the extent necessary for that purpose; and
- No profession or occupation be regulated in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the services to the public.

The Legislature must review all legislation proposing regulation of a previously unregulated profession or occupation and make a determination for regulation based on consideration of the following:

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

The act requires the proponents of legislation for the regulation of a profession or occupation to provide specific information in writing to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees of reference.[1] This required information is traditionally compiled in a "Sunrise Questionnaire."

Music Therapists[2]

Currently, music therapists are not regulated in Florida. The primary proponent seeking regulation of music therapists in Florida is the Florida Music Therapy State Task Force (task force). The task force has completed a Sunrise Questionnaire to provide information concerning the proposed regulation of a currently unregulated profession.

"Music therapy" is defined by the task force to mean "the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." Music therapist serve clinical populations ranging in age from neonates in a hospital's neonatal intensive care unit (NICU) to older adults in hospice care. Music therapy services are provided in a variety of clinical settings, including:

- Psychiatric hospitals;
- Rehabilitative facilities;
- Medical hospitals;
- Outpatient clinics;
- Day care treatment centers;
- Agencies serving persons with developmental disabilities;
- Community mental health centers;
- Drug and alcohol programs;

[1] See s. 11.62(4)(a)-(m), F.S.

[2] Information in this portion of this Bill Analysis is from the Florida Senate Sunrise Questionnaire completed by the Florida Music Therapy State Task Force (on file with the Senate Committee on Health Policy).

- Senior centers;
- Nursing homes;
- Hospice programs;
- Correctional facilities;
- Halfway houses;
- Schools; and
- Private practice.

According to the task force, in some settings, such as certain school districts, the absence of licensure prevents access to music therapy services.

The task force estimates that there are 253 Music Therapists-Board Certified, four Registered Music Therapists, and four Certified Music Therapists in Florida.[3]

Music therapy degree programs are offered at approximately 73 colleges and universities in the United States. These programs are accredited by the American Music Therapy Association (AMTA). To become a music therapist, a student must earn a bachelor's degree or higher in music therapy from an AMTA-approved college or university. These programs require academic coursework and 1,200 hours of clinical training, including an approved supervised internship. An internship may be approved by the academic institution, the AMTA, or by both. Qualified supervision of clinical training is required and coordinated or verified by the academic institution. Internship supervisors must meet minimum requirements outlined by the AMTA Education and Clinical Training Standards.[4]

Currently in Florida, Florida State University (FSU) and the University of Miami (UM) have the only accredited music therapy programs. FSU and UM both offer Bachelor's, Master's, and Doctoral degrees in Music Therapy. FSU graduates approximately 35 - 40 students annually and UM graduates 10 - 12 students annually. Additionally, Florida Gulf Coast University is developing a music therapy program and is in the accreditation process.

National Certification of Music Therapists

There are two national organizations that recognize the music therapy profession: the AMTA and the Certification Board for Music Therapists (CBMT). The CBMT is the only organization that credentials music therapists nationally. The professional credential for a Music Therapist-Board Certified (MT-BC) is granted by the CBMT to individuals who have successfully completed an AMTA-approved academic and clinical training program and have passed a written objective national examination.

[3] The number of music therapists in Florida is based on information provided by the Certification Board for Music Therapists and the National Music Therapy Registry.

[4] A music therapy internship supervisor must have a clinical practice in music therapy (either private or institutional) and demonstrate the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of internship students, and established skills in supervision. *See* AMTA, *Standards for Education and Clinical Training*, "6.2 Clinical Supervisors," *available at* http://www.musictherapy.org/members/edctstan/ (last visited Jan. 13, 2016).

Currently, the majority of music therapist hold the MT-BC credential. Other credentials that a music therapist may have are: Registered Music Therapist (RMT), Certified Music Therapist (CMT), or Advanced Certified Music Therapist (ACMT). The RMT, CMT, and ACMT credentials were granted prior to 1998 and will expire in 2020.[5]

Regulation of Music Therapists in Other States

Currently eight states regulate music therapists through either licensure or registration.[6] The first state to regulate music therapists was Wisconsin in 1998, which provided a State Registry for Music Therapists through the Wisconsin Department of Regulation and Licensing. This was a title protection act that prohibits the use of the title Wisconsin Music Therapist – Registered (WMTR) unless a music therapist is registered with the state of Wisconsin. Wisconsin does not license state music therapists, and registration is voluntary.[7]

Music therapists were first licensed in the states of North Dakota and Nevada in 2011, followed by Georgia in 2012, Rhode Island and Utah in 2014, and Oregon in 2016.[8,9] North Dakota licenses music therapists through the Board of Integrative Health. Nevada licenses music therapists through its Division of Public Health and Behavioral Health. Licensed music therapists in Georgia are overseen by the Georgia Secretary of State and an ad hoc volunteer Advisory Council. Rhode Island created a music therapy registry that is administered by the Rhode Island Department of Health. Utah established a Music Therapy State Certification designation for board certified music therapists that is granted by Utah's Division of Occupational and Professional Licensing. Oregon recently began licensing music therapists under the umbrella of the Health Licensing Office.[10]

Licensure of Health Care Practitioners in Florida Legislature

The DOH is responsible for the licensure of most health care practitioners in the state. In addition to the regulatory authority in specific practice acts for each profession or occupation, ch. 456, F.S., provides the general regulatory provisions for health care professions within the DOH.

Section 456.001, F.S., defines "health care practitioner" as any person licensed under chs.457 (acupuncture); 458 (medicine); 459 (osteopathic medicine); 460 (chiropractic medicine); 461 (podiatric medicine); 462 (naturopathic medicine); 463 (optometry); 464 (nursing); 465 (pharmacy); 466 (dentistry and dental hygiene); 467 (midwifery); 478 (electrology or electrolysis); 480 (massage therapy); 484 (opticianry and hearing aid specialists); 486 (physical

[5] American Music Therapy Association, *Therapeutic Music Services At-A-Glance*, Ver. 14.1 (Feb. 2014), *available at*: http://www.musictherapy.org/assets/1/7/TxMusicServicesAtAGlance_15.pdf. , (last visited Jan. 13, 2016).
[6] *State Licensure*, The Certification Board for Music Therapists, *available at*: http://www.cbmt.org/examination/state-licensure/ (last visited Jan. 13, 2016). New York is the eighth state to regulate music therapists and they do so under the title of Licensed Creative Art Therapist.
[7] *See* Wisconsin Chapter for Music Therapy, *Wisconsin Music Therapy Registry* (2015), *available at* http://musictherapywisconsin.org/about-us/wmtr/ (last visited Jan. 13, 2016).
[8] *See* note 6 supra.
[9] New York is the eighth state to regulate music therapists and they do so under the title of Licensed Creative Art Therapist. *See* note 6 supra.
[10] *See* Health Licensing Office, Music Therapy Program, available at: http://www.oregon.gov/OHLA/MTP/Documents/MTdraftrules.pdf, (last visited Jan. 14, 2016).

therapy); 490 (psychology); 491 (psychotherapy), F.S., or parts III or IV of ch. 483 (clinical laboratory personnel or medical physics), F.S.

Additionally, the miscellaneous professions and occupations regulated in parts I, II, III, V, X, XIII, or XIV (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics) of ch. 468, F.S., are considered health care practitioners under s. 456.001, F.S.

III. Effect of Proposed Changes:

CS/SB 204 creates s. 491.017, F.S., in ch. 491, F.S., relating to Clinical, Counseling and Psychotherapy Services. The purpose of the legislation is, "to recognize that music therapy affects the health, safety, and welfare of the public, and that the practice of music therapy should be subject to regulation to protect the public from the practice of music therapy by unregistered persons."

The bill provides the following definitions related to music therapists:

- Board-certified music therapist" means a person who has completed the education and clinical training requirements established by the American Music Therapy Association and who holds current board certification from the national Certification Board for Music Therapists.
- "Music therapist" means a person registered to practice music therapy pursuant to this section.
- "Music therapy" means the clinical and evidence-based use of music interventions by a board-certified music therapist to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship. The music therapy interventions may include:
  - music improvisation;
  - receptive music listening;
  - song writing;
  - lyric discussion;
  - music and imagery, singing;
  - music performance;
  - learning through music;
  - music combined with other arts;
  - music-assisted relaxation;
  - music-based patient education;
  - electronic music technology;
  - adapted music intervention; and
  - movement to music.

The practice of music therapy does not include the diagnosis or assessment of any physical, mental, or communication disorder.

CS/SB 204 establishes a registration process and responsibilities for music therapists. A person must be registered as a music therapist to practice musical therapy in this state or to use the title

"music therapist," with certain exceptions for a person who does not hold himself or herself out as a music therapist. These exceptions include:

- A person who is licensed, certified, or regulated to practice a profession or occupation in Florida, or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation;
- A person whose training and national certification attests to the person's preparation and ability to practice his or her certified profession or occupation;
- A student practicing music therapy as a part of an accredited music therapy program; or
- A person practicing music therapy under the supervision of a registered music therapist.

A music therapist may:

- Accept referrals for services from medical, developmental, mental health, or education professionals; family members; clients; caregivers; or other persons authorized to provide client services;
- Collaborate with a client's primary care provider or treatment team before providing services to a client with an identified clinical or developmental need;
- Conduct a music therapy assessment of a client and if treatment is indicated, collect information to determine the appropriateness and type of music therapy services to provide for the client;
- Develop an individualized treatment plan for the client that is based on the results of the music therapy assessment and is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness, or educational services being provided to the client;
- Evaluate the client's response to music therapy and modify the music therapy treatment plan, as appropriate;
- Develop a plan for determining when music therapy services are no longer needed;
- Minimize barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborate with and educate the client and the client's family members, caregivers, and any other appropriate persons regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Use appropriate knowledge and skills to inform practice to determine appropriate actions in the context of each specific clinical setting.

The bill authorizes the DOH to adopt rules to implement this section and establish application, registration, and renewal fees estimated necessary to implement the provisions of this section, but specifies that each fee may not exceed $50.

The DOH may deny or revoke a registration or renewal of registration for violations of this section.

The bill provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Music therapists will be required to pay fees associated with registration and renewal not to exceed $50 for either.

B. Private Sector Impact:

Music therapists are required to pay an initial registration fee as well as biennial renewal fees.

C. Government Sector Impact:

The DOH will experience an indeterminate increase in revenues based on music therapist registration application fees and renewal fees. The DOH will also incur a recurring increase in workload and costs associated with the regulation of music therapists and educating the public concerning music therapy and licensure.

VI. Technical Deficiencies:

None

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 491.017 of 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 January 19, 2016:
The CS establishes a title protection act for Music Therapists rather than a full licensure and regulatory structure. Application fees, and registration and renewal fees, are limited to $50 each. Registration as a music therapist is predicated on passing a board certification examination and maintaining that certification.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/19/2016	.	
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The Committee on Health Policy (Braynon) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 491.017, Florida Statutes, is created to read:

491.017 Registration of music therapists.—

(1) LEGISLATIVE INTENT.—It is the intent of this section to recognize that music therapy affects the health, safety, and welfare of the public, and that the practice of music therapy

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should be subject to regulation to protect the public from the practice of music therapy by unregistered persons.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Board-certified music therapist" means a person who has completed the education and clinical training requirements established by the American Music Therapy Association and who holds current board certification from the national Certification Board for Music Therapists.

(b) "Music therapist" means a person registered to practice music therapy pursuant to this section.

(c) "Music therapy" means the clinical and evidence-based use of music interventions by a board-certified music therapist to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. The practice of music therapy does not include the diagnosis or assessment of any physical, mental, or communication disorder.

(3) REGISTRATION.—

(a) The department shall register an applicant as a music therapist when the applicant submits to the department:

1. A completed application form issued by the department;

2. Application and registration fees; and

3. Proof of passing the examination for board certification offered by the national Certification Board for Music

Therapists, or any successor organization, or proof of being transitioned into board certification, and provides proof that the applicant is currently a board-certified music therapist.

(b) A registration issued under this section must be renewed biennially by submitting to the department a renewal fee and proof that the applicant holds an active certificate as a board-certified music therapist.

(c) A registrant shall inform the department within 10 days after a change of the registrant's address or a change in the registrant's status as a board-certified music therapist.

(4) RESPONSIBILITIES OF A MUSIC THERAPIST.—A music therapist is authorized to:

(a) Accept referrals for music therapy services from medical, developmental, mental health, or education professionals; family members; clients; caregivers; or other persons authorized to provide client services.

(b) Collaborate with a client's primary care provider to review the client's diagnosis, treatment needs, and treatment plan before providing services to a client with an identified clinical or developmental need or collaborate with the client's treatment team while providing music therapy services to the client.

(c) Conduct a music therapy assessment of a client to determine if treatment is indicated and, if treatment is indicated, collect systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client.

(d) Develop an individualized music therapy treatment plan, including individualized goals, objectives, and specific music

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therapy approaches or interventions, for the client that is based on the results of the music therapy assessment and is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness, or educational services being provided to the client.

(e) Evaluate the client's response to music therapy and the music therapy treatment plan, documenting change and progress and suggesting modifications, as appropriate.

(f) Develop a plan for determining when music therapy services are no longer needed, in collaboration with the client and the client's physician or other provider of health care or education to the client, family members of the client, and any other appropriate person upon whom the client relies for support.

(g) Minimize barriers to ensure that the client receives music therapy services in the least restrictive environment.

(h) Collaborate with and educate the client and the client's family members, caregivers, and any other appropriate persons regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs.

(i) Use appropriate knowledge and skills to inform practice, including the use of research, reasoning, and problem-solving skills to determine appropriate actions in the context of each specific clinical setting.

(5) PROHIBITED ACTS; EXEMPTIONS.—A person may not practice music therapy or represent himself or herself as being able to practice music therapy in this state unless the person is registered pursuant to this section. This section does not

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prohibit or restrict the practice, services, or activities of the following:

(a) A person licensed, certified, or regulated under the laws of this state in another profession or occupation, or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that person does not represent himself or herself as a music therapist;

(b) A person whose training and national certification attests to the person's preparation and ability to practice his or her certified profession or occupation, if that person does not represent himself or herself as a music therapist;

(c) Any practice of music therapy as an integral part of a program of study for students enrolled in an accredited music therapy program, if the student does not represent himself or herself as a music therapist; or

(d) A person who practices music therapy under the supervision of a registered music therapist, if the person does not represent himself or herself as a music therapist.

(6) DEPARTMENT AUTHORITY.—

(a) The department is authorized to establish application, registration, and renewal fees estimated necessary to implement the provisions of this section, but each fee may not exceed $50.

(b) The department is authorized to adopt rules to implement this section.

(c) The department may deny or revoke registration or renewal of registration for violations of this section.

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

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129 ================ T I T L E A M E N D M E N T ================
130 And the title is amended as follows:
131 Delete everything before the enacting clause
132 and insert:
133 A bill to be entitled
134 An act relating to music therapists; creating s.
135 491.017, F.S.; providing legislative intent; providing
136 definitions; establishing requirements for
137 registration as a music therapist; providing
138 responsibilities of a music therapist; requiring
139 biennial renewal of registration; prohibiting the
140 practice of music therapy unless the therapist is
141 registered; providing exemptions to registration;
142 authorizing the Department of Health to adopt rules
143 and take disciplinary action against an applicant or
144 registrant who violates the act; providing an
145 effective date.

By Senator Clemens

27-00292-16 2016204__

A bill to be entitled

An act relating to music therapists; amending s. 20.43, F.S.; establishing the music therapist profession within the Division of Medical Quality Assurance; creating part XVII of ch. 468, F.S., entitled "Music Therapists"; creating s. 468.851, F.S.; providing legislative intent; creating s. 468.852, F.S.; defining terms; creating s. 468.853, F.S.; creating the Music Therapy Advisory Committee; providing for membership and terms of members; requiring the division director to consult with the advisory committee before adopting or revising rules; authorizing the division to adopt rules; creating s. 468.854, F.S.; establishing requirements for licensure as a music therapist; creating s. 468.855, F.S.; providing application requirements; exempting certain applicants from the examination requirement; requiring certain fees to be deposited into the Medical Quality Assurance Trust Fund; creating s. 468.856, F.S.; establishing a licensure renewal process; creating s. 468.857, F.S.; providing for disciplinary grounds and actions; authorizing investigations by the division for allegations of misconduct; providing an effective date.

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

Section 1. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

27-00292-16 2016204__

20.43 Department of Health.—There is created a Department of Health.

(3) The following divisions of the Department of Health are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.
2. The Board of Medicine, created under chapter 458.
3. The Board of Osteopathic Medicine, created under chapter 459.
4. The Board of Chiropractic Medicine, created under chapter 460.
5. The Board of Podiatric Medicine, created under chapter 461.
6. Naturopathy, as provided under chapter 462.
7. The Board of Optometry, created under chapter 463.
8. The Board of Nursing, created under part I of chapter 464.
9. Nursing assistants, as provided under part II of chapter 464.
10. The Board of Pharmacy, created under chapter 465.
11. The Board of Dentistry, created under chapter 466.
12. Midwifery, as provided under chapter 467.
13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
14. The Board of Nursing Home Administrators, created under part II of chapter 468.
15. The Board of Occupational Therapy, created under part

III of chapter 468.

16. Respiratory therapy, as provided under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Music therapists, as provided under part XVII of chapter 468.

21.~~20.~~ Electrolysis, as provided under chapter 478.

22.~~21.~~ The Board of Massage Therapy, created under chapter 480.

23.~~22.~~ The Board of Clinical Laboratory Personnel, created under part III of chapter 483.

24.~~23.~~ Medical physicists, as provided under part IV of chapter 483.

25.~~24.~~ The Board of Opticianry, created under part I of chapter 484.

26.~~25.~~ The Board of Hearing Aid Specialists, created under part II of chapter 484.

27.~~26.~~ The Board of Physical Therapy Practice, created under chapter 486.

28.~~27.~~ The Board of Psychology, created under chapter 490.

29.~~28.~~ School psychologists, as provided under chapter 490.

30.~~29.~~ The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

31.~~30.~~ Emergency medical technicians and paramedics, as provided under part III of chapter 401.

Section 2. Part XVII of chapter 468, Florida Statutes, consisting of ss. 468.851-468.857, Florida Statutes, is created and entitled "Music Therapists."

Section 3. Section 468.851, Florida Statutes, is created to read:

468.851 Purpose.—The Legislature finds that the practice of music therapy should be subject to regulation to ensure the highest degree of professional conduct and to guarantee the availability of music therapy services provided by qualified professionals. This part is intended to protect the public from unqualified music therapists.

Section 4. Section 468.852, Florida Statutes, is created to read:

468.852 Definitions.—As used in this part, the term:

(1) "Advisory committee" means the Music Therapy Advisory Committee created under s. 468.853.

(2) "Board-certified music therapist" means an individual who has completed the education and clinical training requirements established by the American Music Therapy Association and who holds current board certification from the Certification Board for Music Therapists.

(3) "Director" means the director of the division.

(4) "Division" means the Division of Medical Quality Assurance within the Department of Health.

(5) "Music therapist" means a person licensed to practice music therapy pursuant to this part.

(6) "Music therapy" means the clinical and evidence-based

use of music interventions by a board-certified music therapist to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship. The term does not include the diagnosis or assessment of any physical, mental, or communication disorder.

Section 5. Section 468.853, Florida Statutes, is created to read:

468.853 Music Therapy Advisory Committee.—

(1) There is created within the division a Music Therapy Advisory Committee, which shall consist of five members.

(a) The director of the division shall appoint the members of the advisory committee to 4-year terms. The advisory committee shall consist of persons familiar with the practice of music therapy and provide the director with expertise and assistance in carrying out his or her duties pursuant to this part. The director shall appoint three members who practice as music therapists in this state; one member who is a licensed health care provider and is not a music therapist; and one member who is a layperson.

(b) Members serve without compensation.

(c) Members may serve consecutive terms at the will of the director. Any vacancy shall be filled in the same manner as the regular appointment.

(2) The advisory committee shall meet at least annually or as otherwise called by the director.

(3) The director shall consult with the advisory committee before setting or changing fees required under this part.

(4) The advisory committee shall provide analysis of disciplinary actions taken, appeals and denials, and license

revocations at least annually.

(5) The advisory committee may facilitate:

(a) The development of materials that the director may use to educate the public concerning music therapist licensure, the benefits of music therapy, and the use of music therapy by individuals and within facilities or institutional settings.

(b) Statewide dissemination of information between music therapists, the American Music Therapy Association or any successor organization, the Certification Board for Music Therapists or any successor organization, and the director.

(6) The director shall consult with the advisory committee before rules are adopted or revised pursuant to this section.

(7) The division may adopt rules to implement and administer this part.

Section 6. Section 468.854, Florida Statutes, is created to read:

468.854 Licensure requirements.—

(1) After January 1, 2017, an individual who is not licensed as a music therapist may not use the title "music therapist" or a similar title and may not practice music therapy. This part may not be construed as prohibiting or restricting the practice, services, or activities of any of the following:

(a) Any individual licensed, certified, or regulated under the laws of this state in another profession or occupation, or personnel supervised by a licensed professional in this state, performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that individual does not represent

himself or herself as a music therapist.

(b) Any individual whose training and national certification attests to the individual's preparation and ability to practice his or her certified profession or occupation, if that individual does not represent himself or herself as a music therapist.

(c) Any practice of music therapy as an integral part of a program of study for a student enrolled in an accredited music therapy program, if that student does not represent himself or herself as a music therapist.

(d) Any individual who practices music therapy under the supervision of a licensed music therapist, if that individual does not represent himself or herself as a music therapist.

(2) A music therapist may accept referrals for music therapy services from medical, developmental, mental health, or education professionals, family members, clients, or other caregivers.

(3) A music therapist must:

(a) Before providing music therapy services to a client for an identified clinical or developmental need, collaborate, as applicable, with the primary care provider to review the client's diagnosis, treatment needs, and treatment plan;

(b) During the provision of music therapy services to a client, collaborate, as applicable, with the client's treatment team;

(c) Conduct a music therapy assessment of a client to determine if treatment is indicated and, if treatment is indicated, must collect systematic, comprehensive, and accurate information to determine the appropriateness and type of music

therapy services to provide for the client;

(d) Develop an individualized music therapy treatment plan for the client which is based upon the results of the music therapy assessment. Such treatment plan must include individualized goals and objectives that focus on the assessed needs and strengths of the client and must specify music therapy approaches and interventions to be used to address these goals and objectives;

(e) Implement an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;

(f) Evaluate the client's response to music therapy and the music therapy treatment plan, documenting change and progress and suggesting modifications, as appropriate;

(g) Develop a plan for determining whether music therapy services continue to be needed. In making this determination, the music therapist shall collaborate with the client, the client's physician or other provider of health care or education to the client and family members of the client, and any other appropriate person upon whom the client relies for support;

(h) Minimize any barriers to ensure that the client receives music therapy services in the least restrictive environment;

(i) Collaborate with and educate the client and the client's family, the caregiver of the client, or any other appropriate person regarding the needs of the client which are being addressed in music therapy and the manner in which the

music therapy treatment addresses those needs; and

(j) Use appropriate knowledge and skills to inform practice, including the use of research, reasoning, and problem-solving skills to determine appropriate actions in the context of each specific clinical setting.

Section 7. Section 468.855, Florida Statutes, is created to read:

468.855 Issuance of licenses.—

(1) The division shall issue a music therapist license to an applicant who submits an application, on a form and in the manner approved by the division; applicable fees; and evidence satisfactory to the division that:

(a) The applicant is at least 18 years of age;

(b) The applicant holds a bachelor's degree or higher in music therapy, or its equivalent, from a program approved by the American Music Therapy Association or any successor organization within an accredited college or university;

(c) The applicant successfully completed a minimum of 1,200 hours of clinical training, with at least 180 hours in pre-internship experiences and at least 900 hours in internship experiences in an internship approved by an academic institution, the American Music Therapy Association or any successor organization, or both;

(d) The applicant is in good standing based on a review of the applicant's music therapy licensure history in other jurisdictions, including a review of any alleged misconduct or neglect in the practice of music therapy on the part of the applicant; and

(e) The applicant provides proof of passing the examination

for board certification offered by the Certification Board for Music Therapists or any successor organization or provides proof of being transitioned into board certification, and provides proof that the applicant is currently a board-certified music therapist.

(2) The division shall issue a license to an applicant for a music therapy license when the applicant completes and submits an application upon a form and in such manner as the division prescribes, accompanied by applicable fees and evidence satisfactory to the division that the applicant is licensed and in good standing as a music therapist in another jurisdiction where the qualifications required are equal to or greater than those required in this part at the date of application.

(3) The division shall waive the examination requirement until January 1, 2020, for an applicant who is designated as a registered music therapist, certified music therapist, or advanced certified music therapist and who is in good standing with the National Music Therapy Registry.

(4) Fees collected pursuant to this part shall be deposited into the Medical Quality Assurance Trust Fund as provided under s. 456.025.

Section 8. Section 468.856, Florida Statutes, is created to read:

468.856 Licensure renewal.—

(1) A license issued under this part must be renewed biennially. A license shall be renewed upon payment of a renewal fee if the applicant is in compliance with this part at the time application for renewal is made.

(2) To renew a license the licensee must provide:

(a) Proof of maintenance of status as a board-certified music therapist; and

(b) Proof of completion of a minimum of 40 hours of continuing education in a program approved by the Certification Board of Music Therapists or any successor organization, and any other continuing education requirements established by the division.

(3) A licensee shall inform the division of any changes to his or her address.

(4) Failure to renew a license results in forfeiture of the license. Licenses that have been forfeited may be restored within 1 year after the expiration date upon payment of renewal and restoration fees. Failure to restore a forfeited license within 1 year after the date of its expiration results in the automatic termination of the license, and the division may require the individual to reapply for licensure as a new applicant.

(5) Upon the written request of a licensee, the division may place an active license on inactive status, subject to an inactive status fee established by the division. The licensee, upon request and payment of the inactive license fee, may continue on inactive status for a period up to 2 years. An inactive license may be reactivated at any time by making a written request to the division and by fulfilling the requirements established by the division.

Section 9. Section 468.857, Florida Statutes, is created to read:

468.857 Disciplinary grounds and actions.—

(1) The following acts constitute violations of this part:

(a) Falsification of information submitted in connection with licensure or failure to maintain status as a board-certified music therapist.

(b) Failure to timely pay fees.

(c) Failure to provide requested information in a timely manner.

(d) Conviction of a felony.

(e) Conviction of any crime that reflects an inability to practice music therapy with due regard for the health and safety of clients and patients, or with due regard for the truth in filing claims with Medicare, Medicaid, or any third-party payor.

(f) Inability or failure to practice music therapy with reasonable skill and consistent with the welfare of clients and patients, including, but not limited to, negligence in the practice of music therapy; intoxication; incapacity; and abuse of or engaging in sexual contact with a client or patient.

(g) Any related disciplinary action by another jurisdiction.

(2) The division may conduct investigations into alleged violations of this section.

(3) The division may impose one or more of the following sanctions for a violation of this part:

(a) Suspension of a license.

(b) Revocation of a license.

(c) Denial of a license.

(d) Refusal to renew a license.

(e) Probation with conditions.

(f) Reprimand.

(g) A fine of at least $100, but not more than $1,000, for

each violation.

Section 10. This act shall take effect July 1, 2016.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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

SENATOR JEFF CLEMENS
27th District

September 17, 2015

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

Chair Bean:

I respectfully request that SB 204 – Music Therapists be added to the agenda for the next Committee on Health Policy meeting.

SB 204 provides licenses to board-certified music therapists in Florida to increase access to qualified music therapy services for Florida residents and limits the potential for harm to the public by ensuring music therapy can only be offered by licensed therapists.

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

Sincerely,

Senator Jeff Clemens
Florida Senate District 27

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

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/9/16
Meeting Date

SB 204
Bill Number (if applicable)

Topic Music therapy — support amendment

Amendment Barcode (if applicable) 676326

Name Ron Watson

Job Title Lobbyist

Address 3738 Mundon Way
Street

Phone (850) 567-1202

Tallahassee FL 32309
City *State* *Zip*

Email watson.strategies@comcast.net

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

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

Representing Certification Board for Music Therapists

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

SB 204
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Music Therapy

Name Ron Watson

Job Title Lobbyist

Address 3738 Mundon Way
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 850 567-1202

Email Watson.Strategies@comcast.net

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

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

Representing Certification Board for Music Therapists

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

01/19/16
Meeting Date

SB 204
Bill Number (if applicable)

Topic Music Therapy

Amendment Barcode (if applicable)

Name Lori Gooding

Job Title Co-Chair, Florida Music Therapy Task Force

Address 7784 Bass Ridge Trail
Street

Phone (850) 644-4295

Tallahassee FL 32312
City *State* *Zip*

Email lgooding@fsu.edu

Speaking: ☑ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date	Bill Number (if applicable)
	204

Topic Music Therapy

Amendment Barcode (if applicable)

Name Steve Sandler

Job Title

Address 803 Chestwood Ave (Street)

Phone 850 345-0281

Tallahassee (City) FL (State) 32303 (Zip)

Email SSandler77@comcast.net

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

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

Representing Parkinson's Outreach Association

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-19-16
Meeting Date

SB 204
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Music Therapy

Name Caleb Trotter

Job Title Attorney

Address 930 G St
Street

Phone 916-419-7111

Sacramento CA 95814
City *State* *Zip*

Email crt@pacificlegal.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Pacific Legal Foundation

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 212
INTRODUCER:	Health Policy Committee and Senator Gaetz
SUBJECT:	Ambulatory Surgical Centers
DATE:	January 20, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 212 allows patients in an ambulatory surgical center (ASC) to stay in the center for up to 24 hours. Current law requires that patients in an ASC be discharged on the same working day and restricts patients from staying overnight in an ASC.

The bill also requires, as a condition of licensure, that ASCs provide services to Medicaid and Medicare patients as well as patients who qualify for charity care. The bill defines "charity care" as uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

II. Present Situation:

Ambulatory Surgical Centers

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.[1]

[1] Section 395.002(3), F.S, defines "Ambulatory surgical center" or "mobile surgical facility" to mean a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the

In Florida, ambulatory procedures are performed in two settings, hospital-based outpatient facilities and freestanding ASCs. Currently, there are 431 licensed ASCs in Florida.[2] Of these, 413 are Medicare and/or Medicaid certified and 381 are accredited by either the Accreditation Association for Ambulatory Health Care (AAAHC) or by the Joint Commission.[3] In 2008, Medicare paid for 39.1 percent of all procedures performed in ASCs while Medicaid paid for 5.6 percent and commercial payors paid for 46.6 percent.

Between April 2014 and Mach 2015, there were 2,933,433 visits to ASCs in Florida.[4] Hospital outpatient facilities accounted for 31 percent and free standing ASCs accounted for 59 percent of the total number of visits. Freestanding ASC average charges range from $2,930 to $7,333 and hospital based ASC average charges range from $7,727 to $26,034 for the same time period.[5] Two of the most popular procedures to have performed on adults at an ASC include cataract procedures with 249,184 performed and colonoscopies with 218,745 performed, also during the same time period.[6]

In a survey of ASC research and literature, the Office of Program Policy Analysis and Government Accountability (OPPAGA) found that, generally, the impact that any competition between ASCs and hospitals had on hospitals was limited and that ASCs can save money when performing certain procedures. Additionally, OPPAGA did not identify any patterns associated with access to services in ASCs and found that the studies largely agreed that ASCs, in general, provide timely service and had low rates of unexpected safety events.[7]

ASC Licensure

ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.[8] Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including the:

- Affidavit of compliance with fictitious name;
- Registration of articles of incorporation; and
- ASC's zoning certificate or proof of compliance with zoning requirements.[9]

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practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003, F.S. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

[2] See AHCA presentation on Ambulatory Surgical Centers, slide 10, presented to the Health Policy Committee on June 10, 2015, (on file with the Senate Committee on Health Policy).

[3] Id.

[4] Agency for Health Care Administration, Florida Health Finder Search, http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx (last viewed January 14, 2016).

[5] Id.

[6] Id.

[7] Ambulatory Surgical Centers and Recovery Care Centers, OPPAGA, January 19, 2016, on file with Senate Health Policy Committee staff.

[8] Sections 395.001-395.1065, F.S., and Part II, Chapter 408, F.S.

[9] Rule 59A-5.003(4), F.A.C.

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including the:

- Governing body bylaws, rules and regulations;
- Roster of registered nurses and licensed practical nurses with current license numbers;
- Fire plan; and
- Comprehensive Emergency Management Plan.[10]

Rules for ASCs

Pursuant to s. 395.1055, F.S., AHCA is authorized to adopt rules for hospitals and ASCs. Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals, but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.

AHCA rule ch. 59A-5, F.A.C., implements the minimum standards for ASCs. Those rules also require policies and procedures to ensure the protection of patient rights.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, laboratory services, and radiologic services. In providing these services, ACSs are required to have certain professional staff available, including:

- A qualified person responsible for the daily functioning and maintenance of the surgical suite;
- An anesthesiologist, physician, a certified registered nurse anesthetist under the on-site medical direction of a licensed physician, or an anesthesiologist assistant under the direct supervision of an anesthesiologist who must be in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged;
- A registered professional nurse who is responsible for coordinating and supervising all nursing services;
- A registered professional circulating nurse for a patient during that patient's surgical procedure; and
- A registered professional nurse who must be in the recovery area at all times when a patient is present.[11]

[10] Rule 59A-5.003(5), F.A.C.
[11] Rule 59A-5.0085, F.A.C.

Infection Control Rules

ASCs are required to establish an infection control program involving members of the medical, nursing, and administrative staff. The program must include written policies and procedures reflecting the scope of the infection control program. The written policies and procedures must be reviewed at least every 2 years by the infection control program members. The infection control program must include:

- Surveillance, prevention, and control of infection among patients and personnel;
- A system for identifying, reporting, evaluating and maintaining records of infections;
- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC; and
- Development and coordination of training programs in infection control for all personnel.[12]

Emergency Management Plan Rules

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency. The ASC must review the plan and update it annually.[13]

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission or the AAAHC. The AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs. The AHCA is authorized to accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements. The AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.[14]

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements. However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.[15]

Medicare Requirements

ASCs are required to have an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.[16]

[12] Rule 59A-5.011, F.A.C.
[13] Rule 59A-5.018, F.A.C.
[14] Rule 59A-5.004, F.A.C.
[15] Id.
[16] 42 C.F.R. §416.2

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body, or licensed by a state agency, and CMS determines that such accreditation or licensure provides reasonable assurance that the conditions for coverage are met.[17] All of the CMS conditions for coverage requirements are specifically required in AHCA rule ch. 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require ASCs to have a:

- Governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- Quality assessment and performance improvement program;
- Transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- Disaster preparedness plan;
- Organized medical staff;
- Fire control plan;
- Sanitary environment;
- Infection control program; and
- Procedure for patient admission, assessment and discharge.

III. Effect of Proposed Changes:

CS/SB 212 amends the definition of "ambulatory surgical center" in s. 395.002, F.S., to allow a patient to be admitted and discharged from an ASC within 24 hours. Current law requires that patients be discharged from an ASC within the same working day and restricts patients from staying at an ASC overnight.

The bill also amends s. 395.003, F.S., to require, as a condition of licensure, that ASCs provide services to Medicaid and Medicare patients as well as patients who qualify for charity care. The bill defines "charity care" as uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

The bill also includes conformed changes for statutory cross-references.

The bill establishes an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[17] 42 C.F.R. §416.26(a)(1)

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 212 may have an indeterminate positive fiscal impact on patients in Florida who are able to have a surgical procedure performed in an ASC if the costs are less in these settings than in a hospital.

The bill may have an indeterminate negative fiscal impact on hospitals if more patients choose to have their procedures performed in an ASC rather than in a hospital.

The bill may have a negative fiscal impact on ASCs that are required to provide services to Medicare and Medicaid patients as well as patients who qualify for charity care if the ASCs do not currently provide such services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.002 and 395.003.

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 January 19, 2016:
The CS amends SB 212 to remove all provisions of the bill except a change to the definition of "ambulatory surgical center" which allows patients to recover in an ASC for 24 hours, rather than requiring that patients be released on the same business day. The CS

also requires that ASCs provide services to Medicaid and Medicare patients as well as patients who qualify for charity care. The CS defines "charity care" as uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

B. Amendments:

None.

974206

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/20/2016	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (3) of section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.—As used in this chapter:

(3) "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted

974206

to and discharged from such facility within 24 hours ~~the same working day and is not permitted to stay overnight~~, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

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

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to ambulatory surgical center; amending s. 395.002, F.S.; redefining "ambulatory surgical center" or "mobile surgical facility"; providing an effective date.

539582

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/20/2016	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (974206) (with title amendment)

Between lines 25 and 26
insert:

Section 2. Subsections (6), (7), (8), (9), and (10) of section 395.003, Florida Statutes, are renumbered as subsections (7), (8), (9), (10), and (11), respectively, and subsection (6) is added to that section, to read:

395.003 Licensure; denial, suspension, and revocation.—

539582

(6) As a condition of licensure and license renewal as an ambulatory surgical center each such facility must provide services to Medicare patients, Medicaid patients, and patients who qualify for charity care. For the purposes of this subsection, "charity care" means uncompensated care delivered to uninsured patients having incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

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

And the title is amended as follows:

Between lines 35 and 36

insert:

amending s. 395.003, F.S.; requiring, as a condition of licensure and license renewal, that ambulatory surgical centers provide services to specified patients;

487492

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/20/2016	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 136
and insert:
section.

By Senator Gaetz

1-00100A-16 2016212__

A bill to be entitled

An act relating to recovery care services; amending s. 395.001, F.S.; providing legislative intent regarding recovery care centers; amending s. 395.002, F.S.; revising and providing definitions; amending s. 395.003, F.S.; including recovery care centers as facilities licensed under chapter 395, F.S.; creating s. 395.0171, F.S.; providing admission criteria for a recovery care center; requiring emergency care, transfer, and discharge protocols; authorizing the Agency for Health Care Administration to adopt rules; amending s. 395.1055, F.S.; authorizing the agency to establish separate standards for the care and treatment of patients in recovery care centers; amending s. 395.10973, F.S.; directing the agency to enforce special-occupancy provisions of the Florida Building Code applicable to recovery care centers; amending s. 395.301, F.S.; providing for format and content of a patient bill from a recovery care center; amending s. 408.802, F.S.; providing applicability of the Health Care Licensing Procedures Act to recovery care centers; amending s. 408.820, F.S.; exempting recovery care centers from specified minimum licensure requirements; amending ss. 394.4787 and 409.975, F.S.; conforming cross-references; providing an effective date.

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

1-00100A-16 2016212__

Section 1. Section 395.001, Florida Statutes, is amended to read:

395.001 Legislative intent.—It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, construction, maintenance, and operation of hospitals, ambulatory surgical centers, recovery care centers, and mobile surgical facilities by providing for licensure of same and for the development, establishment, and enforcement of minimum standards with respect thereto.

Section 2. Subsections (3), (16), and (23) of section 395.002, Florida Statutes, are amended, subsections (25) through (33) are renumbered as subsections (27) through (35), respectively, and new subsections (25) and (26) are added to that section, to read:

395.002 Definitions.—As used in this chapter:

(3) "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within 24 hours ~~the same working day and is not permitted to stay overnight~~, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and

practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

(16) "Licensed facility" means a hospital, ambulatory surgical center, recovery care center, or mobile surgical facility licensed in accordance with this chapter.

(23) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital, ambulatory surgical, recovery, or mobile surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(45), reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

(25) "Recovery care center" means a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital.

(26) "Recovery care services" means postsurgical and postdiagnostic medical and general nursing care provided to patients for whom acute care hospitalization is not required and an uncomplicated recovery is reasonably expected. The term

includes postsurgical rehabilitation services. The term does not include intensive care services, coronary care services, or critical care services.

Section 3. Subsection (1) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 395.001-395.1065 and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to ss. 395.001-395.1065. A license issued by the agency is required in order to operate a hospital, ambulatory surgical center, recovery care center, or mobile surgical facility in this state.

(b)1. It is unlawful for a person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a "hospital," "ambulatory surgical center," "recovery care center," or "mobile surgical facility" unless such facility has first secured a license under the provisions of this part.

2. This part does not apply to veterinary hospitals or to commercial business establishments using the word "hospital," "ambulatory surgical center," "recovery care center," or "mobile surgical facility" as a part of a trade name if no treatment of human beings is performed on the premises of such establishments.

(c) Until July 1, 2006, additional emergency departments located off the premises of licensed hospitals may not be authorized by the agency.

Section 4. Section 395.0171, Florida Statutes, is created

to read:

395.0171 Recovery care center admissions; emergency and transfer protocols; discharge planning and protocols.—

(1) Admissions to a recovery care center shall be restricted to patients who need recovery care services.

(2) All patients must be certified by their attending or referring physician or by a physician on staff at the facility as medically stable and not in need of acute care hospitalization before admission.

(3) A patient may be admitted for recovery care services upon discharge from a hospital or an ambulatory surgery center. A patient may also be admitted postdiagnosis and posttreatment for recovery care services.

(4) A recovery care center must have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital.

(5) A recovery care center must have procedures for discharge planning and discharge protocols.

(6) The agency may adopt rules to implement this subsection.

Section 5. Subsections (2) and (8) of section 395.1055, Florida Statutes, are amended, and subsection (10) is added to that section, to read:

395.1055 Rules and enforcement.—

(2) Separate standards may be provided for general and specialty hospitals, ambulatory surgical centers, recovery care centers, mobile surgical facilities, and statutory rural hospitals as defined in s. 395.602.

(8) The agency may not adopt any rule governing the design,

construction, erection, alteration, modification, repair, or demolition of any public or private hospital, intermediate residential treatment facility, recovery care center, or ambulatory surgical center. It is the intent of the Legislature to preempt that function to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern hospitals, intermediate residential treatment facilities, recovery care centers, and ambulatory surgical centers.

(10) The agency shall adopt rules for recovery care centers which provide for an annual review of recovery care center policies and protocols governing licensure, utilization, patient safety, pharmacy services, infection control, and medical and nursing practices by a panel comprised of a physician, a nurse and a pharmacist who are licensed in Florida and who are not employed by or receiving compensation from a recovery care center. The rules must include fair and reasonable minimum standards for ensuring that recovery care centers have:

(a) A dietetic department, service, or other similarly titled unit, either on the premises or under contract, which shall be organized, directed, and staffed to ensure the provision of appropriate nutritional care and quality food service.

(b) Procedures to ensure the proper administration of medications. Such procedures shall address the prescribing,

ordering, preparing, and dispensing of medications and appropriate monitoring of the effects of such medications on the patient.

(c) A pharmacy, pharmaceutical department, or pharmaceutical service, or similarly titled unit, on the premises or under contract.

Section 6. Subsection (8) of section 395.10973, Florida Statutes, is amended to read:

395.10973 Powers and duties of the agency.—It is the function of the agency to:

(8) Enforce the special-occupancy provisions of the Florida Building Code which apply to hospitals, intermediate residential treatment facilities, recovery care centers, and ambulatory surgical centers in conducting any inspection authorized by this chapter and part II of chapter 408.

Section 7. Subsection (3) of section 395.301, Florida Statutes, is amended to read:

395.301 Itemized patient bill; form and content prescribed by the agency; patient admission status notification.—

(3) On each itemized statement submitted pursuant to subsection (1) there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER or RECOVERY CARE CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to identify clearly and plainly the ownership status of the licensed facility. Each itemized statement must prominently display the phone number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or his or her representative, and the

billing department.

Section 8. Subsection (30) is added to section 408.802, Florida Statutes, to read:

408.802 Applicability.—The provisions of this part apply to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, 483, and 765:

(30) Recovery care centers, as provided under part I of chapter 395.

Section 9. Subsection (29) is added to section 408.820, Florida Statutes, to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(29) Recovery care centers, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(10).

Section 10. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(30) ~~395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 11. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers

participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(30) ~~395.002(28)~~.

4. Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid

rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 12. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Education, *Chair*
Appropriations
Education Pre-K - 12
Ethics and Elections
Health Policy
Higher Education
Rules

SENATOR DON GAETZ
1st District

Committee Request

To: Senator Aaron Bean, Chair
Health Policy Committee

Subject: Committee Presentation Request

Date: October 8, 2015

I respectfully request that Senate Bill 212, Recovery Care Services, be placed on the Health Policy Committee agenda at your convenience. Thank you for your time and consideration.

Respectfully,

Senator Don Gaetz

REPLY TO:
❒ 4300 Legendary Drive, Suite 230, Destin, FL 32541 (850) 897-5747 FAX: (888) 263-2259
❒ 420 Senate Office Building, 404 South Monroe Street, Tallahassee, FL 32399-1100 (850) 487-5001
❒ 5230 West U.S. Highway 98, Administration Building, 2nd Floor, Panama City, FL 32401 (850) 747-5856

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

212
Bill Number (if applicable)

539582
Amendment Barcode (if applicable)

Topic Ambulatory Surgical Centers

Name Melissa Faust

Job Title Policy Analyst

Address 208 W. College Ave, Ste. 109
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-408-1218

Email mfaust@afphq.org

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Americans for Prosperity

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/2016
Meeting Date

212
Bill Number (if applicable)

Topic Ambulatory Surgical Centers

Amendment Barcode (if applicable)

Name Melissa Faust

Job Title Policy Analyst

Address 200 W. College Ave., Ste. 109
Street

Phone 850-408-1218

Tallahassee FL 32301
City *State* *Zip*

Email mfaust@afphq.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Americans for Prosperity

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

SB-212
Bill Number (if applicable)

Topic 23 Hour Stay

Amendment Barcode (if applicable)

Name Kathleen Myers

Job Title Director of Operations for SCA

Address 1402 Lexi Davis Street
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City *State* *Zip*

Phone 407-426-8331

Email Kathy.Myers@scdsurgery.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-19-2016
Meeting Date

SB 212
Bill Number (if applicable)

Topic 23 hour stay

Amendment Barcode (if applicable)

Name John W McCutcheon MD

Job Title Retired

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Ovieda FL 32765
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Email JohnMc1950@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Self

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

212
Bill Number (if applicable)

Topic Health Care

Amendment Barcode (if applicable)

Name DAVID SHAPIRO

Job Title Board Member

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TALLAHASSEE FL 32312
City *State* *Zip*

Email dshapiromd@yahoo.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL. Society of Ambulatory Surgical Centers

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ ~~No~~

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-19-2016
Meeting Date

212
Bill Number (if applicable)

Topic Healthcare

Amendment Barcode (if applicable)

Name Michael Mackenzie

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Speaking: ☑ For ☐ Against ☐ Information

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

Representing Panama City Surgery

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

2/2
Bill Number (if applicable)

Topic Recovery Care Services

Amendment Barcode (if applicable)

Name Fraser Cobbe

Job Title Executive Director

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City *State* *Zip*

Email fcobbe@cobbemanagement.com

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

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

Representing Florida Orthopaedic Society

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

SB 212
Bill Number (if applicable)

Topic ASC

Amendment Barcode (if applicable)

Name Bill Bell

Job Title General Counsel

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Street

Phone 222 9800

Tlh Fl 32301
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Email billbell@fhcaca.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Florida Hospital/ASN

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 526
INTRODUCER:	Senator Grimsley
SUBJECT:	Reimbursement of Medicaid Providers
DATE:	January 13, 2016
REVISED:	

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

I. Summary:

SB 526 amends s. 409.901, F.S., to add a definition of "usual and customary charge" specific to the Medicaid program. The term excludes free or discounted charges or goods based on a person's uninsured, indigent, or other financial hardship status.

The changes made by SB 526 are intended to clarify existing law and are remedial in nature.

The bill is effective July 1, 2016.

II. Present Situation:

Florida Medicaid Program

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

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

The Medicaid program has a variety of reimbursement arrangements with providers and suppliers; however, regardless of those payment arrangements the AHCA is required to make

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

timely payment arrangements upon receipt of a properly completed claim form. Section 409.907(5)(a), F.S., specifically states:

> (5) The agency:
>
> (a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the agency, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

Florida law further allows, with some exceptions, for Medicaid services to be reimbursed on a fee-for-service basis, in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, subject to any policy limitations in the General Appropriations Act. The statute specifies the amount billed by the provider as the provider's usual and customary charge, or the maximum allowable fee established by the agency, whichever amount is less, with the exception of those services or goods that the agency reimburses based on capitation rates, average costs, or negotiated fees.[2]

The Florida Medicaid Provider General Handbook, promulgated as Rule 59G-5.020 of the Florida Administrative Code, also requires that Medicaid services be reimbursed at the lesser of the Medicaid fee or the provider's usual and customary charge, except for cost-based or capitation reimbursed providers. For prescribed drug services, a similar rule applies. Providers must ensure that the average charge does not exceed the charge to all other customers in any quarter for the same drug, quantity, and strength.[3,4]

Medicaid managed care plans must reimburse non-contracted providers for emergency services for their enrollees at either the lesser of the provider's charges, usual and customary charges for similar services, the charge mutually agreed upon by the parties within 60 days of claim submission, or the Medicaid rate. [5]

All of these Medicaid statutes or administrative rule references use the term "usual and customary charges"; however, the term is not currently defined in either state law or administrative rule.

---

[2] Section 409.908(3), F.S. *See also* s. 409.908(11), F.S., addressing reimbursement for independent laboratory services, s. 409.908(14), F.S., pertaining to reimbursement for prescribed drugs, and s. 409.908(20), F.S., relating to renal dialysis facilities.
[3] Rule 59G-4.250, F.A.C.
[4] Agency for Health Care Administration, *Florida Medicaid Prescribed Drug Services, Coverage, Limitations and Reimbursement Handbook* (July 2014), pp. 16, 88, https://www.flrules.org/Gateway/reference.asp?No=Ref-04163 (last visited Dec. 29, 2015).
[5] *See* s. 409.9128(5), F.S. and s. 409.967, F.S.

Definition of Usual and Customary

In the context of health care claims, the term "usual and customary charge" has been accepted as a term of art and its definition generally agreed upon by the parties transacting business, in this case the health care provider and the insurer or claims payor.

The American Medical Association (AMA) defines "usual, customary and reasonable" or "UCR" as:

> 1. Our AMA adopts as policy the following definitions:
>
> (a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
> (b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
> (c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.[6]

Medicare and Medicaid Programs

The federal CMS provides a definition of UCR on its website as: "the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount."[7]

Additionally, federal regulations further define "customary charges":

> **(a)** ***Customary charge defined.*** The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in § 405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. Payment for covered services would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be

[6] American Medical Association, H-385-923, *Definition of Usual, Customary and Reasonable" (UCR),* https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-385.923.HTM *(*last visited Jan. 6, 2016).
[7] Centers for Medicare and Medicaid Services, *Glossary - Usual, Customary and Reasonable (UCR),* https://www.healthcare.gov/glossary/UCR-usual-customary-and-reasonable/ (last visited: Jan. 6, 2016).

> taken into account by the carrier in determining the amount which is considered to be a reasonable charge for a service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.[8]

The regulations permit a physician to vary his or her charges for the same service, and under the Medicare program, the carrier would then develop a median or midpoint of his or her charges as the customary charge. The customary charge is not expected to remain the same and may be amended as long as the new customary charge is not above the top range of the prevailing charges.[9]

A proposed regulation for Medicare laboratory services was released in October 2015 which would change reimbursement beginning January 1, 2017 to reflect market rates for most lab tests.[10]

Medicaid federal regulations also define customary charges specific to inpatient and outpatient facility services as "customary charges of the provider that must not be more than the prevailing charges in the locality for comparable services under comparable circumstances."[11]

For the Florida Medicaid program, subsection 409.908(3), F.S., establishes payment directions for reimbursement on a fee-for-service basis. Such payments are to be: "the amounts billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency." Subsection (11) of that same section addresses independent laboratory services, requiring reimbursement to be "the least of the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the agency." The statute does not define usual and customary charge.

The Florida Medicaid Handbook, as promulgated in Rule 59G-5.020, F.A.C., does describe the UCR reimbursement methodology more precisely for pharmacy claims, specifically Rule 59G-4.250, F.A.C. The policy handbook defines UCR and re-states it as the provider's charges must not exceed the average charge to all other customers in any quarter for the same drug, quantity, and strength.[12]

Medicaid managed care plans must act in accordance with a different state statute when enrollees receive emergency services from non-contracted providers and reimburse these providers the lesser of:

- The provider's charges;
- The usual and customary provider's charges for similar services in the community where provided;

[8] *See* 42 CFR 405.503 (2015).
[9] Id.
[10] *See* Medicare Program; Medicare Clinical Diagnostic Laboratory Tests Payment System; Proposed Rule; Vol. 80 Fed. Reg. 59386 (Oct. 1, 2015)(to be codified at 42 CFR Part 414).
[11] 42 CFR 447.325 (2015).
[12] Agency for Health Care Administration, *Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook* (July 2014), p. 1-2.

- The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or
- The Medicaid rate.[13]

The AHCA initiated rulemaking in September 2014 to update its existing definitions and adopt a definition for "usual and customary charge." The proposed definition under that notice meant that the usual and customary charge phrase related only to Medicaid-enrolled independent laboratory service providers and meant the most frequent price or fee accepted as full payment by the provider from the provider's non-Medicaid Florida customers.[14]

Administrative petitions against the rule were filed by several laboratory providers for Medicaid with the State of Florida Division of Administrative Hearings (DOAH) that sought to invalidate the proposed rule as an "invalid exercise of delegated legislative authority."[15] Under a Settlement Agreement, the litigating parties agreed that the AHCA would not rely upon the proposed definition of usual and customary charge as stated in the proposed rule for any agency action, unless it is adopted as a rule and the AHCA would withdraw the definition from the Notice of Proposed Rule.[16] The AHCA withdrew the entire Proposed Rule in the January 13, 2015 publication of the Florida Administrative Registrar.[17]

Reimbursement for Laboratory Services - Qui Tam Action Against Certain Providers[18]

In a *qui tam* action, a private party, known as a relator, brings an action against a person or a corporation on behalf of the government. Such actions are also known as whistle blower lawsuits. The private citizen plaintiff is authorized to prosecute the lawsuit; however, the government may intervene in the action. If the suit is successful, the relator receives a share of the award.

In an action under the Federal False Claims Act (FCA), the *qui tam* action is against a party who has defrauded the federal government.[19] A relator in a successful False Claims Action may receive up to 30 percent of the government's award. Florida also has its own Florida False Claims Act under ss. 68.081 -092, F.S., which allows the Department of Legal Affairs or a person to bring a *qui tam* action. A person who brings an action under Florida's statute receives at least 15 percent, but not more than 25 percent of the proceeds of any successful action or settlement of the claim.

In 2007, Hunter Labs and Chris Riedel filed a *qui tam* action under the Florida False Claims Act in the circuit court in Leon County, alleging that LabCorp and Quest Diagnostics (LabCorp/Quest) had defrauded the Medicaid program by overcharging for laboratory services.

[13] *See* ss. 409.9128(5) and 409.967, F.S.
[14] Vol. 40. Fla. Admin. Register, p. 4145 (Sept. 25, 2014).
[15] Laboratory Corp. of America v. Agency for Health Care Admin., Case No. 14-5381RP and Quest Diagnostic v. Agency for Health Care Admin. v. Agency for Health Care Admin., Case No. 14-5507RP (Fla. DOAH 2014) *Cases Consolidated.*
[16] Id at 3.
[17] *See* Vol. 4, Florida Administrative Register, p. 178 (Jan. 13, 2015).
[18] *See State of Florida ex rel. Hunter Laboratories, LLC and Chris Riedel v. Quest Diagnostics, Inc., et al, in the Circuit Court for the Second Judicial Circuit in and for Leon County, case number 2007-CA-003549.*
[19] *See* 31 U.S.C. §3279.

In 2013, the state Attorney General (AG) intervened in the lawsuit alleging that LabCorp/Quest defrauded the state by failing to charge the Medicaid program its lowest charge to any other third party payer for laboratory services.

Following the 2014 DOAH Consent Order on the AHCA's "invalid exercise of delegated authority," the AG modified its legal theory against LabCorp/Quest in the *qui tam* action. The AG alleges that LabCorp/Quest defrauded the Medicaid program by charging more than their usual and customary charge and defined usual and customary charge as any amount accepted by LabCorp/Quest as payment from any other third-party payer.[20]

Although litigation of the petitions with DOAH over the administrative rule have been resolved, the *qui tam action* is currently ongoing.

III. Effect of Proposed Changes:

Section 1 - The bill adds a definition for "usual and customary charge" to s. 409.901, F.S., as applicable to the Medicaid program. The "usual and customary charge" is defined as the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before any discount, rebate, or supplemental plan is applied. Free or discounted charges for services or goods based on a person's economic hardship status are not included in the definition.

Section 2 - The bill provides that the changes made to s. 409.901, F.S., clarify existing law and are remedial in nature.

Section 3 - The effective date of the bill is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[20] Defendant Laboratory Corp. of America and Laboratory Corp. of America Holdings' Memorandum in Support of their Motion to Dismiss the State's Amended Intervention Complaint, at 5-6, State of Florida ex rel Hunter Laboratories, LLC and Chris Riedel v. Quest Diagnostics, Inc., No. 2007-CA-003549 (2nd Cir. Apr. 28, 2014).

D. Other Constitutional Issues:

SB 526 provides that it is intended to clarify existing law and is remedial in nature. Retroactive application of a statute is generally unconstitutional if the statute impairs vested rights, creates new obligations, or imposes new penalties.[21]

To determine whether a statute should be retroactively applied, courts apply two interrelated inquiries. First, courts determine whether there is clear evidence of legislative intent to apply the statute retrospectively. If so, then courts determine whether retroactive application is constitutionally permissible.[22]

The second prong looks to see if a vested right is impaired. To be vested, a right must be more than a mere expectation based on an anticipation of the continuance of an existing law. It must be an immediate, fixed right of present or future enjoyment.[23] This bill contains a finding that it is remedial. "Remedial statutes or statutes relating to remedies or modes of procedure, which do not create new or take away vested rights, but only operate in furtherance of the remedy or confirmation of rights already existing, do not come within the legal conception of a retrospective law, or the general rule against retrospective operation of statutes."[24]

To the extent this law confirms a definition of "usual and customary charge" already in existence, this law may be constitutionally permissible.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

For purposes of Medicaid billing, a Medicaid provider or supplier may be required to modify its billing system to accommodate how it calculates charges for Medicaid enrollees if its definition of usual and customary is different than the definition proposed under SB 526.

Additionally, to the extent that a payor aligns its payment practices to those of the Medicaid program, the addition of a statutory definition for usual and customary may impact that payor's own reimbursement guidelines.

[21] *See State Farm Mutual Automobile Insurance Company v. Laforet*, 658 So.2d 55, 61 (Fla. 1995).
[22] *See Florida Ins. Guar. Ass'n, Inc., v. Devon Neighborhood Ass'n, Inc.*, 67 So.3d 187, 194 (Fla. 2011); *See, also Metropolitan Dade County v. Chase Federal Housing Corp.*, 737 So.2d 494, 499 (Fla. 1999).
[23] *See R.A.M. of South Florida, Inc. v. WCI Communities, Inc.*, 869 So.2d 1210, 1218 (Fla. 2d DCA 2004).
[24] *City of Lakeland v. Catinella*, 129 So.2d 133, 136 (Fla. 1961).

C. Government Sector Impact:

The AHCA reports the bill's clarification of the term "usual and customary charge" will have no operational or fiscal impact on the Medicaid program.[25] Adding the definition to s. 409.901, F.S., will clarify a term that is used in multiple sections of the statutes relating to Medicaid, but is not currently defined in either statute or administrative rule.

VI. Technical Deficiencies:

The definition for "usual and customary" references both providers and suppliers of goods and services. The Medicaid definitions section, s. 409.901, F.S., defines only "Medicaid provider" or "provider" and does not include the term "supplier." It may not be clear for which Medicaid vendors the definition is applicable.

It determining the usual and customary charges by a provider or supplier, the definition does not clarify if the services or goods provided to an uninsured consumer must be medically or necessary or not to be included in the calculation.

VII. Related Issues:

Litigation over how to define, calculate, and what information sources should be used in the calculation for UCRs have been an issue in many states. The AMA and several state medical societies have filed several lawsuits against large insurers which used the same database as their benchmark on which to determine out-of-network payments. For example, when an insured member used an out-of-network provider, the insurer may have covered 80 percent of the UCR of that visit and the insured member would then be responsible for the remaining 20 percent. The AMA alleged that the insurers systematically used unreliable or inaccurate data to calculate the UCR to set those reimbursement amounts.

The New York Attorney General's Office began an investigation in 2008 to determine if insurers had defrauded consumers through manipulation of reimbursement rates. As a result, the investigation found that one such database was defective and that most major insurers used it to set rates for out-of-network reimbursement. New York's Department of Insurance issued a new regulation in 2009 requiring "usual and customary rates" to reflect market rates and prohibited the use of third party sources with a pecuniary interest in the development or use of the UCR. The plans involved signed a Settlement Agreement which required their financial contribution towards the creation of the FAIR Health systems as a replacement database which collects millions of health care bills; however, the Settlement Agreement did not require the plans to use this system as the new benchmark.[26]

In 2009, the United State Senate Commerce Committee (Committee) conducted an investigation into how the insurance industry reimburses consumers for services who buy "out-of-network" health insurance coverage. The Committee found that in every region of the United States, large health insurance companies had been using the same two faulty databases to under-pay insurance

[25] Agency for Health Care Administration, *Senate Bill* 526 *Agency Analysis*, p. 2, (Oct. 15, 2015).
[26] Physicians for a National Health Program, *Insurers Dodge Intent of Ingenix Settlement, (New York Times, April 23, 2012),* Nina Bernstein, http://www.pnhp.org/news/2012/april/insurers-dodge-intent-of-ingenix-settlement (last visited: Jan. 6, 2016).

claims. While many of the companies responding to the Committee's correspondence noted that the information was used only on a small percentage of their claims, the report highlighted that "even a small percentage of the tens of millions of claims these insurance companies pay every year is a substantial number."[27]

In 2010, Florida's First District Court of Appeal reviewed a case involving the calculation of reimbursement charges and reimbursement rates for emergency medical services between a hospital and an insurance plan where no contractual relationship existed for health maintenance organization enrollees. Part of the appeal involved the variety of ways that prices are set for emergency services, including defining "usual and customary provider charges."

The court noted that "when a statute does not define a term, we rely on the dictionary to determine the definition."[28] Using Black's Law Dictionary:

- "Charge" is defined as "price, cost, or expense."[29]
- "Usual" is defined as "ordinary, customary, and expected based on previous experience."[30]
- "Customary" is defined as "a record of all of the established legal and quasi-legal practices in a community."[31]

Taking the three terms together, the *Baker* court concluded that "usual and customary charges" in the context of the statute meant fair market value and fair market value is "the price that a willing buyer will pay and a willing seller will accept in an arm's length transaction.[32] The court made one exception to this willing buyer and willing seller scenario: reimbursement rates for Medicaid and Medicare are set by government agencies and, therefore, it would not be appropriate to consider the amount accepted by providers for patients covered by these programs.[33]

VIII. Statutes Affected:

This bill substantially amends section 409.901 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

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[27] U.S. Senate Committee on Commerce, Science and Transportation, Office of Oversight and Investigations, *Underpayments to Consumers by the Health Insurance Industry (Staff Report for Chairman Rockefeller, June 24, 2009)*, https://www.commerce.senate.gov/public/index.cfm/reports?ID=1C8A4657-86C1-4461-9927-3727CB502EBF (last visited Jan. 6, 2016).

[28] *See* Baker County Medical Services, Inc. v. Aetna Health Mgmt., 31 So.3d 842, 845(Fla. 2010), quoting Green v. State, 604 So.2d 471, 473 (Fla. 1992).

[29] Id. *See also* Black's Law Dictionary 248 (8th ed. 2004).

[30] Id. *See also* quoting also Black's Law Dictionary at 1579.

[31] Id. *See also* Black's Law Dictionary at 413.

[32] Baker County Medical Services, Inc. v. Aetna Health Mgmt., 31 So3d 842, 845 (Fla. 2010). *See also* United States v. Cartwright, 411 U.S. 546, 551, 93 S.Ct. 1713, 36 L.Ed.2d 528 (1973).

[33] Id at 845-846.

B. Amendments:

None.

720102

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (11) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in

720102

policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(11) A provider of independent laboratory services shall be reimbursed on the basis of competitive bidding or for the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency. For purposes of ss. 409.901-409.9201

720102

and with respect to a provider of independent laboratory services, the term "usual and customary charge" means the amount routinely billed by the provider to an uninsured consumer for services or goods before the application of any discount, rebate, or supplemental plan. Free or discounted charges for services or goods based on a person's uninsured or indigent status or other financial hardship are not usual and customary charges. This subsection is intended to be remedial in nature and to clarify existing law, and shall apply retroactively.

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

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid providers of independent laboratory services; amending s. 409.908, F.S.; providing a definition of "usual and customary charge" for providers of independent laboratory services; providing for applicability; providing an effective date.

By Senator Grimsley

21-00570A-16 2016526__

A bill to be entitled

An act relating to reimbursement of Medicaid providers; amending s. 409.901, F.S.; defining the term "usual and customary charge" for purposes of Medicaid billing; providing applicability; providing an effective date.

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

Section 1. Subsection (29) is added to section 409.901, Florida Statutes, to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(29) "Usual and customary charge" means the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before application of any discount, rebate, or supplemental plan. The term does not include free or discounted charges for services or goods based upon a person's uninsured or indigent status or other financial hardship.

Section 2. The changes made by this act to s. 409.901, Florida Statutes, are intended to clarify existing law and are remedial in nature.

Section 3. This act shall take effect July 1, 2016.

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

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 22, 2015

I respectfully request that **Senate Bill 504**, relating to Laser Hair Removal and **SB 526**, relating to Reimbursement of Medicaid Providers be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Denise Grimsley
Florida Senate, District 21

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

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

526
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Paul Lambert

Job Title _____

Address 263 Rosehill Drive North
Street
Tallahassee, FL 32312
City *State* *Zip*

Phone 850 597-2696

Email plambert@paullambertlaw.com

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

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

Representing _____

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

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

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

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

S-001 (10/14/14)

The Florida Senate

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 938
INTRODUCER:	Health Policy Committee and Senator Benacquisto
SUBJECT:	Retail Sale of Dextromethorphan
DATE:	January 19, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 938 prohibits a retail entity from knowingly and willingly selling a finished drug product containing dextromethorphan (DXM) to an individual less than 18 years of age. DXM is most commonly used to relieve coughs due to colds or influenza. The bill requires proof of age from any individual presumed to be less than 25 years of age prior to purchasing a finished drug product with any quantity of DXM. The requirement does not apply to medication sold by a retail entity pursuant to a valid prescription.

CS/SB 938 provides for a written first warning, then a civil citation of no more than $100 for each subsequent violation for retailers, wholesalers, and distributers for selling DXM to a person 18 years of age or younger in violation of this act. However, a manufacturer, distributor, or retailer may avoid the fine for the employee's or representative's sale upon a showing of a good faith effort to comply with the requirements. An employee or representative who sells DXM in violation of this act is subject to a written warning.

The bill establishes requirements for the delivery of civil citations to the manager on duty by local law enforcement and for the specific content of the citations. Civil citation recipients will also be notified of a dispute process with hearings held in the local jurisdiction. Enforcement of this act shall remain with local law enforcement and with the officials charged with the enforcement of the laws of this state.

The act does not impose restrictions on the placement of products in a retail store, direct access by consumers to products, or the maintenance of transaction records. This act preempts any local ordinance regulating the sale, distribution, receipt, or possession of DXM, and it is not subject to further regulation by such political subdivisions.

The bill has an indeterminate fiscal impact and is effective January 1, 2017.

II. Present Situation:

Dextromethorphan (DXM) is an antitussive medicine most commonly used to relieve coughs due to colds or influenza.[1] It is available without a prescription and sold under popular brand names such as Robitussin, Pediacare, Coricidin, and Vicks 44. The federal Drug Enforcement Agency (DEA) reports that the most commonly abused products are Robitussin and Coricidin.[2] Illicit use of these drugs is also known as "Robo-tripping" or "skittling."[3] DXM can be found in the form of cough syrup, tablets, capsules or powder.

DXM is in almost half of all over-the-counter (OTC) drugs sold in the United States.[4] More than 120 OTC products contain DXM either alone or in combination with other drugs such as analgesics (for example: acetaminophen), antihistamines, decongestants, and/or expectorants.[5] DXM was first approved by the Food and Drug Administration (FDA) in 1958 as a safe and effective cough suppressant. In response to growing reports of teenagers dying from the use of raw DXM, the FDA issued a warning about its dangers in 2005.[6] A total of 10.7 million DXM medications were dispensed in 2013.[7]

On its own, DXM is very safe; however, when taken in large doses, it may cause hallucinations, a heightened sense of awareness, and altered time perception.[8] Cough medicine abuse seems to be most popular among teens and younger children as cough medicine is often cheap, easy to get, and legal. A powdered version of DXM is sold over the internet.

At high doses, DXM can cause:
- Impaired vision;
- Sweating and fever;
- Rapid breathing;
- Increased and irregular heart rate and blood pressure;
- Nausea, vomiting, and diarrhea;

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[1] Mayo Clinic, *Dextromethorphan,* http://www.mayoclinic.org/drugs-supplements/dextromethorphan-oral-route/description/drg-20068661 (last visited Jan. 13, 2016).
[2] Drug Enforcement Administration, *Dextromethorphan* (March 2014), http://www.deadiversion.usdoj.gov/drug_chem_info/dextro_m.pdf (Last visited Jan. 13, 2016).
[3] Id.
[4] WebMD, *Teen Abuse of Cough and Cold Medicine,* http://www.webmd.com/parenting/teen-abuse-cough-medicine-9/teens-and-dxm-drug-abuse (last visited Jan. 13, 2016).
[5] *Supra* note 2.
[6] U.S. Food and Drug Administration, *Dextromethorphan Talk Paper* (May 20, 2005), http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm151133.htm (last visited Jan. 13, 2016).
[7] *Supra* note 4.
[8] Id.

- Slurred speech;
- Impaired judgment and mental function;
- Memory loss;
- Rapid eye movements;
- Hallucinations and dissociative effects; and
- Coma.[9]

The American Association of Poison Control Centers reported 45,748 case mentions, 33,811 single exposures, and six deaths related to DXM as of the March 2014 DEA update.[10]

DXM is not currently a controlled substance nor a regulated chemical under the Controlled Substances Act (CSA).[11] The CSA is a federal statute that prescribes and regulates the United States' drug policy which includes the manufacture, importations, possession, use, and distribution of certain substances. Federal law provides five schedules of controlled substances, known as Schedules I, II, III, IV, and V. The placement of a substance under a specific schedule is made based on a number of criteria for the drug or substance:

- Potential for abuse;
- Accepted medical use in treatment in the United States;
- Safety for use of the drug or substance; and
- Abuse of the drug or substance which leads to psychological or physical dependence.[12]

For example, a Schedule I substance has a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for its use as opposed to a Schedule V drug that has a low potential for abuse relative to a Schedule IV drug, has a currently accepted medical use for treatment in the United States, and abuse of the drug or other substance may lead to limited physical or psychological dependence relative to the drugs or substances in Schedule IV.[13]

In Congress, the DXM Abuse Prevention Act of 2015 (H.R. 3250) was introduced in July 2015 to specifically address DXM issues. The legislation would:

- Restrict its sale to individuals under 18 years of age, except those with a valid prescription or on active military duty;
- Require retailers to verify individuals are at least 18 years of age and to implement an electronic, point of sale verification system;
- Provide affirmative defenses to retailers who check identifications and reasonably conclude the identification is valid and the individual is 18 years of age;
- Create penalties for violations ranging from a warning for a first violation to up to $5,000 for a fourth or subsequent violation;
- Prohibit possession or receipt of unfinished DXM by any person not registered, licensed, or approved under federal or state law to practice pharmacy, engage in pharmaceutical production, or manufacture or distribute drug ingredients;
- Prohibit the distribution of unfinished DXM to unregistered or unlicensed persons; and

[9] Id.
[10] *Supra* note 2.
[11] Comprehensive Drug Abuse Prevention and Control Act of 1970, H.R. 18583, 91st Cong. (1970).
[12] 21 U.S.C. §812(b) (2014).
[13] Id.

- Establish a civil penalty of up to $100,000 for the unfinished DXM possession, receipt, and distribution violations.

The legislation has not been heard in committee.

III. Effect of Proposed Changes:

CS/SB 938 creates an undesignated section of law to establish restrictions on the sale of dextromethorpham (DXM) to individuals younger than 18. The bill provides definitions for:

- "Finished drug product" which means a drug legally marketed under the Federal Food, Drug, and Cosmetic Act that is in finished dosage form. The term "drug" has the same meaning as provided in s. 499.003(18), F.S.
- "Proof of Age" which means any document issued by a governmental agency that contains the date of birth and a description or photograph of the person purchasing the finished drug product. The term includes, but is not limited to, a passport, driver license, or a government identification card issued by this state, another state, or any branch of the United States Armed Forces.

The bill prohibits the sale of any finished drug product containing any quantity of DXM by any retail entity knowingly or willfully to any individual under the age of 18 without a valid prescription. A person 18 years of age or younger may not purchase a finished drug product containing any quantity of DXM, without a prescription.

Under the bill, an employee or representative of a retailer of a finished drug product containing any quantity of DXM is required to obtain proof of age from any purchaser prior to sale unless it would be reasonable to presume the purchaser is 25 years of age or older.

Each sales location of a manufacturer, distributor, or retailer whose employees or representatives sells DXM in violation of this act is subject to a written warning for the first warning and a civil citation of not more than $100 for each subsequent violation. Civil citations may accrue and be recovered in a civil action by the local jurisdiction. However, the fine may be waived if the manufacturer, distributor, or retailer demonstrated a good faith effort to comply with the requirements.

An employee or representative of a manufacturer, distributor, or retailer who sells DXM during the course of his or her employment in violation of these requirements, is subject to a written warning.

If a person possesses or receives DXM with the intent to distribute, a civil citation of not more than $100 for each violation shall be assessed by the local jurisdiction. A civil citation must also provide information on how to dispute the citation and clearly state that the citation is not a criminal violation. No consequences are imposed on a person who purchases DXM if no intention to distribute exists.

CS/SB 938 requires a civil citation that is directed towards a manufacturer, distributor, or retailer be delivered to the manager on duty at the time the citation is issued. If not available, the local law enforcement officer, is required to attempt to contact the manager; or, if unsuccessful, the

local law enforcement officer may leave a copy with an employee who is 18 years of age or older and mail a copy of the citation by certified mail to the business owner's address, as listed on the Department of State's records.

The bill provides specific components for the civil citation, including:

- The date and approximate time of the sale in the violation;
- The location of the sale, including the address;
- The name of the employee or representative that completed the sale;
- Information on how to dispute the citation;
- Notice that the citation is a non-criminal violation;[14]and
- How to dispute the notice and what to expect in the dispute process.

CS/SB 938 requires uniform application of the program with enforcement through local law enforcement and other officials charged with enforcement of state laws.

The bill does not impose any restrictions on the placement of products in retail stores, direct access of customers to finished drug products, or the maintenance of transaction records. The act also does not apply to medication containing DXM sold by a retail entity pursuant to a valid prescription.

CS/SB 938 does not create a criminal violation; a person who violates this act commits a non-criminal violation as defined in s. 775.08(3), F.S.[15]

CS/SB 938 preempts any local ordinances regulating the sale, distribution, receipt, or possession of DXM and DXM is not subject to any further regulation by county, municipality, or other political subdivisions of the state.

The bill is effective January 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[14] In Florida law, the term "non-criminal violation" or "non-criminal offenses" refers to offenses that are punishable by no other penalty other than a fine, forfeiture, or other civil penalty. A non-criminal violation is one that does not constitute a crime and a conviction for one these offenses would not give rise to any legal disability based on a criminal offense. Examples of non-criminal offenses include some traffic-related offenses, parking violations or citations for loud-noises.
[15] Id.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Retailers, manufacturers, and distributers would be required to train employees and associates to check the identification of any individuals purchasing any quantity of DXM who appeared to be less than 25 years of age.

Unlawful sales subjects the retailers, manufacturers, and distributers to a $100 fine after a written warning in most cases. However, if a manufacturer, distributor, or retailer makes a "good faith effort" to comply with this law, it will not incur the $100 fine for the unlawful sale by an employee or associate. Persons who possess or receive DXM in violation of this bill, with the intention to distribute the DXM, are subject to a $100 fine.

C. Government Sector Impact:

The Department of Health has indicated that there would be no fiscal impact to implement the provisions of this act. As the regulator of pharmacies, the department is assumed to have the responsibility of monitoring the manufacturers, retailers, and distributers in their compliance efforts as well as the good faith efforts of their employees and associates.

Local law enforcement agencies will be required to monitor the activities of retailers, manufacturers, and distributors for the unlawful sales of DXM. Written warnings are required for first time offenders and citations for repeat offenders. In those instances when individuals elect to dispute their citations and fines, courts in the county where the citation was issued may incur costs related to holding hearings and disposing of the matter.

Counties, municipalities, and other political subdivisions of the state are preempted from any local regulation over the sale, distribution, possession, or receipt of DXM.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill prohibits the purchase of a finished drug product containing any quantity of DXM by a person 18 years old and younger. This age description includes an 18 year old who is considered an adult under the law and is different from the age range to describe to whom sale of DXM may not be made. The sale may not be made to "persons younger than 18 years of age." This description does not include an 18 year old individual.

An exception is made for products sold pursuant to a valid prescription. The bill does not address situations where a person younger than 18 years of age may be an emancipated minor or on active military duty, an exception made in the proposed federal legislation.

VIII. Statutes Affected:

This bill creates an undesignated section of law in 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 January 19, 2016:
The committee substitute:

- Modifies the definitions for "finished drug product" and "proof of age";
- Subjects each sales location of a manufacturer, distributor, and retailer whose employee or representative sells dextromethorphan (DXM) to someone under age 18 to a violation of this act and provides for a written first warning followed by a civil citation with no more than a $100 fine for each subsequent violation;
- Provides that fines assessed under this act may accrue and may be recovered in a civil action brought by the local jurisdiction;
- Subjects an employee or representative of a manufacturer, distributor, or retailer who sells DXM in violation of this act to a written warning;
- Subjects a person who possesses or receives DXM with the intent to distribute to a civil citation and fine for each violation which may be recovered in a civil action;
- Describes the contents of a civil citation;
- Provides a process for notification of a written warning or civil citation to the manager on duty;
- Requires uniformity in application across the state, but enforcement remains with local law enforcement departments and officials charged with enforcement of state laws; and
- Clarifies that the bill does not create a criminal violation.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/19/2016	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Restrictions on sale of dextromethorphan.-

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

(a) "Finished drug product" means a drug legally marketed under the Federal Food, Drug, and Cosmetic Act that is in finished dosage form. For purposes of this paragraph, the term "drug" has the same meaning as provided in s. 499.003(18).


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(b) "Proof of age" means any document issued by a governmental agency that contains the date of birth and a description or photograph of the person purchasing the finished drug product. The term includes, but is not limited to, a passport, a driver license, or an identification card issued by this state, another state, or any branch of the United States Armed Forces.

(2)(a) A manufacturer, distributor, or retailer, or its employees and representatives, may not knowingly or willfully sell a finished drug product containing any quantity of dextromethorphan to a person younger than 18 years of age.

(b) A person 18 years of age or younger may not purchase a finished drug product containing any quantity of dextromethorphan.

(3) An employee or representative of a retailer making a retail sale of a finished drug product containing any quantity of dextromethorphan must require and obtain proof of age from the purchaser before completing the sale, unless from the purchaser's outward appearance the person making the sale would reasonably presume the purchaser to be 25 years of age or older.

(4)(a) Each sales location of a manufacturer, distributor, or retailer whose employee or representative, during the course of the employee's or representative's employment or association with the manufacturer, distributor, or retailer, sells dextromethorphan in violation of this section is subject to a written warning for an initial violation and, for each subsequent violation, a civil citation imposing a fine of not more than $100, which shall accrue and may be recovered in a civil action brought by the local jurisdiction. A manufacturer,

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distributor, or retailer who demonstrates a good faith effort to comply with this section is not subject to citation.

(b) An employee or representative of a manufacturer, distributor, or retailer who, during the course of the employee's or representative's employment or association with the manufacturer, distributor, or retailer, sells dextromethorphan in violation of this section is subject to a written warning.

(c) A person who possesses or receives dextromethorphan in violation of this section with the intent to distribute is subject to a civil citation imposing a fine of not more than $100 for each violation, which shall accrue and may be recovered in a civil action brought by the local jurisdiction. A civil citation issued to a person pursuant to this paragraph shall include information regarding how to dispute the citation and shall clearly state that the violation is a noncriminal violation.

(5) A civil citation issued to a manufacturer, distributor, or retailer pursuant to this section shall be provided to the manager on duty at the time the citation is issued. If a manager is not available, a local law enforcement officer shall attempt to contact the manager to issue the citation. If the local law enforcement officer is unsuccessful in contacting the manager, he or she may leave a copy of the citation with an employee 18 years of age or older and mail a copy of the citation by certified mail to the owner's business address, as filed with the Department of State, or he or she may return to issue the citation at a later time. The civil citation shall provide:

(a) The date and approximate time of the sale in violation

of this section.

(b) The location of the sale, including the address.

(c) The name of the employee or representative that completed the sale.

(d) Information regarding how to dispute the citation.

(e) Notice that the violation is a noncriminal violation.

(6) To dispute the citation, the recipient of the citation must provide notice of the dispute to the clerk of the county court in the jurisdiction in which the violation occurred within 15 days after receipt of the citation. The local jurisdiction, through its duly authorized officers, shall hold a hearing in the court of competent jurisdiction when a citation for a violation of this section is issued, when the violation is disputed, and when the recipient is issued the citation by a local law enforcement officer employed by or acting on behalf of the jurisdiction. If the court finds in favor of the jurisdiction, the court shall require payment of the fine as provided in this section.

(7) This section shall be applied uniformly throughout the state. Enforcement of this section shall remain with local law enforcement departments and officials charged with the enforcement of the laws of the state.

(8) This section does not:

(a) Impose any restriction on the placement of products in a retail store, direct access of customers to finished drug products, or the maintenance of transaction records.

(b) Apply to a medication containing dextromethorphan that is sold by a retailer pursuant to a valid prescription.

(c) Create a criminal violation. A person who violates this

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section commits a noncriminal violation as defined in s. 775.08(3).

(9) This section preempts any ordinance regulating the sale, distribution, receipt, or possession of dextromethorphan enacted by a county, municipality, or other political subdivision of the state, and dextromethorphan is not subject to further regulation by such political subdivisions.

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

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the retail sale of dextromethorphan; providing definitions; prohibiting a manufacturer, distributor, or retailer, or its employees and representatives, from knowingly or willfully selling a finished drug product containing dextromethorphan to a person younger than 18 years of age; prohibiting a person younger than 18 years of age from purchasing a finished drug product containing dextromethorphan; requiring an employee or representative of a retailer making a retail sale of a finished drug product containing any quantity of dextromethorphan to obtain certain proof of age from the purchaser; providing an exception; providing penalties; providing requirements for imposing or disputing civil citations; specifying information to

be provided in such citations; providing applicability; preempting local government regulation of dextromethorphan; providing an effective date.

By Senator Benacquisto

30-00935-16 2016938__

A bill to be entitled

An act relating to the retail sale of dextromethorphan; providing definitions; prohibiting a retail entity from knowingly or willfully selling a finished drug product containing dextromethorphan to a person younger than 18 years of age; prohibiting a person younger than 18 years of age from purchasing a finished drug product containing dextromethorphan; requiring a person making a retail sale of a finished drug product containing any quantity of dextromethorphan to obtain certain proof of age from the purchaser; providing an exception; providing penalties; providing applicability; preempting local government regulation of dextromethorphan; providing an effective date.

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

Section 1. Restrictions on sale of dextromethorphan.—

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

(a) "Finished drug product" means a drug legally marketed under the Federal Food, Drug, and Cosmetic Act that is in finished dosage form.

(b) "Proof of age" means any document issued by a governmental agency that contains the date of birth and a description or photograph of the person purchasing the finished drug product. The term includes, but is not limited to, a passport, military identification card, or driver license.

(2)(a) A retail entity may not knowingly or willfully sell

30-00935-16 2016938__

a finished drug product containing any quantity of dextromethorphan to a person younger than 18 years of age.

(b) A person younger than 18 years of age may not purchase a finished drug product containing any quantity of dextromethorphan.

(3) A person making a retail sale of a finished drug product containing any quantity of dextromethorphan must require and obtain proof of age from the purchaser before completing the sale, unless from the purchaser's outward appearance the person making the sale would reasonably presume the purchaser to be 25 years of age or older.

(4)(a) A manufacturer, distributor, or retailer whose employee or representative, during the course of the employee's or representative's employment or association with the manufacturer, distributor, or retailer, sells dextromethorphan in violation of this section is subject to a $100 fine, except that a manufacturer, distributor, or retailer who demonstrates a good faith effort to comply with this section is not subject to such penalty.

(b) An employee or representative of a manufacturer, distributor, or retailer who, during the course of the employee's or representative's employment or association with the manufacturer, distributor, or retailer, sells dextromethorphan in violation of this section is subject to a $25 fine.

(c) A person who purchases dextromethorphan in violation of this section is subject to a $25 fine.

(d) A person who possesses or receives dextromethorphan in violation of this section, with the intent to distribute, is

subject to a $25 fine.

(5) This section does not:

(a) Impose any restriction on the placement of products in a retail store, direct access of customers to finished drug products, or the maintenance of transaction records.

(b) Apply to a medication containing dextromethorphan that is sold by a retail entity pursuant to a valid prescription.

(6) This section preempts any ordinance regulating the sale, distribution, receipt, or possession of dextromethorphan enacted by a county, municipality, or other political subdivision of the state, and dextromethorphan is not subject to further regulation by such political subdivisions.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR LIZBETH BENACQUISTO
30th District

COMMITTEES:
Banking and Insurance, *Chair*
Appropriations, *Vice Chair*
Appropriations Subcommittee on Health and Human Services
Education Pre-K-12
Higher Education
Judiciary
Rules

JOINT COMMITTEE:
Joint Legislative Auditing Committee
Joint Select Committee on Collective Bargaining

December 18, 2015

The Honorable Aaron Bean
Senate Health Policy, Chair
302 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399

RE: SB 938- Retail Sale of Dextromethorphan

Dear Mr. Chair:

Please allow this letter to serve as my respectful request to agenda SB 938, Relating to Retail Sale of Dextromethorphan, for a public hearing at your earliest convenience.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,

Lizbeth Benacquisto
Senate District 30

Cc: Sandra Stovall

REPLY TO:
❒ 2310 First Street, Suite 305, Fort Myers, Florida 33901 (239) 338-2570
❒ 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5030

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

19 JANUARY 2016
Meeting Date

SB 938
Bill Number (if applicable)

Topic DEXTROMETHORPHAN – SALES RESTRICTIONS

Amendment Barcode (if applicable)

Name SEAN MOORE

Job Title ASSOCIATE DIRECTOR, STATE GOVERNMENT AFFAIRS

Address 1625 EYE STREET, NW STE 600
Street

Phone 202-429-3537

WASHINGTON DC 20006
City *State* *Zip*

Email smoore@chpa.org

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

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

Representing CONSUMER HEALTHCARE PRODUCTS 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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Jan 19th
Meeting Date

938
Bill Number (if applicable)

Topic Support SB 938 - DXM

Amendment Barcode (if applicable)

Name Chris Hansen

Job Title Ballard Partners

Address 403 E. Park Ave
Street

Tallahassee FL 32301
City *State* *Zip*

Phone

Email

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Bayer Corp.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 998
INTRODUCER:	Health Policy Committee and Senator Ring
SUBJECT:	Treatment Programs
DATE:	January 21, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 998 establishes licensure, regulatory, operational, and administrative standards for adolescent and child residential treatment programs (ACRT) and adolescent and child outdoor programs (ACO). An ACRT offers room and board, and provides specialized treatment, specialized therapies, and rehabilitation or habilitation services for an adolescent or child between the ages of 6 and 18, with emotional, psychological, developmental, or behavioral problems or disorders or substance abuse problems. An ACO offers wilderness hiking and camping experiences as a form or rehabilitation and treatment for the same population group of ACRTs. Both of these programs are intended to assist the adolescent or child acquire the social and behavioral skills necessary for healthy adjustment to school, family life, and community.

II. Present Situation:

Current law provides for a variety of residential programs for persons with emotional maladies, substance abuse dependencies, and developmental disabilities. Multiple state agencies have responsibility for establishing and enforcing regulatory standards for these programs, including the Department of Children and Families (department), the Agency for Health Care Administration (agency), and the Agency for Persons with Disabilities (APD).

Residential Treatment Facilities

Mental Health

Mental health residential treatment centers are licensed under s. 394.875, F.S. Long-term residential facilities include facilities for residential treatment [for adults] and resident treatment centers for children and adolescents.[1]

The purpose of a residential treatment facility is to be part of a comprehensive treatment program for mentally ill individuals in a community-based residential setting.[2] A mental health residential treatment facility must provide a long term, homelike residential environment that provides care, support, assistance and limited supervision in daily living to adults diagnosed with a serious and persistent major mental illness who do not have another primary residence. The average length of stay must be 60 days or longer. Residential treatment centers are divided into five licensure classifications, referred to as levels. The level designation depends upon the functional capabilities of the residents and the care and supervision needed by those residents. Different regulatory standards apply to each level.[3]

The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services to children and adolescents who are experiencing an acute mental or emotional crisis, have a serious emotional disturbance or mental illness,[4] or have an emotional disturbance.[5,6] Children may be admitted through the mental health system or through the protective custody provisions in ch. 39, F.S.[7] Similar residential settings include therapeutic group homes. The department, in consultation with the agency, has adopted rules governing a residential treatment center for children and adolescents which specify licensure standards for: admission; length of stay; program and staffing; discharge and discharge planning; treatment planning; seclusion, restraints and time-out; rights of patients; use of psychotropic medications; and standards for the operation of such facilities.[8]

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[1] "Child" means a person from birth until the person's 13th birthday. *See* s. 394.492(3), F.S. "Adolescent" means a person who is at least 13 years of age but under 18 years of age. *See* s. 394.492(1), F.S.
[2] Section 394.875(1)(b), F.S.
[3] Rule 65E-4.016(1), F.A.C.
[4] "Child or adolescent who has a serious emotional disturbance or mental illness" means a person under 18 years of age who is diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation. The term includes a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1), F.S.
[5] "Child or adolescent who has an emotional disturbance" means a person under 18 years of age who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation. The term does not include a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1). 394.492(5), F.S.
[6] Section 394.875(1)(c), F.S.
[7] Rule chapter 65E-9, F.A.C.
[8] *See* Section 394.875(8), F.S., and Rule Chapters 65E-9, and 65G-2, F.A.C.

A license issued by the agency is required in order to operate or act as a residential treatment center or a residential treatment center for children and adolescents in this state.[9] In addition to other documentation required for licensure, applicants must provide proof of liability insurance coverage in amounts set by the department and the agency by rule.[10] The agency and the department may enter and inspect any licensed facility and access clinical records of any client to determine compliance with applicable laws and rules and may inspect an unlicensed premises with the permission of the person in charge or pursuant to a warrant.[11]

Substance Abuse Services

Under ch. 397, F.S., relating to Substance Abuse Services, residential treatment is defined as a service provided in a structured live-in environment within a nonhospital setting on a 24-hours-per-day, 7-days-per-week basis, and is intended for individuals who meet the placement criteria for this component.[12] The department is responsible for licensing and regulating licensable service components delivering substance abuse services on behalf of service providers under ch. 397, F.S.[13] The department has adopted rules relating to the licensure and operation of providers of substances abuse services.[14]

Developmental Disabilities

Residential facilities also exist for persons with developmental disabilities. For example, a group home facility is a residential facility which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents.[15] The capacity of a group home facility is at least 4 but not more than 15 residents.

An intermediate care facility for the developmentally disabled (ICF/DD) is a residential facility licensed and certified under state law and also certified by the Federal Government, pursuant to the Social Security Act, as a provider of Medicaid services to persons who have developmental disabilities.[16]

The APD provides, through its licensing authority and by rule, license application procedures, provider qualifications, facility and client care standards, requirements for client records, requirements for staff qualifications and training, and requirements for monitoring foster care facilities, group home facilities, residential habilitation centers,[17] and comprehensive transitional education programs that serve APD clients.[18]

[9] Section 394.875(2), F.S.
[10] Section 394.876(2), F.S.
[11] Section 394.90(1) and (2), F.S.
[12] Section 394.311(22)(a)9., F.S.
[13] Section 397.321(6), F.S.
[14] *See* Rule chs. 65D-30 and 65G-2, F.A.C.
[15] Section 393.063(17), F.S.
[16] Section 400.960(6), F.S.
[17] A residential habilitation center is a community residential facility licensed under this ch. 393, F.S., which provides habilitation services. The capacity these facilities may not be fewer than nine residents. However, licensure of new residential habilitation centers creased after October 1, 1989.
[18] Section 393.067(1), F.S.

Wilderness Camps

The department regulates wilderness camps as residential child-caring agencies.[19] Rules provide for a short-term wilderness program which is a residential program of 60 days or less, that emphasizes behavioral changes through rigorous fitness training and conditioning in a wilderness environment. Rules also authorize a wilderness camp which is a residential child caring program that provides a variety of outdoor activities that take place in a wilderness environment. Although wilderness programs are exempted[20] from several regulations applicable to residential programs, these programs are currently subject to existing regulation. [21]

III. Effect of Proposed Changes:

Adolescent and Child Residential Treatment Program

Section 394.88, F.S., is created to establish an adolescent and child residential treatment program (ACRT) within the statutory chapter relating to mental health. The purpose of the new program is to offer room and board and to provide, or arrange for the provision of, specialized treatment, specialized therapies,[22] and rehabilitation or habilitation[23] services for adolescents and children between 6 and 18 years of age with emotional, psychological, developmental, or behavioral problems or disorders or substance abuse problems. An ACRT assists these youth in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.

Rehabilitative services is described within the definition of "mental health services" and "substance abuse services" in the part[24] of the Florida Statutes applicable to the new residential treatment program created in this bill. Within the definition of mental health services, rehabilitative services is described to mean, services which are intended to reduce or eliminate the disability that is associated with mental illness. Rehabilitative services may include assessment of personal goals and strengths, readiness preparation, specific skill training, and assistance in designing environments that enable individuals to maximize their functioning and community participation.[25] Within the definition of substance abuse services, rehabilitation services is described to include residential, outpatient, day or night, case management, in-home, psychiatric, and medical treatment, and methadone or medication management.[26]

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[19] Section 409.175(2)(j), F.S.
[20] *See for example* Rule 65C-14.090, F.A.C.
[21] *See* Rules 65C-14.001, and 65C-14.110 – 65C-14.115, F.A.C.
[22] Specialized therapies is defined in s. 393.063, F.S., to mean means those treatments or activities prescribed by and provided by an appropriately trained, licensed, or certified professional or staff person and may include, but are not limited to, physical therapy, speech therapy, respiratory therapy, occupational therapy, behavior therapy, physical management services, and related specialized equipment and supplies.
[23] Habilitation services in defined in s. 393.063, F.S., to mean the process by which a client is assisted to acquire and maintain those life skills which enable the client to cope more effectively with the demands of his or her condition and environment and to raise the level of his or her physical, mental, and social efficiency. It includes, but is not limited to, programs of formal structured education and treatment.
[24] Part IV of ch. 394, F.S., Community Substance Abuse and Mental Health Services.
[25] Section 394.67(15)(b), F.S.
[26] Section 394.67(24)(d), F.S.

An ACRT is defined as a 24-hour group living environment for four or more individuals unrelated to the owner or provider. An ACRT must be licensed by the agency in accordance with the general facility licensing standards in part II of ch. 408, F.S. The department, in consultation with the agency and the APD must adopt rules for licensure, administration, and operation of ACRTs.

The director of an ACRT, who is responsible for the operation of the program, the program facility, and the day-to-day supervision of the residents may be a psychiatrist or a psychologist. Similar programs currently authorized in statute require a psychiatrist to serve as the medical director to oversee the development and revision of the treatment plan and the provision of mental health services provided to children.[27] The director, or a staff member who has been appointed by the director to serve at the director's substitute, must be on site at the program facility at all times. The director must maintain a current list of all program residents at the facility.

Additional program staff must include physicians, psychologists, mental health counselors, or advanced registered nurse practitioners who have been trained in providing medical services and treatment to adolescents and children to provide treatment to the residents. These health care practitioners must also be specifically trained for providing applicable services to adolescents and children diagnosed with mental health and substance abuse problems and to residents with disabilities depending upon the makeup of the residents.

All staff who have contact with residents must undergo a level 2 background screening. The bill establishes minimum staffing ratios of:

- Two health care practitioners licensed in a profession listed in the previous paragraph at all times, and
- One to four professional staff-to-resident ratio during awake hours.

A treatment plan must exist for each resident. The treatment plan must be review and signed when the resident enrolls in the ACRT and periodically thereafter. The director and the resident's parent or legal guardian must sign the treatment plan.

An ACRT is required to maintain documentation evidencing compliance with local zoning, business licenses, building code, fire safety code, and health code requirements. An ACRT also must obtain approval from applicable governmental agencies for new program services or increased resident capacity. If the ACRT provides services to residents with disabilities, it must be located where schools, churches, recreation facilities, and other community facilities are available.

An ACRT must:

- Provide a curriculum approved by the Department of Education. If the program provides its own school, it must be approved by the State Board of Education, the Southern Association of Colleges and Schools, or another educational accreditation organization; and
- Conduct counseling sessions or other appropriate treatment, including skills development therapy. These services must be documented for in each resident's individual record.

[27] *See* Rule 65E-9.007(3), F.A.C., Licensure of Residential Treatment Centers, Staffing.

The department may establish by rule additional staffing requirements to ensure resident safety and service delivery as well as other requirements relating to the treatment and care of residents consistent with the ACRT.

Adolescent and Child Outdoor Program

Section 394.89, F.S., is created to establish an adolescent and child outdoor program (ACO) within the statutory chapter relating to mental health. The purpose of the new program is to offer wilderness hiking and camping experiences through field group activities and expeditions as a form of rehabilitation and treatment for participants between the ages of 6 and 18 years of age with emotional, psychological, developmental, or behavioral problems or disorders or substance abuse problems. An ACO assists these youth in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community. An ACO may be established as an independent program or as an adjunct and subsidiary program to an ACRT.

The definition of a program participant or participant specifically excludes the parent or contracting agent that enrolls the adolescent or child in the program.

An ACO must be licensed by the agency in accordance with the general facility licensing standards in part II of ch. 408, F.S. The department, in consultation with the agency and the APD, must adopt rules to establish requirements for licensure, administration, and operation of ACOs. In addition, the department is authorized to establish rules relating to additional staffing requirements to those specifically enumerated in the bill. All local, state, and federal regulations and professional licensing requirements must be met by a program as a condition of licensure.

The agency is tasked with reviewing and approving a program's training plan that specifies the programs goals and methodologies. This plan must also address governing a participant's conduct and the consequences for his or her conduct while enrolled in the program.

An ACO must employ a psychiatrist or psychologist as its program supervisor, who is responsible for and has authority over all policies and activities of the program. Additional responsibilities include:

- Coordinating office and support services,
- Supervising the operations of the program,
- Ensuring staff is adequately trained,
- Maintaining enrollment records, including a current list of participants, the participant's group field activity or expedition and geographic location. This list must be updated every 24 hours; and
- Developing and signing a written plan for each group field activity and expedition.

CS/SB 998 requires an ACO to provide an educational component approved by the Department of Education to a participant if he or she is absent from school or educational setting for more than 30 days. The program supervisor must coordinate with the local school board to provide the educational component as part of a participant's program experience prior to enrolling the participant. To offer educational credit to a participant, the ACO must be recognized and approved by the State Board of Education.

Each ACO must provide to its participants access to a multidisciplinary team of licensed health care practitioners who have been trained in providing medical services and treatment to adolescents and children. This team must include, at a minimum, a physician and at least one of the following: clinical social worker, mental health counselor, marriage and family therapist, and certified school counselor.

Each group field activity or expedition must have field staff working directly with the participants. Support staff must also be assigned responsibility for the delivery of supplies to the field, mail delivery, communications, and first aide support.

All professional and non-professional staff as well as all providers who may be in contact with participants must undergo a level 2 background screening before any contact occurs.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

As drafted, private resources will be used to cover the costs for the residential treatment program and the outdoor youth program. At this time these costs are indeterminate.

C. Government Sector Impact:

The agency, department, and APD will incur costs for rulemaking, licensing, inspecting, and enforcing the two programs. The impact is indeterminate at this time.

VI. Technical Deficiencies:

The bill does not include fees to cover the costs of licensing, inspecting, and enforcing the provisions in the two programs.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 394.88 and 394.89.

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 January 19, 2016:

The committee substitute:

- Changed the title of the two programs from residential treatment programs to adolescent and child residential treatment programs and from outdoor youth programs to adolescent and child outdoor programs.
- Limited the scope of the programs to youth between the ages of 6 – 18.
- Removed most of the prescriptive regulatory structure and substituted a regulatory framework with rulemaking authority.
- Clarified agency, department, and APD responsibilities for licensure and rulemaking.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/19/2016	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 394.88, Florida Statutes, is created to read:

394.88 Adolescent and child residential treatment programs.—

(1) The purpose of an adolescent and child residential treatment program is to offer room and board and to provide, or

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arrange for the provision of, specialized treatment, specialized therapies as defined in s. 393.063, and services for rehabilitation or habilitation as defined in s. 393.063, for adolescents and children with emotional, psychological, developmental, or behavioral problems or disorders, or substance abuse problems. In an adolescent and child residential treatment program, adolescents and children are assisted in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.

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

(a) "Adolescent and child residential treatment program" or "program" means a privately owned and operated 24-hour group living environment for four or more adolescents or children unrelated to the owner or provider.

(b) "Program resident" or "resident" means an adolescent or child at least 6 and no more than 18 years of age who enrolls and participates in a program.

(3) An adolescent and child residential treatment program must be licensed by the Agency for Health Care Administration in accordance with part II of chapter 408. The department, in consultation with the agency and the Agency for Persons with Disabilities, shall establish by rule requirements for licensure, administration, and operation of programs and program facilities consistent with this section.

(4)(a) A program must employ a licensed psychiatrist or a psychologist licensed under chapter 490 as the director of the program. The director is responsible for the operation of the program, the program facility, and the day-to-day supervision of program residents. The director or a member of program staff

appointed by the director as his or her substitute must be present at the program facility at all times. The director shall maintain on site a current list of all program residents.

(b) Program staff must include, in addition to the director, physicians licensed under chapter 458 or chapter 459, psychologists licensed under chapter 490 or chapter 491, mental health counselors licensed under chapter 491, or advanced registered nurse practitioners licensed under part 1 of chapter 464 and certified under s. 464.012 who have been trained in providing medical services and treatment to adolescents and children to serve as professional program staff providing treatment to residents. Such professional program staff must be specifically trained in providing medical services and treatment to adolescents and children diagnosed with mental health and substance abuse problems and to residents with disabilities if the program serves these populations. A program must have a minimum of two such professional staff members on duty at all times and must maintain a professional staff-to-resident ratio of no less than 1 to 4 during awake hours. All program staff, professional and non-professional, and all providers who may be contracted to provide services to residents must undergo a level 2 background screening before engaging in any activity that brings them into contact with a resident. The department may establish by rule further staffing requirements to ensure resident safety and service delivery consistent with this section.

(5) A program must ensure that a treatment plan exists for each resident. The treatment plan must be reviewed and signed at the time a resident enrolls and periodically after enrollment,

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as provided in the treatment plan, by the director of the program and the resident's parent or legal guardian. The department may establish by rule further requirements relating to the treatment and care of residents consistent with this section.

(6) A program must maintain written documentation of compliance with the following local requirements, as applicable:

(a) Zoning ordinances.

(b) Business license requirements.

(c) Building codes.

(d) Firesafety codes and standards.

(e) Health codes.

(f) Approval from appropriate governmental agencies for new program services or increased consumer capacity.

A program facility that provides services to residents with disabilities must be located where schools, churches, recreation facilities, and other community facilities are available. The department may establish by rule further requirements relating to the program facility, including, but not limited to, interior and exterior building dimensions, housing and kitchen standards, meal plan guidelines, medication management, resident privacy and accountability for his or her personal effects, and cleanliness and safety standards, consistent with this section.

(7) A program must:

(a) Provide a curriculum approved by the Department of Education to residents. A program that provides its own school must be recognized and approved by the State Board of Education, the Southern Association of Colleges and Schools, or another

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educational accreditation organization.

(b) Conduct individual, group, couple, and family counseling sessions or other appropriate treatment, including skills development therapy, at least weekly, or more often if required by a resident's treatment plan. The program must document the time, date, and nature of such services, including the signature of the counselor providing them, in the individual record for each resident.

Section 2. Section 394.89, Florida Statutes, is created to read:

394.89 Adolescent and child outdoor programs.—

(1) The purpose of an adolescent and child outdoor program is to offer wilderness hiking and camping experiences through program field group activities and expeditions as a form of rehabilitation and treatment for adolescents or children with emotional, psychological, developmental, or behavioral problems or disorders, or substance abuse problems. In an adolescent and child outdoor program, adolescents and children are assisted in acquiring the social and behavioral skills necessary for a healthy adjustment to school, family life, and community.

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

(a) "Adolescent and child outdoor program" or "program" means a privately owned and operated 24-hour group wilderness hiking and camping experience for four or more adolescents or children unrelated to the owner or provider. A program may be established independently or as an adjunct and subsidiary of an adolescent and child residential treatment program established pursuant to s. 394.88.

(b) "Program participant" or "participant" means an

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adolescent or child at least 6 and no more than 18 years of age who enrolls and participates in a program. The term does not include the parent or contracting agent that enrolls the adolescent or child in the program.

(3)(a) An adolescent and child outdoor program must be licensed by the Agency for Health Care Administration in accordance with part II of chapter 408. The department, in consultation with the agency and the Agency for Persons with Disabilities, shall establish by rule requirements for licensure, administration, and operation of programs consistent with this section. All local, state, and federal regulations and professional licensing requirements must be met by a program as a condition of licensure by the agency. The agency must review and approve a program's training plan specifying the program's goals and methodologies. The training plan must include provisions governing a participant's conduct and the consequences for his or her conduct while enrolled in the program.

(b) A program must provide an educational component approved by the Department of Education to a participant who is absent from his or her school or educational setting for more than 30 days. Before enrolling a participant, the program supervisor must coordinate with the local school board to provide an educational component as part of the participant's program experience. To offer educational credit to participants, the program must be recognized and approved by the State Board of Education.

(4)(a) A program must employ a licensed psychiatrist or a psychologist licensed under chapter 490 as its program

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supervisor. The program supervisor is responsible for and has authority over the policies and activities of the program. The program supervisor shall coordinate office and support services, supervise the operations of the program, and ensure that all program staff are adequately trained. The program supervisor shall maintain on file at all times enrollment records of all participants and a current list of participants, including each participant's group field activity or expedition and his or her geographic location. The list must be updated every 24 hours. The program supervisor must develop and sign a written plan for each group field activity and expedition. Plans must not expose participants to unreasonable risks.

(b) Each group field activity or expedition must have field staff working directly with the participants. A program must have field support staff members who are responsible for the delivery of supplies to the field, mail delivery, communications, and first aid support.

(c) Each program must provide its participants access to a multidisciplinary team of licensed health care providers and licensed mental health counselors who have been trained in providing medical services and treatment to adolescents and children and which includes, at a minimum, the following:

1. A physician licensed under chapter 458 or chapter 459.

2. At least one of the following:

a. A psychologist licensed under chapter 490 or chapter 491.

b. A licensed clinical social worker.

c. A mental health counselor licensed under chapter 491.

d. A licensed marriage and family therapist.

e. A certified school counselor.

(d) All program staff, professional and non-professional, and all providers who may be contracted to provide services to participants must undergo a level 2 background screening before engaging in any activity that brings them into contact with a participant. The department may establish by rule further staffing requirements consistent with this section.

Section 3. This act shall take effect July 1, 2016.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to adolescent and child treatment programs; creating s. 394.88, F.S.; providing purpose of adolescent and child residential treatment programs; defining terms; requiring licensure by the Agency for Health Care Administration; requiring the Department of Children and Families to adopt rules for the licensure, administration, and operation of programs and program facilities; providing staffing requirements; requiring a treatment plan for each resident; requiring a review of treatment plans; requiring written documentation of compliance with certain local requirements; providing location requirements for program facilities under certain circumstances; authorizing the department to establish certain requirements; requiring a program to provide a

curriculum; requiring a program to conduct certain counseling sessions; creating s. 394.89, F.S.; providing purpose of adolescent and child outdoor programs; defining terms; requiring licensure by the agency; requiring the department to adopt rules for the licensure, administration, and operation of programs; providing regulations and licensing requirements for programs; providing administrative requirements for programs; requiring programs to have an educational component approved by the Department of Education under certain circumstances; providing requirements and qualifications for program staff; requiring the program supervisor to maintain a current list and enrollment records of all participants; requiring program supervisors to develop a written plan for each field group activity and expedition; providing an effective date.

By Senator Ring

29-00384-16 2016998__

A bill to be entitled

An act relating to treatment programs; creating s. 394.88, F.S.; providing purposes of residential treatment programs; defining a term; requiring licensure by the Agency for Health Care Administration; requiring the Department of Children and Families to adopt rules for the licensure, administration, and operation of programs; providing staffing requirements; requiring a treatment plan for each resident; requiring a review of treatment plans; requiring written documentation of compliance with certain local requirements; providing requirements for facilities and furnishings; providing requirements for the operation of program food service; providing requirements for the storage and administration of medications; providing requirements for programs that provide services to residents with substance abuse problems; providing requirements for programs that provide services to children and youth; providing requirements for programs that provide services to residents with disabilities; creating s. 394.89, F.S.; providing purposes of outdoor youth programs; defining terms; requiring licensure by the agency; requiring the department to adopt rules for the licensure, administration, and operation of programs; providing regulations and licensing requirements for programs; providing administrative requirements for programs; requiring programs to have an educational component approved by the Department of Education; providing

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requirements and qualifications for program staff; requiring the field director of the program to maintain a current list and enrollment records of all participants; requiring field directors to develop a written plan for each field group activity and expedition; requiring approval of each plan by program governing boards; requiring program staff to record an inventory of the personal items of a participant; requiring the return of personal items to a participant upon program completion; requiring programs to provide clothing and equipment to participants for field group activities and expeditions; providing field group activity and expedition requirements; providing requirements for field offices; providing minimum staff-to-participant ratios for program field group activities and expeditions; requiring staff training; requiring staff members, interns, and volunteers to receive annual physical examinations; requiring staff members, interns, and volunteers to agree to submit to drug and alcohol screening; providing enrollment requirements for program participants; providing fire, health, and safety standards for stationary program camps; requiring local offices of the Department of Health to inspect such camps; providing water and nutritional requirements for program field group activities and expeditions; providing requirements for the medical care of participants; providing requirements for the administration of medications to participants;

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

providing requirements for a safety support system; requiring compliance with environmental impact or land use standards; providing requirements for the management of emergency situations; providing requirements for emergency preparedness and for the prevention of infectious and communicable diseases; providing that a parent or guardian has the choice of not using an escort transportation service; defining the term "escort transportation service"; providing requirements for the transportation of participants; providing requirements for a solo component to program offerings; providing for the debriefing of program participants; providing for written evaluations of program activities by parents, guardians, and participants; providing procedural requirements for incidents of suspected child abuse or neglect; providing for the investigation of suspected child abuse or neglect; providing for the termination of program personnel for convictions of child abuse; providing for the immediate suspension or revocation of licenses of programs under certain circumstances; providing for the denial of licensure to programs under certain circumstances; providing for the immediate revocation of licenses for violations of statutory requirements; providing an effective date.

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

Section 1. Section 394.88, Florida Statutes, is created to

read:

394.88 Residential treatment programs.—

(1) The purpose of a residential treatment program is to offer room and board and to provide, or arrange for the provision of, specialized treatment and rehabilitation or habilitation services for individuals with emotional, psychological, developmental, or behavioral problems or disorders or chemical dependencies. In a residential treatment program, such individuals are assisted in acquiring the social and behavioral skills necessary for living independently in the community.

(2) As used in this section, the term "residential treatment program" or "program" means a 24-hour group living environment for four or more individuals unrelated to the owner or provider.

(3) A residential treatment program must be licensed by the agency. The department, in consultation with the agency, shall establish by rule requirements for licensure, administration, and operation of residential treatment programs consistent with this section.

(4)(a) A program must employ a manager who is responsible for the operation of the program, the program facility, and the day-to-day supervision of program residents. A licensed psychologist may hold the position of manager. The manager or a member of program staff appointed by the manager as his or her substitute must be present at the program facility at all times. The manager shall maintain on site a current list of all program residents.

(b) Program staff must include licensed physicians,

psychologists, mental health counselors, and advanced registered nurse practitioners who have been trained in providing medical services and treatment to individuals diagnosed with mental health and substance abuse problems, to individuals with disabilities, and to children and youth if the program serves these populations.

1. A program must have a minimum of two staff members on duty at all times and must maintain a staff-to-resident ratio of no less than 1 to 4. This ratio may be reduced only during overnight sleeping hours. A program with mixed-gender residents must have at least one male and one female staff member on duty at all times.

2. A program that provides services to children and youth must have on staff:

a. A licensed mental health counselor who provides a minimum of 1 hour of service per week per child or youth resident.

b. A licensed medical practitioner who, by written agreement, provides, as needed, a minimum of 1 hour of service per week for every two child or youth residents.

c. A licensed clinical professional who supervises all staff members who are trained to work with children and youth who have emotional or behavioral problems or disorders.

3. A program must ensure that licensed substance abuse counselors on staff and all unlicensed staff are supervised by a licensed clinical professional.

4. A program that provides services for residents with disabilities must designate, for the supervision of the services and the facility, a staff member who is adequately trained to

provide the services and treatment described in the treatment plans for such residents.

(c) A program must have a staff person trained and certified in first aid and cardiopulmonary resuscitation (CPR) on duty at all times.

(d) A program may accept and use students and volunteers on its staff. The program must provide for the evaluation and screening of students and volunteers and adequate training to ensure that they are qualified to perform assigned tasks. Students and volunteers must be informed verbally and in writing of program objectives and the scope of the services to be provided by the program.

(5) A program must ensure that a treatment plan exists for each resident. The treatment plan must be reviewed and signed at the time a resident enrolls and periodically after enrollment, as provided in the treatment plan, by the licensed clinical professional who supervises the program.

(6) A program must maintain written documentation of compliance with the following local requirements, as applicable:

(a) Zoning ordinances.

(b) Business license requirements.

(c) Building codes.

(d) Firesafety codes and standards.

(e) Health codes.

(f) Approval from appropriate governmental agencies for new program services or increased consumer capacity.

A program facility that provides services to residents with disabilities must be located where schools, churches, recreation

facilities, and other community facilities are available.

(7) A program must ensure that the appearance and cleanliness of its facility, including all buildings and surrounding areas, are maintained. A program must take reasonable measures to ensure a safe physical environment for all residents and staff. The program must store hazardous chemicals and materials in locked spaces that are adequately ventilated and kept at a proper temperature pursuant to the direction of the local fire department official.

(a) A program must ensure that its facility has adequate space to maintain an administrative office for records, secretarial work, and bookkeeping and additional space to conduct private and group counseling sessions. A program facility must be of sufficient size and design to provide indoor space for free and informal activities and to respect the privacy needs of residents. A live-in staff member must have a separate living space with a private bathroom.

(b) No more than four residents, and no more than two residents with disabilities, may be housed in a single bedroom. Multiple-occupant bedrooms must provide a minimum of 60 square feet per resident. Single-occupant bedrooms must be a minimum of 80 square feet in size. Measurements of bedroom size may not include storage space. Bedrooms and other sleeping areas must have a source of natural light and must be ventilated by mechanical means or equipped with a screened window that opens. A program must provide a separate bed for each resident. Beds must be of solid construction and may not be portable. A program must provide clean linens to a resident upon arrival at the program facility and at least weekly for the duration of the

enrollment of the resident in the program. Sleeping quarters for male residents must be structurally separate from sleeping quarters for female residents. A resident must be allowed to decorate and personalize his or her bedroom consistent with respect for other residents and property.

(c) A program facility must have separate bathrooms for male and female residents. Bathrooms must be maintained in good operating order and in a clean and safe condition and must accommodate residents with physical disabilities as required. A program facility bathroom must include mirrors secured to its walls at convenient heights, be properly equipped with toilet paper, towels, soap, and other items required for personal hygiene, and be ventilated by mechanical means or equipped with a screened window that opens. A program must provide a minimum ratio of one toilet, one bathroom sink, and one tub or shower for every six residents. All toilets, baths, and showers must be designed and constructed to provide individual privacy for the user. A program facility must be designed so that bathroom location and access minimize disturbance of residents during sleeping hours.

(d) Furniture and equipment used at a program facility must be of sufficient quantity, variety, and quality to meet program and resident needs and must be maintained in a clean and safe condition.

(e) A program that allows residents to do laundry individually must provide equipment and supplies for washing, drying, and ironing. A program that provides a common laundry service for linens and clothing must provide containers for soiled laundry separate from storage for clean linens and

clothing. All laundry appliances must be maintained in a clean and safe operating condition.

(8)(a) A program must employ a food service manager. If the food service manager is not a licensed dietitian or nutritionist, he or she must schedule consultations on a regular basis with a licensed dietitian or nutritionist. All meals served by the program must be from dietitian-approved or nutritionist-approved menus.

(b) The food service manager shall maintain a current list of residents with special nutritional needs, record in a resident's service record information relating to special nutritional needs, and provide nutrition counseling to residents as appropriate.

(c) Meals served by the program may be prepared at the facility or catered. The program must provide three regular meals a day to residents and must provide nutritious food to a resident within 4 hours after the resident arrives at or returns to the program facility. Program kitchens must have clean, safe, and operational equipment for the preparation, storage, serving, and cleanup of all meals. Adequate dining space must be provided for all residents. The dining space must be maintained in a clean and safe condition. A program must establish and post kitchen rules and privileges that take into account the needs of its residents. If the program allows residents to prepare meals, the program must establish a written policy that includes the following:

1. Rules that residents must follow to acquire and retain kitchen privileges.

2. Guidelines and procedures for menu planning.

3. Nutritional and sanitation requirements.

4. A schedule of the responsibilities of each resident enjoying kitchen privileges for food preparation, cleanup, and kitchen maintenance.

(9) A program must have locked storage for medications and ensure that residents receive prescription medication according to the prescriptions of qualified physicians, as required by law. A program must designate qualified staff to perform the following tasks:

(a) Administer medication.

(b) Supervise self-medication.

(c) Record all instances of medication and self-medication, including time and dosage, according to prescription.

(d) Record the effects of medication and self-medication on the residents receiving them.

(10) A program that provides services to residents with substance abuse problems must:

(a) Not admit an individual as a resident who is experiencing convulsions or delirium tremens or who is in shock, in a coma, or unconscious.

(b) Ensure and document that a staff member who provides direct service to residents completes a first aid and cardiopulmonary resuscitation (CPR) training course and certification within 6 months after being hired. All such staff members must complete refresher training courses as required by the certifying agency.

(c) Require residents, as a condition of admission, to be tested for tuberculosis and require applicants for jobs at a program facility, as a condition of employment, to be tested for

tuberculosis. Residents and staff of the program must be tested for tuberculosis annually or as directed by the Department of Health.

(11) A program that provides services to children and youth must:

(a) Provide a curriculum approved by the Department of Education to child and youth residents. A program that provides its own school must be recognized and approved by the State Board of Education, the Southern Association of Colleges and Schools, or another educational accreditation organization.

(b) Conduct individual, group, couple, and family counseling sessions or other appropriate treatment, including skills development therapy, at least weekly, or more often if required by a child or youth resident's treatment plan. The program must document the time, date, and nature of such services, including the signature of the counselor providing them, in the individual record for each resident.

(c) Safely store the personal funds of a child or youth resident. The program must keep an accurate record of all funds deposited and withdrawn for use by a child or youth resident. The program must maintain a record of receipts signed by the child or youth resident and an appropriate program staff member for resident purchases that exceed $20 in cost per item.

(12) A program that provides services to residents with disabilities must:

(a) Establish rules governing the daily operation and activities of the program facility which are applicable to all residents, staff, and family members on the premises of the facility. The program must make such rules available in written

form to residents and visitors at the facility.

(b) Establish a program policy for the amount of time a resident's family members or friends may stay at the program facility as overnight guests.

(c) Ensure that a resident with a disability has an individual plan that addresses appropriate day treatment.

(d) Maintain on file a monthly schedule of activities which must be shared with residents and is available for review at the request of residents or visitors.

(e) Maintain a record of all earned and unearned income and consumer service fees of residents.

(f) In conjunction with the parent or legal guardian of a resident with a disability and the Agency for Persons with Disabilities support coordinator, apply for unearned income benefits to which a resident with a disability is entitled.

Section 2. Section 394.89, Florida Statutes, is created to read:

394.89 Outdoor youth programs.—

(1) The purpose of an outdoor youth program is to offer wilderness hiking and camping experiences through program field group activities and expeditions as a form of rehabilitation treatment and services for youth with emotional, psychological, developmental, or behavioral problems or disorders or chemical dependencies. In an outdoor youth program, individuals are assisted in acquiring the social and behavioral skills necessary for living independently in the community.

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

(a) "Field office" means the office in which all coordination of field operations for the outdoor youth program

takes place.

(b) "Participant" means the youth who is provided the service by the outdoor youth program. The term does not include the parent or contracting agent that enrolls the youth in the program.

(3)(a) An outdoor youth program must be licensed by the agency. The department, in consultation with the agency, shall establish by rule requirements for licensure, administration, and operation of outdoor youth programs consistent with this section. All local, state, and federal regulations and professional licensing requirements must be met by an outdoor youth program as a condition of licensure by the agency. The agency must review and approve a program's training plan, which must include provisions governing a participant's conduct and the consequences for his or her conduct while enrolled in the program. The program executive director shall ensure that all information provided to parents, the community, and the media by or on behalf of the program is factually correct.

(b) A program must provide an educational component approved by the Department of Education to a participant who is absent from his or her school or educational setting for more than 1 month. Before enrolling a participant, the program's administrators must coordinate with the local school board to provide an educational component as part of the participant's program experience. To offer educational credit to participants, the program must be recognized and approved by the State Board of Education.

(4)(a) A program must have a governing board and an executive director. The governing board and executive director

are responsible for and have authority over the policies and activities of the program. The executive director shall coordinate office and support services, supervise the operations of the program, and ensure that all program staff are adequately trained. The executive director may be a licensed psychologist. He or she must meet, at a minimum, the following qualifications:

1. Be at least 25 years of age.

2. Have a bachelor's degree in recreational therapy or comparable training and experience in a related discipline.

3. Have 2 years of outdoor youth program administrative experience.

4. Demonstrate to the satisfaction of the agency a thorough knowledge and understanding of the laws and rules related to the licensing and operation of an outdoor youth program.

(b) A program must have a field director who has primary responsibility for field activities and participants, coordinates field operations, manages the field staff, and operates the field office. The field director must go into the field and visit a program field group activity or expedition at least 2 days each week that the program has participants in the field, with no more than 5 days between visits. He or she must prepare a report following each visit which documents the condition of the participants and the interactions between participants and staff. The field director must also use the field visits to ensure that the program is in compliance with this section and program policies and rules. The field director shall maintain at the field office a current list of all participants and a record of all field visit reports. The field director must meet, at a minimum, the following qualifications:

1. Be at least 25 years of age.

2. Have a bachelor's degree in recreational therapy or comparable training and experience in a related discipline.

3. Have 2 years of outdoor youth program field experience.

4. Be certified in first aid at the time of employment and, thereafter, be annually trained and certified in first aid and cardiopulmonary resuscitation (CPR).

5. Demonstrate to the satisfaction of the agency a thorough knowledge and understanding of the laws and rules related to the licensing and operation of an outdoor youth program.

(c) A program must have field support staff members who are responsible for the delivery of supplies to the field, mail delivery, communications, and first aid support. A field support staff member must meet, at a minimum, the following qualifications:

1. Be at least 21 years of age.

2. Have a high school diploma or a General Educational Development certification.

3. Be certified in first aid at the time of employment and, thereafter, be annually trained and certified in first aid and cardiopulmonary resuscitation (CPR).

4. Have completed an initial staff training course, as provided in this section.

(d) Each program field group activity or expedition must have a senior field staff member working directly with the participants who meets, at a minimum, the following qualifications:

1. Be at least 21 years of age.

2. Have a high school diploma, or a General Educational

Development certification, and have completed 30 semester or 45 quarter hours of college-level coursework in recreational therapy or comparable experience and training in a related field.

3. Have 6 months' outdoor youth program field experience or comparable experience. This experience must be documented in the individual's personnel file.

4. Be certified in first aid at the time of employment and, thereafter, be annually trained and certified in first aid and cardiopulmonary resuscitation (CPR).

5. Have completed an initial staff training course, as provided in this section.

(e) Each program field group activity or expedition must have field staff working directly with the participants who meet, at a minimum, the following qualifications:

1. Be at least 20 years of age.

2. Have a high school diploma or a General Educational Development certification.

3. Have 48 days of outdoor youth program field experience or comparable experience. This experience must be documented in the individual's personnel file.

4. Exhibit leadership skills.

5. Be certified in first aid at the time of employment and, thereafter, be annually trained and certified in first aid and cardiopulmonary resuscitation (CPR).

6. Have completed an initial staff training course, as provided in this section.

(f) A program may have assistant field staff, if necessary, to meet the required staff-to-participant ratio. An assistant

field staff member must meet, at a minimum, the following qualifications:

1. Be at least 19 years of age.

2. Have a high school diploma or its equivalent.

3. Have 24 days of outdoor youth program field experience.

4. Exhibit leadership skills.

5. Be certified in first aid at the time of employment and, thereafter, be annually trained and certified in first aid and cardiopulmonary resuscitation (CPR).

6. Have completed an initial staff training course, as provided in this section.

(g) Each program must have accessible to participants a multidisciplinary team of licensed clinical professionals which includes, at a minimum, the following:

1. A licensed physician.

2. At least one of the following:

a. A licensed psychologist.

b. A licensed clinical social worker.

c. A licensed mental health counselor.

d. A licensed marriage and family therapist.

e. A certified school counselor.

(h) A program may have as members of its staff academic and clinical interns who are placed to learn program practices as part of their degree requirements. Interns must be at least 19 years of age and complete the initial training course required under this section regardless of background experience. Clinical interns who are fulfilling requirements for licensure must be under the supervision of a licensed clinical professional in the program. Academic interns must be supervised by appropriate

program staff, as designated by the program executive director. Interns may not supervise participants at any time.

(i) A program may use program volunteers. Volunteers must be under the direct, constant supervision of program staff at all times. Volunteers must be at least 18 years of age and complete the initial training course required under this section regardless of background experience. Volunteers may not supervise participants at any time.

(5)(a) The field director shall maintain on file at the field office at all times a current list and enrollment records of all participants. The program must ensure that there is a written plan developed by the field director for each field group activity and expedition. The plan must not expose participants in the program to unreasonable risks and must be approved and signed by the field director and the program executive director, who must submit the plan to the program governing board for final approval.

(b) Program staff must record an inventory of the personal items that a participant brings with him or her upon enrollment in the program and must return all inventoried items, except contraband, to the participant following program completion. The participant or the participant's parent or legal guardian must sign, upon verification, the inventory list acknowledging its accuracy at the time the inventory is recorded and again when inventoried items are returned to the participant.

(c) A program must provide each participant with clothing and equipment to protect the participant from the environment during his or her program field group activity or expedition experience. This equipment may not be denied, removed from, or

made unavailable to a participant as a consequence of the participant's behavior or for any other reason. If a participant refuses or cannot carry all of his or her equipment, the field or expedition group of which he or she is a member shall cease hiking, and the reasons for his or her refusal or inability to continue must be established and resolved before hiking resumes. A program executive director must ensure that program staff are trained as to the requirements of this paragraph and must ensure that compliance with such requirements is monitored regularly. Field group activity and expedition equipment must include the following:

1. Sunscreen, which program staff shall ensure is used appropriately by the participant.

2. Insect repellent.

3. A frame or frameless backpack, the packed weight of which may not exceed 20 percent of the participant's body weight. If the participant is required to carry other items in addition to the backpack, the total weight carried may not exceed 30 percent of the participant's body weight.

4. Personal hygiene items.

5. Feminine hygiene supplies.

6. Sleeping bags rated for the seasonal conditions of the field group activity or expedition.

7. Shelters and ground pads for colder months when the average nighttime temperature is 39° F. or lower.

8. A set of basic clothing items for each participant sufficient for ordinary activities and additional items for each participant sufficient for protection against seasonal changes in the environment during the field group activity or

expedition.

(d) A program must provide participants with clean clothing at least weekly and must provide a means for participants to bathe or clean their bodies at least twice weekly. Female participants must be issued products for feminine hygiene purposes.

(e) Hiking may not exceed the physical capability of the weakest member of the field or expedition group. Hiking is prohibited at temperatures above 90° F. or below 10° F. Field staff must carry thermometers that accurately display current temperature. If a participant cannot or will not hike, the field or expedition group may not continue unless imminent danger exists.

(f) A program field group activity or expedition must have a field group activity or expedition plan, including map routes and anticipated schedules. A field group activity or expedition plan must be recorded in the field office and at least one copy carried by field staff during the field group activity or expedition.

(g) Field staff must maintain a signed, daily log or dictate a recorded log to be transcribed and signed immediately upon completion of the field group activity or expedition. All log entries must be recorded in permanent ink and made available to agency staff upon request. The log must contain detailed descriptions of any of the following that occur during the field group activity or expedition:

1. Accidents.

2. Injuries.

3. Medications administered.

4. Physical health concerns of a participant.

5. Behavioral problems exhibited by a participant.

6. All unusual occurrences.

(h) Outgoing and incoming mail to or from parents, guardians, or attorneys may not be restricted and must be delivered in as prompt a manner as the location of the participant and the circumstances dictate. Incoming mail may not be read or censored without written permission from a parent or legal guardian. A program may establish a policy defining the circumstances under which incoming mail must be opened in the presence of staff. Contraband in the possession of a participant or received by a participant in the mail must be confiscated by program staff.

(i) Each program staff member must carry with him or her a reliable timepiece, which may include a wristwatch or pocket watch, for the purposes of accurately determining the time of day and recording the time of day in log notes and incident reports and for other documentation purposes.

(j) A program must establish policies and procedures for the recognition of and responses to suicidal ideation which include review by a program clinical professional of the placement of a suicide watch on a participant.

(6)(a) An outdoor youth program must maintain a field office from which program field group activities, expeditions, and all other program activities are coordinated and monitored. A program must maintain and monitor communications by telephone and Internet connection to and from the field office at all times when a participant is engaged in a program field group activity or expedition or is in the field. A program field

director must ensure that members of field office staff are within 1 hour travel time from the location of all program field group activity and expedition participants or other participants at any time. Field office staff must respond immediately to any emergency situation. A program field director must ensure that a contact telephone number is posted on the field office door at any time field office staff are not present. At such times, he or she must ensure that on-call staff continually monitor communications and are within 15 minutes travel time from the field office.

(b) A program field director shall ensure that field office staff and field staff are properly trained and supervised and that personnel files and records for field office staff and field staff are maintained. Field office staff must perform the following duties:

1. Maintain written records regarding current staff and participants, including, but not limited to, demographic information, eligibility qualifications, and medical information and forms.

2. Maintain a current list of the names of field staff and participants in each program field group activity and on each program expedition.

3. Maintain a master map of all program field activity areas and expeditions.

4. Maintain copies of each field group activity and expedition map and each expedition route with its schedule and itinerary. Such copies must be provided to the agency and local law enforcement authorities upon request.

5. Maintain a log of all communications to and from the

field office and field staff.

6. Provide training and orientation to field staff.

7. Maintain and monitor all communications with the field office and field staff.

8. Maintain, store, and inspect program equipment.

9. Respond immediately to all medical incidents by providing first aid treatment and obtaining the services of emergency personnel and other providers as indicated.

10. Provide information regarding the program to the agency upon request.

(7)(a) A program field group activity or expedition must be supervised by at least two staff members at all times, one of whom must be a senior field staff member.

(b) A mixed-gender field group activity or expedition must be supervised by at least one female staff member and one male staff member.

(c) The size of a program field group activity or expedition may not exceed 16 individuals, including staff members, and the field group activity or expedition must have a staff-to-participant ratio of no less than 1 to 4. For purposes of determining the minimum number of staff members that must be included in a field group activity or expedition, interns and volunteers accompanying the field group activity or expedition are designated as participants. Notwithstanding this paragraph, field group activity or expedition size may not exceed the lowest limit provided by federal regulation or local ordinance in the jurisdiction in which the program is operated.

(8)(a) A program must provide a minimum of 80 hours of initial training to individuals who become members of program

staff. Initial staff training may not be considered complete until a staff member has demonstrated to the field director proficiency in each of the following:

1. Counseling, teaching, and supervising youth.

2. Water, food, and shelter procurement, preparation, and conservation.

3. Low-impact wilderness expedition and environmental conservation principles, methods, and procedures.

4. Group management, including containment, control, safety, conflict resolution, and behavior management.

5. Safety procedures for the protection of human life, the prevention of fire, and the handling of fuel.

6. Safe equipment and tool use.

7. Emergency methods and procedures for medical treatment, evacuation, sheltering or escaping from weather conditions, communication signaling, fire control and extinguishment, and searching for runaway or lost participants.

8. Sanitation procedures for the storage, handling, and use of water and food and for the confinement and disposal of waste.

9. Wilderness medicine, including health issues related to acclimation and exposure to the environment and the elements.

10. Cardiopulmonary resuscitation (CPR), first aid, and the contents and use of first aid kits.

11. Navigation, including map and compass use and contour and celestial navigation.

12. Adaptation to local environmental conditions, including terrain, weather, insects, poisonous plants, adverse situations, and conditions necessitating emergency evacuation.

13. Leadership and judgment.

14. Report writing, including the development and maintenance of logs and journals.

15. Knowledge of federal, state, and local regulations and requirements, including statutes and rules of the agency, the department, the Department of Environmental Protection, the Department of Agriculture, the Florida Fish and Wildlife Commission, the United States Forest Service, and the National Park Service.

(b) The field director must document in each staff member's personnel file the completion of the minimum 80 hours of initial training and whether the staff member has demonstrated proficiency levels under the requirements of paragraph (a). Initial training must continue for a staff member until he or she meets the requirements of paragraph (a). A staff member may not be included in assessing compliance with the staff-to-participant ratio required under paragraph (7)(c) until he or she has met the requirements of paragraph (a).

(c) A program must also provide ongoing training to staff members in order to improve proficiency in knowledge and skills and to maintain certifications. This training must be documented in the personnel file of a staff member.

(9) Before engaging in any field activity and on an ongoing annual basis, a staff member, an intern, or a volunteer must have a physical examination and a review of his or her health history conducted and signed by a licensed medical professional. A recognized physical stress assessment must be completed as part of the physical examination. A physical examination of a staff member must be documented in his or her personnel file. All staff members, interns, and volunteers must agree to submit

to drug and alcohol screening as required by federal and state law.

(10)(a) Participants must be at least 13 years of age and less than 18 years of age to enroll in a program.

(b) Not more than 30 days before enrollment in a program, a participant must complete and submit to the field office his or her health history on forms provided by the program. The history must be verified and signed by a parent or legal guardian and must include a description of physical or medical limitations and medications prescribed for the participant.

(c) Not more than 15 days before enrollment in a program, a participant must have a physical examination. The examination must be documented on a form provided by the program. The form must be signed by a licensed medical professional and submitted to the program before the participant is enrolled.

(d) The physical examination form provided by the program must prominently display a notice that clearly describes the location, terrain, environmental features, and physical demands of the program field group activity or expedition in which the participant seeks to enroll. The examination form must document the following tests and results from the physical examination of the participant:

1. A complete urinalysis that includes a drug screening and a screening for possible infections.

2. A complete blood count.

3. A comprehensive metabolic panel.

4. A physical stress assessment.

5. A determination by the licensed medical professional if detoxification is indicated for the participant before

enrollment in the program.

6. A pregnancy test for a female participant.

7. Other tests deemed necessary by the examining licensed medical professional.

(e) Before enrollment, a program must conduct an admissions screening of the participant. The screening must be supervised by a licensed clinical professional and include the following:

1. A review of the participant's social and psychological history with his or her parent or legal guardian.

2. An interview with the participant.

3. A review of the participant's health history and physical examination by a licensed medical professional.

(f) Before enrollment, a participant who has a history of a chronic psychological disorder must receive a psychological evaluation. The evaluation must be reviewed by a licensed psychologist on the staff of the program before the participant is enrolled.

(g) A participant's medical record must be documented and maintained at the field office, and a copy of the record must be carried in a waterproof container by a staff member assigned to the participant's program field group activity or expedition until the completion of the field group activity or expedition.

(h) After the start of a program field group activity or expedition, staff members shall closely monitor all participants for at least 3 days to detect any health problem resulting from difficulty in adjusting to the field group activity or expedition environment.

(11)(a) An outdoor youth program that maintains a designated location for the housing of participants is

considered stationary and is subject to additional fire, health, and safety standards. A stationary program camp must be inspected by a certified firesafety inspector before being occupied and on an annual basis for license renewal. A copy of the inspection report must be maintained at the program camp. The inspection must include the evaluation and approval of the following safety equipment and building requirements and features:

1. Fire extinguishers. Each fire extinguisher must be inspected annually by a fire extinguisher service agency. At least one type 2A10BC fire extinguisher must be in each of the following locations as required by the firesafety inspector:

a. On each floor in any building that houses participants;

b. In any room where cooking or heating of food or other items takes place; and

c. In a group of tents not more than 75 feet from the nearest tent.

2. Smoke detectors. At least one smoke detector must be in each kitchen area and in each room or space where a participant sleeps.

3. Escape routes. A minimum of two escape routes to the outside from each room or space where participants sleep must be mapped out and maintained.

4. Flammable liquids. Flammable liquids may not be used to start fires, be stored in structures that house participants, or be stored near ignition sources. If a generator is used at the program camp, it must be refueled only by staff members and only when it is not running and is cool to the touch.

5. Electrical wiring. All wiring must be properly attached,

and the electrical system must have appropriate fuses and breakers to prevent system overloads.

(b) A stationary program camp shall be inspected by the local county health department before being occupied and on an annual basis for license renewal. A copy of the inspection report must be maintained at the program camp. The inspection must include the evaluation and approval of the following supplies and operational systems:

1. Food. Food must be stored, prepared, and served in a manner that protects it from contamination.

2. Water supply. The water supply must be tested for the array of contaminants for which water systems at restaurant and lodging establishments are tested.

3. Sewage disposal. Sewage must be disposed through a public system or, in absence of a public system, in a manner approved by the local county health department.

(12)(a) An outdoor youth program must make available at least 6 quarts of potable water per individual per day plus 1 additional quart per individual for each 5 miles hiked. Access to water must be available at all times during hiking.

(b) In temperatures above 90° F., staff members must ensure that participant water intake is a minimum of 3 quarts per day. Electrolyte replacement must be available for members of a program field group activity or expedition at all times.

(c) In temperatures above 80° F., water must be available for dousing a participant's body, and other cooldown techniques must be available as needed for the purpose of cooling participants.

(d) Water must be available at each campsite. Water cache

location information must be verified daily with field support staff before the field group or expedition leaves camp.

(e) A field group activity or expedition may not depend on aerial drops to replenish the group with water. Aerial water drops may be used only for emergency situations.

(f) All water from natural sources must be treated and sanitized to eliminate health hazards.

(13)(a) An outdoor youth program must have a written menu listing and describing all food supplied to a participant during the period of enrollment. Food items must provide a minimum of 3,000 calories per day and must include fresh fruit and vegetables at least twice a week. A program's daily menu must be from a balance of the food groups. Forage items may not be included in determinations of daily caloric intake. If fire or a heating source is not available, other food of equal caloric value which does not require cooking must be provided to participants.

(b) Food may not be withheld from a participant as a punishment or for any other reason. Program fasting for more than 24 hours during a program field group activity or expedition is prohibited.

(c) A program must adjust the menu to provide a 30 to 100 percent increase in minimum dietary needs as energy expenditure from exercise or due to cold weather or other climate conditions increases. A program must offer daily multiple vitamin supplements to participants.

(14)(a) A program must provide at least one first aid kit to a field group activity or expedition. First aid kits must contain sufficient supplies appropriate for the activity,

location, and environmental conditions of the particular field group activity or expedition. A program must ensure that first aid treatment is provided in a prompt manner to an injured or a sick participant. If a participant incurs an illness or has a physical complaint that cannot be treated by first aid, the program must immediately arrange for the participant to be seen and treated as indicated by a licensed medical professional. Program staff must conduct and document a foot check of all participants at least twice daily.

(b) A program must provide a participant an assessment of his or her physical condition by a licensed health care professional at least once every 14 days of enrollment in the program. A certified emergency medical technician may perform such an assessment. The assessment must include, but is not limited to, the measurement and recording of a participant's blood pressure, heart rate, allergic reactions, and general physical condition. Any assessment concern must be documented and the participant taken to the appropriate medical professional for treatment and provided appropriate medication as needed. A participant may not suffer any consequence as a result of requesting to see a health care professional or for anything reported to a health care professional.

(c) All prescription and over-the-counter medications must be kept in the secure possession of designated staff members. Such staff members shall provide medications to participants only to be used or administered as prescribed by a qualified licensed medical practitioner. Such staff members are required to do the following:

1. Supervise the use of all medications.

2. Record each instance of medication use, including the participant's name and the date, time, and medication dosage.

3. Record the effects of medication use, if any.

4. Document any instance of a missed administration of prescription medication.

5. Document any lost or missing prescription medication.

(15) An outdoor youth program must have a safety support system with the following components:

(a) A radio communications system that provides reliable two-way radio communications on a daily basis. The system must include additional charged battery packs. A program must have a reliable backup system of contact in the event the radio system fails.

(b) Support vehicles and a field office, all equipped with first aid kits and other first aid equipment.

(c) Procedures to conduct an emergency evacuation from or make a rapid response to all field locations. Field support staff must have access at all times to contact names and locations and telephone numbers of local law enforcement personnel and other first responders.

(d) A policy of uninterrupted communication access between program groups in the field and field support staff. Field support staff must continuously monitor the location of program field group activities and the location and progress of program expeditions and maintain the capability for radio or telephone contact with such field groups and expeditions at all times. Daily morning and afternoon contact information for field staff and field support staff must be provided to the field office no later than the day before. Any change in such contact

information must be immediately relayed to the field office. Field staff must have the ability to contact field support staff and the field office on a continuous basis.

(16) All program field group activities and expeditions must adhere to federal, state, and local environmental or land use requirements regarding sanitation and low-impact camping. Program staff shall daily instruct participants in the observance of low-impact camping principles and practices. Personal hygiene supplies must be biodegradable.

(17)(a) In preparation for emergencies, a program must designate a hierarchy of staff authority and make individual staff assignments within that hierarchy.

(b) A program must have a written plan of action for disaster and casualty management to include a universal plan component for the evacuation of participants and staff or for a rapid field response. The plan of action must also contain components for the transport and relocation of participants, when necessary, and the supervision of participants after evacuation or relocation. Emergency evacuation equipment must be on standby availability at the field office or stationary program camp. A program must have standby protocols with local rescue services in preparation for possible emergency evacuation needs. A program must review such protocols with the local rescue services at 6-month intervals.

(c) A program must have a written plan for medical emergencies and for making arrangements for a participant's medical care, including notification of the participant's physician and nearest relative or guardian. A program must have a written agreement with a provider for medical emergency

evacuation, as needed.

(18) A program must establish policies and procedures designed to prevent or eliminate the spread of infectious and communicable diseases among participants and staff members.

(19) A program must establish policies and procedures that ensure the safe and comfortable transport of a participant between his or her home and the program location. A program may not require a participant's parent or guardian to use an escort transportation service, whether provided by the program or by an independent transportation service, as a condition for enrollment of the participant in the program. The decision to use an escort transportation service must be the independent choice of the participant's parent or guardian. A program that provides an escort transportation service must provide the parent or guardian of a participant with the contact information for at least two other escort transportation services to provide an independent option for procuring these services. As used in this subsection, the term "escort transportation service" means providing a responsible escort by an adult, for a fee, to accompany a participant during transport between the participant's home and the program location at enrollment or between the program location and the participant's home after completion of the program activities.

(20) There must be a written policy and procedures for transporting participants while they are enrolled in the program. A program must ensure that there are means of transportation readily available at all times sufficient to evacuate all participants and staff members in case of emergency. A staff member assigned to drive vehicles must follow

all safety requirements under the program's policy and procedures and the laws of this state. Each vehicle used by the program must be equipped with an adequately supplied first aid kit. When transporting one or more participants for any reason except in an emergency situation, there must be at least one male and one female staff member present at all times, unless the participant or participants being transported are all of the same gender, in which case all of the staff may be of that same gender. A staff member assigned to drive vehicles must have a valid driver license and must adhere to all local, state, and federal laws relating to the operation of motor vehicles. Participants and staff must wear seat belts at all times while in a moving vehicle.

(21) An outdoor youth program that has a solo experience for a participant as a component of a program offering must establish and follow a written policy and procedures for conducting the solo experience, which must include the following:

(a) A written description of the solo component, which must be designed to ensure that a participant is not exposed to unreasonable risks.

(b) A requirement that staff members must be familiar with the site chosen to conduct solo experiences.

(c) A requirement that staff members develop a written plan for each solo experience which includes provisions for the supervision of the participant during the solo experience and which addresses potential emergency situations during the solo experience.

(22) Following the completion of a program activity,

program staff must provide each participant with a debriefing, including a written summary of the participant's experience and role in the activity and the progress he or she made in acquiring outdoor or wilderness hiking and camping skills. An outdoor youth program must encourage parents, guardians, participants, and other involved individuals to submit written evaluations of the participants' program experiences. A program must provide questionnaires and mailing instructions for that purpose and retain submitted evaluations for 2 years.

(23)(a) An outdoor youth program must establish written procedures for handling any suspected incident of child abuse or neglect, including the following:

1. A procedure for immediately notifying law enforcement officials and the parent or legal guardian of a suspected victim following the report of a suspected incident.

2. A procedure for ensuring that the suspected staff member, director, or member of the governing body does not work directly with the suspected victim or any other participant until the investigation has been completed and, if charges are filed, the case has been finally adjudicated.

3. A procedure for ensuring that a director or member of the governing body suspected of abuse or neglect is relieved of his or her responsibility and authority over the policies and activities of the program and any other youth program until the investigation has been completed and, if charges are filed, the case has been finally adjudicated.

4. A procedure for disciplining any staff member, director, or member of the governing body involved in an incident of child abuse or neglect, including by termination of employment if

found guilty of a felony offense of child abuse or neglect, or loss of position, including a directorship position, if found guilty of a misdemeanor offense of child neglect.

(b) If a person in a management position, a director, or a member of the governing body is suspected of child abuse or neglect, the outdoor youth program must submit to an extensive review by the agency and law enforcement officials to determine whether the program can be operated safely if allowed to continue or if it should be terminated and its license revoked. The licensing and law enforcement review must be completed no later than 72 hours after the suspected incident of child abuse or neglect occurs.

(c) The agency must immediately suspend and may revoke an outdoor youth program license if a program fails to comply with paragraph (a) or paragraph (b).

(d) A license may not be issued to a youth outdoor program with an owner, a silent owner, or a member of management staff who was or is an owner, a silent owner, or a member of management staff in a program in which a suspected incident of child abuse or neglect occurred, until the investigation of the suspected incident and any charge and associated licensing violations are resolved.

(e) A license may not be issued to a youth outdoor program with an owner, a silent owner, or a member of management staff who was or is an owner, a silent owner, or a member of management staff in a program in which charges of child abuse or neglect resulted in a criminal conviction or civil or administrative findings that the allegations were true.

(24) Due to the difficulty of monitoring outdoor programs

and the inherent dangers of the wilderness, a single violation of the requirements of this section may result in immediate revocation of the outdoor youth program license, the immediate cessation of program activities, and the removal of participants from program locations.

Section 3. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 11, 2016

I respectfully request that **Senate Bill #998**, relating to Residential Treatment Facilities, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Jeremy Ring

Senator Jeremy Ring
Florida Senate, District 29

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1034
INTRODUCER:	Senator Simmons
SUBJECT:	Health Care Providers
DATE:	January 7, 2016
REVISED:	

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

I. Summary:

SB 1034 revises the description of volunteer, uncompensated services under the Access to Health Care Act (the act) to allow a free clinic to receive and use appropriations or grants from a governmental entity or nonprofit corporation to support the delivery of the contracted services by volunteer health care providers without jeopardizing the sovereign immunity protections afforded under the act. This support may include employing providers to supplement, coordinate, or support the volunteers.

The bill also clarifies that employees and agents of a health care provider fall within the sovereign immunity protections of the contracted health care provider when providing health care services pursuant to the contract. Section 768.28, F.S., is likewise amended to specifically include a health care provider's employees or agents to avoid any potential ambiguity between the provisions in that section of law and the act.

The bill is effective July 1, 2016.

II. Present Situation:

Access to Health Care Act

Section 766.1115, F.S., is entitled "The Access to Health Care Act" (the act). It was enacted in 1992 to encourage health care providers to provide care to low-income persons.[1] The act is

[1] Low-income persons are defined in the act as a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the Department of Health who voluntarily chooses to participate in a program offered or approved by the department. Section 766.1115(3)(e), F.S. A single individual whose annual income does not exceed $23,540 is at 200 percent of the federal poverty level using Medicaid data. *See 2015 Poverty Guidelines, Annual Guidelines* (September 13 2015) *available at*: http://aspe.hhs.gov/poverty/15poverty.cfm (last visited Jan. 7, 2016).

administered by the Department of Health (department) through the Volunteer Health Services Program.[2] Volunteers complete an enrollment application with the department which includes personal reference and background checks.[3]

This section of law extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who, as agents of the state, provide volunteer, uncompensated health care services to low-income individuals. These health care providers are considered agents of the state under s. 768.28(9), F.S., for purposes of extending sovereign immunity while acting within the scope of duties required under the act.

A contract under the act must pertain to volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient or any public or private third-party payor for the specific services provided to the low-income recipients covered by the contract.[4]

Health care providers under the act include:[5]

- A birth center licensed under ch. 383, F.S.[6]
- An ambulatory surgical center licensed under ch. 395, F.S.[7]
- A hospital licensed under ch. 395, F.S.[8]
- A physician or physician assistant licensed under ch. 458, F.S.[9]
- An osteopathic physician or osteopathic physician assistant licensed under ch. 459, F.S.[10]
- A chiropractic physician licensed under ch. 460, F.S.[11]
- A podiatric physician licensed under ch. 461, F.S.[12]
- A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of ch. 464, F.S., or any facility that employs nurses licensed or registered under part I of ch. 464, F.S., to supply all or part of the care delivered under the act.[13]
- A dentist or dental hygienist licensed under ch. 466, F.S.[14]
- A midwife licensed under ch. 467, F.S.[15]

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[2] *See* Florida Dep't of Health, Division of Public Health Statistics and Performance Management, *Volunteer Health Services* available at http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteerism-volunteer-opportunities/index.html (last visited Jan. 8, 2016); and Rule Chapter 64I-2, F.A.C.
[3] Florida Dep't of Health, Division of Public Health Statistics and Performance Management, *Volunteer Services Policy*, pp. 12-13, *available at* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/VHS2PolicyDOHP380-7-14.pdf (last visited Jan. 7, 2016).
[4] Section 766.1115(3)(a), F.S.
[5] Section 766.1115(3)(d), F.S.
[6] Section 766.1115(3)(d)1., F.S.
[7] Section 766.1115(3)(d)2., F.S.
[8] Section 766.1115(3)(d)3., F.S.
[9] Section 766.1115(3)(d)4., F.S.
[10] Section 766.1115(3)(d)5., F.S.
[11] Section 766.1115(3)(d)6., F.S.
[12] Section 766.1115(3)(d)7., F.S.
[13] Section 766.1115(3)(d)8., F.S.
[14] Section 766.1115(3)(d)13., F.S.
[15] Section 766.1115(3)(d)9., F.S.

- A health maintenance organization certificated under part I of ch. 641, F.S.[16]
- A health care professional association and its employees or a corporate medical group and its employees.[17]
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.[18]
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.[19]
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as a physician, physician assistant, nurse, or midwife.[20]
- Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, that delivers health care services provided by the listed licensed professionals, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

A governmental contractor is defined in the act as the department, a county health department, a special taxing district having health care responsibilities, or a hospital owned and operated by a governmental entity.[21]

The act further specifies additional contract requirements. The contract must provide that:

- The governmental contractor retains the right of dismissal or termination of any health care provider delivering services under the contract.
- The governmental contractor has access to the patient records of any health care provider delivering services under the contract.
- The health care provider must report adverse incidents and information on treatment outcomes.
- The governmental contractor or the health care provider must make patient selection and initial referrals.
- The health care provider is subject to supervision and regular inspection by the governmental contractor.[22]
- The health care provider must accept all referred patients; however, the contract may specify limits on the number of patients to be referred.[23]

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of legal actions alleging medical negligence.[24]

[16] Section 766.1115(3)(d)10., F.S.
[17] Section 766.1115(3)(d)11., F.S.
[18] Section 766.1115(3)(d)12., F.S.
[19] Section 766.1115(3)(d)14., F.S.
[20] Section 766.1115(3)(d)15., F.S.
[21] Section 766.1115(3)(c), F.S.
[22] Section 766.1115(4), F.S.
[23] Rule 64I-2.003(2), F.A.C.
[24] Section 766.1115(5), F.S.

According to the department, from July 1, 2014, through June 30, 2015, 12,569 licensed health care volunteers (plus an additional 9,938 clinic staff volunteers) provided 373,588 health care patient visits with a total value of donated goods and services of more than $271 million, under the act.[25] The Florida Department of Financial Services, Division of Risk Management, reported that as of January 7, 2015, that 10 claims had been filed against the Volunteer Health Care Provider Program under s. 766.1115, F.S., since February 15, 2000.[26]

Legislative Appropriation to Free and Charitable Clinics

The use of prior fiscal year appropriations by the Florida Association of Free and Charitable Clinics under the act had been restricted to clinic capacity building purposes via the contract with the department which distributed the appropriations. Clinic capacity building was limited to products or processes that increase skills, infrastructure and resources of clinics. The department did not authorize these funds to be used to build capacity through the employment of clinical personnel.

The department cautiously interpreted the provision in the act relating to volunteer, uncompensated services, which states that a health care provider must receive no compensation from the governmental contractor for any services provided under the contract. Accordingly, the department's interpretation precluded the use of the appropriation for this purpose.

The Florida Association of Free and Charitable Clinics received a $9.5 million appropriation in the 2015-2016 General Appropriations Act through the department.[27] However, this fiscal year's appropriation was vetoed by the Governor "because the funds could not be used for services, and therefore it is not a statewide priority for improving cost, quality, and access in healthcare."[28]

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result

[25] Florida Dep't of Health, *Volunteer Health Services 2014-2015 Annual Report* (December 1, 2015), *available at* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/VHS1415annualreport.pdf (last visited Jan. 7, 2016).
[26] Id at A-1.
[27] Chapter 2015-232, Laws of Fla., line item 441.
[28] Governor Rick Scott, *Veto Message to Secretary of State Ken Detzner* (June 23, 2015), p. 35, *available at* http://www.flgov.com/wp-content/uploads/2015/06/Transmittal%20Letter%206.23.15%20-%20SB%202500-A.pdf (last visited Jan. 7, 2016).

of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. The recovery by any one person is limited to $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000.[29] The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature.[30]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[31] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity:

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.[32]

The court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[33] The court explained:

> Whether CMS [Children's Medical Services] physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. This Court has held that the right to control depends upon the terms of the employment contract. . . . CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[34] Manual and CMS Consultant's Guide which contain CMS policies and rules governing its relationship with the consultants. The Consultant's Guide states that all services provided to CMS patients must be authorized in advance by the clinic medical director. The language of the HRS Manual ascribes to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel. The manual also grants to the CMS medical director absolute authority over payment for treatments proposed by consultants. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it can refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.

[29] Section 768.28(5), F.S.
[30] *Id.*
[31] *Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997).
[32] *Id.* at 703, quoting from the *Restatement (Second) of Agency* s. 14N (1957).
[33] *Id.* at 703.
[34] Florida Department of Health and Rehabilitative Services.

> Our conclusion is buttressed by HRS's acknowledgement that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, HRS has acknowledged full financial responsibility for the physicians' actions. HRS's interpretation of its manual is entitled to judicial deference and great weight.[35]

III. Effect of Proposed Changes:

Access to Health Care Act (Section 1)

The bill authorizes a free clinic to receive and use appropriations or grants from a governmental entity or nonprofit corporation to support the delivery of contracted services by volunteer health care providers under the Access to Health Care Act without those funds being deemed compensation which might jeopardize the sovereign immunity protections afforded in the act. The bill authorizes these appropriations or grants to be used for the employment of health care providers to supplement, coordinate, or support the delivery of services by volunteer health care providers. The bill states that the receipt and use of the appropriation or grant does not constitute the acceptance of compensation for the specific services provided to the low-income recipients covered by the contract.

The bill inserts the phrase "employees or agents" in several provisions in the act to clarify that employees and agents of a health care provider, which typically are paid by a health care provider, fall within the sovereign immunity protections of the contracted health care provider when acting pursuant to the contract. Subsection (5) of the act currently recognizes employees and agents of a health care provider. This subsection requires the governmental contractor to provide written notice to each patient, or the patient's legal representative, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider *or any employee or agent thereof* acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28, F.S.

The bill provides for efficiencies in health care delivery under the contract by requiring the patient, or the patient's legal representative, to acknowledge in writing receipt of the notice of agency relationship between the government contractor and the health care provider at the initial visit only. Thereafter, the notice requirement is met by posting the notice in a place conspicuous to all persons.

Sovereign Immunity (Section 2)

Section 768.28, F.S., is amended to specifically include a health care provider's employees or agents so as to avoid any potential ambiguity between the provisions in that section of law and the act.

[35] *Stoll*, 694 So. 2d at 703 (Fla. 1997) (internal citations omitted).

Additional Provisions and Effective Date

The bill removes obsolete language and makes technical and grammatical changes.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Contracted free clinics may receive governmental funding in the form of an appropriation or grant without the concern of restrictions on such funding for certain uses that might be imposed by the act. The receipt of any such funding is speculative at this point and therefore the amount is indeterminate.

Private health care providers currently delivering services to uninsured individuals may see a reduction in their uncompensated care costs as these individuals seek care in these clinics with expanded resources.

C. Government Sector Impact:

The department will be responsible for management of the contracts with the clinics.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 766.1115 and 768.28.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Simmons

10-01528-16 20161034__

A bill to be entitled

An act relating to health care providers; amending s. 766.1115, F.S.; revising the definitions of the terms "contract" and "health care provider"; deleting an obsolete date; extending sovereign immunity to employees or agents of a health care provider that executes a contract with a governmental contractor; clarifying that a receipt of specified notice must be acknowledged by a patient or the patient's representative at the initial visit; requiring the posting of notice that a specified health care provider is an agent of a governmental contractor; amending s. 768.28, F.S.; revising the definition of the term "officer, employee, or agent" to include employees or agents of a health care provider; providing an effective date.

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

Section 1. Paragraphs (a) and (d) of subsection (3) and subsections (4) and (5) of section 766.1115, Florida Statutes, are amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(3) DEFINITIONS.—As used in this section, the term:

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor for volunteer, uncompensated services which allows the health care provider to deliver health care

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services to low-income recipients as an agent of the governmental contractor. ~~The contract must be for volunteer, uncompensated services, except as provided in paragraph (4)(g).~~ For services to qualify as volunteer, uncompensated services under this section, the health care provider, or any employee or agent of the health care provider, must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or a public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract, except as provided in paragraph (4)(g). A free clinic as described in subparagraph (d)14. may receive a legislative appropriation, a grant through a legislative appropriation, or a grant from a governmental entity or nonprofit corporation to support the delivery of contracted services by volunteer health care providers, including the employment of health care providers to supplement, coordinate, or support the delivery of such services. The appropriation or grant for the free clinic does not constitute compensation under this paragraph from the governmental contractor for services provided under the contract, nor does receipt or use of the appropriation or grant constitute the acceptance of compensation under this paragraph for the specific services provided to the low-income recipients covered by the contract.

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association ~~and its employees~~ or a corporate medical group ~~and its employees~~.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited

program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(4) CONTRACT REQUIREMENTS.—A health care provider that executes a contract with a governmental contractor to deliver health care services ~~on or after April 17, 1992,~~ as an agent of the governmental contractor, or any employee or agent of such health care provider, is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider, or any employee or agent of such health care provider, shall continue to be an agent for purposes of s. 768.28(9) for 30 days after a determination of ineligibility to allow for treatment until the individual transitions to treatment by another health care provider. A health care provider, or any employee or agent of such health care provider, under contract with the state may not be named as a defendant in any action arising out of medical care or treatment ~~provided on or after April 17, 1992,~~ under contracts entered into under this section. The contract must provide that:

(a) The right of dismissal or termination of any health care provider delivering services under the contract is retained by the governmental contractor.

(b) The governmental contractor has access to the patient records of any health care provider delivering services under the contract.

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if the incidents and information pertain to a patient treated under the contract. The health care provider shall submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities under this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Patient selection and initial referral must be made by the governmental contractor or the provider. Patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

(e) If emergency care is required, the patient need not be

referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.

(f) The provider is subject to supervision and regular inspection by the governmental contractor.

(g) ~~As an agent of the governmental contractor for purposes of s. 768.28(9), while acting within the scope of duties under the contract,~~ A health care provider licensed under chapter 466, as an agent of the governmental contractor for purposes of s. 768.28(9), may allow a patient, or a parent or guardian of the patient, to voluntarily contribute a monetary amount to cover costs of dental laboratory work related to the services provided to the patient within the scope of duties under the contract. This contribution may not exceed the actual cost of the dental laboratory charges.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.—The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing at the initial visit, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to ~~the~~

~~provisions of~~ s. 768.28. Thereafter, or with respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the health care provider, or federally funded community health center, is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to ~~the provisions of~~ s. 768.28.

Section 2. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(9)

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider, and its employees or agents, when providing services pursuant to s. 766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph (10)(f); and any public defender or her or his employee or agent, including, among others, an assistant public defender and an investigator.

Section 3. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 5, 2016

I respectfully request that **Senate Bill 1034**, relating to Health Care Providers, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 10

File signed original with committee office

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1496
INTRODUCER:	Senator Bradley
SUBJECT:	Transparency in Health Care
DATE:	January 15, 2016
REVISED:	1/19/16

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

I. Summary:

SB 1496 increases the transparency and availability of healthcare pricing and quality of service information. The Agency for Health Care Administration (AHCA) is required to contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures by a common-named service bundle to facilitate price comparison of typical health care services provided in hospitals and ambulatory surgery centers (ASC). Quality indicators for services at the facilities will also be made available to the consumer to facilitate health care decision making.

Hospitals and ASCs are required to provide access to the searchable service bundles on their website. Consumers will be presented with estimated average payment and estimated payment ranges for each service bundle, by facility, facilities within geographic boundaries, and nationally. The hospital and ASC must notify consumers of other health care providers that may bill separately from the facility as well as information about the facility's financial assistance policies and collection procedures.

The hospital's and ASC's website must also provide hyperlinks to the websites of insurers and health maintenance organizations (HMOs) for which the facility is in-network or a preferred provider to enable an insured patient to research cost-sharing responsibilities for the service bundle. Insurers and HMOs are required to provide on their websites a method for policy holders to estimate their cost-sharing responsibilities by service bundle based on the insured's policy and known plan usage. These estimates shall include both in-network and out-of-network providers. Insurers and HMOs are also required to provide hyperlinks on their website to the AHCA's performance outcome and financial data.

Consumers may request personalized good faith estimates of charges for nonemergency medical services from hospitals, ASCs, and health care practitioners relating to medical services provided in the hospital or ASC. The bill also requires nursing homes, home health agencies, and home

medical equipment providers to provide consumers with good faith estimates of medical services and supplies. These good faith estimates must be provided to the consumer within 7 days after the request. Information must also be provided about the health care provider's financial assistance policies and collection procedures.

A patient may also request an itemized bill or statement from the hospital and ASC after discharge. The hospital or ASC must provide an itemized bill or statement within 7 days that is specific, written in plain language, and identifies all services provided by the facility, as well as rates charged, amounts due, and the payment status. The itemized bill or statement must inform the patient to contact his or her insurer regarding the patient's share of costs. The facility must provide records to verify the bill or statement upon request.

The bill requires the Consumer Advocate in the Department of Financial Services to receive and investigate complaints from insured and uninsured patients concerning billing practices. If, after investigating a complaint, the Consumer Advocate determines the billing practices and charges were unfair, the Consumer Advocate will report these findings to the AHCA and the Department of Health (DOH) for regulatory and disciplinary action. The bill provides for penalties for unconscionable prices. The Consumer Advocate is also authorized to mediate billing complaints and negotiate payment arrangements.

The bill requires health insurers and HMOs that participate in the state group health insurance plan or Medicaid managed care to submit claims data to the vendor selected by the AHCA. The bill grants a premium tax credit of .05 percent to health insurers and HMOs that submit data to the vendor and establishes a tax credit of $50 per employee per submission, up to $500,000, which may be used against either Florida's sales and use tax or corporate income tax for employers with plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) that submit qualifying health care claims information to the vendor selected by the AHCA.

II. Present Situation:

Healthcare Price and Quality Transparency

In general, the term transparency when applied to healthcare refers to the ability of a patient, or the public, to investigate and compare different healthcare providers for pricing and quality of care for one or more procedures. Although simple sounding, healthcare price transparency is difficult to implement due to legal challenges, the manner in which healthcare is provided, and the manner in which healthcare costs are paid. Demonstrating this difficulty, the Health Care Incentives Improvement Institute gave an F grade to 45 out of 50 states, including Florida, in their 2015 Report Card on State Price Transparency Laws.[1, 2]

Some difficulties in implementing healthcare price transparency include:

[1] Health Care Incentives Improvement Institute, *Report Card on State Price Transparency Laws*, (July 2015), *available at* http://www.hci3.org/wp-content/uploads/files/files/2015_Report_PriceTransLaws_06.pdf (last visited on Jan. 14, 2016).
[2] Only one state, New Hampshire, received an A rating, which Colorado and Maine received B's, and Vermont and Virginia received C's.

- Legal barriers including the confidentiality of some contractual information between healthcare providers and insurers as well and health insurer trade secret information.[3]
- Difficulty in determining who will be providing care and whether or not all providers are in a patient's insurance network.[4]
- General confusion over billing practices. Many hospital bills, and bills provided by other healthcare facilities, consist of billing codes and names of procedures or medications provided which may not be easily understood by a layperson. Additionally, it may be difficult to determine whether or not charges included on the bill have been paid, need to be paid, or will be paid by a third party such as a health insurer.
- Difficulty drawing comparisons between patient's particular situations. For example, an older patient may be more fragile and require more recovery time and caution when administering a procedure and, therefore, may be charged more than a younger patient for the same procedure. Additionally, actual payment amounts to the healthcare provider may differ from patient to patient depending on whether or not that patient has insurance and the magnitude of any discounts that the insurer has negotiated with that healthcare provider.

Common Definitions in Healthcare Pricing

Another basic difficulty in interpreting healthcare pricing is understanding the definition of many terms used. Some common definitions used include:

- "Charge," which means the dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.
- "Cost," the definition of which varies by the party incurring the expense:
  - To the patient, cost is the amount payable out of pocket for healthcare services.
  - To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
  - To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
  - To the employer, cost is the expense related to providing health benefits (premiums or claims paid).
- "Price," which means the total amount a provider expects to be paid by payers and patients for healthcare services.
- "Out-of-pocket payment," which means the portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles.[5]

Current Florida Requirements for Healthcare Price and Quality Transparency

Current Florida law establishes multiple requirements regarding healthcare cost and quality transparency. Examples of such requirements include:

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[3] Id.

[4] Anne Weiss and Susan Dentzer, *Three Key Lessons from the Health Care Transparency Summit*, Robert Wood Foundation, (April 16, 2015) http://www.rwjf.org/en/culture-of-health/2015/04/3_key_lessons_fromt.html?cid=xrs_rss-pr (last visited on Jan. 14, 2016).

[5] Healthcare Financial Management Association Price Transparency Taskforce, *Price Transparency in Health Care*, p.2 (2014) (on file with the Senate Committee on Health Policy).

- Florida's Patient's Bill of Rights and Responsibilities[6] which establishes the right of patients to, among other rights, be given information of known financial resources for the patient's health care, a reasonable estimate of charges before a procedure, and an itemized bill. The bill of rights also requires facilities to post a link to AHCA performance and financial data.
- Hospitals and ASCs as a licensure requirement must provide patients and their physicians with itemized bills upon request.[7]
- Pharmacies, health insurers, and HMOs are required to inform customers of the availability of the AHCA's quality and cost information.[8]
- HMOs are required to disclose financial data to customers and provide customers with estimated costs for services.[9]

The Florida Center for Health Information and Policy Analysis

Section 408.05, F.S., establishes the Florida Center for Health Information and Policy Analysis (Florida Center). The Florida Center is required to establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of collected and extant health-related data. The Florida Center is responsible for:

- Collecting adverse incident reports from hospitals, ASCs, HMOs, nursing homes, and assisted living facilities (ALF);
- Collecting discharge data from licensed hospitals, ASCs, emergency departments, cardiac catheterization laboratories and lithotripsy;
- Administering patient injury reporting, tracking, trending, and problem resolution programs for hospitals, ASCs, nursing homes, ALFs, and some HMOs
- Processing patient data requests and providing technical assistance;
- Administering www.FloridaHealthFinder.gov, Florida's state run webpage which provides easy access to health care information through health care quality comparison tools, a health encyclopedia, and other resources. The public may access the website to learn about medical conditions, compare health care facilities and providers, and find health care resources. The website also allows users to compare price ranges for some commonly offered healthcare services between healthcare providers.[10, 11]

The Florida Commission on Healthcare and Hospital Funding

On May 5, 2015, Governor Rick Scott signed executive order 15-99 that established the Commission on Healthcare and Hospital Funding (commission).[12] The commission was created to investigate and advise on the role of taxpayer funding for hospitals, insurers, and healthcare

[6] Section 381.026, F.S.
[7] Section 395.301, F.S.
[8] Sections 465.0244, 627.54, and 641.54, F.S
[9] Section 641.54, F.S.
[10] See *Florida Center for Health Information and Policy Analysis*, http://www.ahca.myflorida.com/schs/index.shtml (last visited on Jan. 14, 2016) and the Florida Health Finder FAQ, http://www.floridahealthfinder.gov/media/training-video.aspx (last visited on Jan. 14, 2016)
[11] Quality and price data is available on the website and searchable for approximately 150 conditions. Email from Orlando Pryor, AHCA Legislative Affairs Office (Jan. 15, 2016) (on file with the Senate Committee on Health Policy).
[12] Executive order 15-99, *available at* http://www.flgov.com/wp-content/uploads/orders/2015/EO_15-99.pdf, (last visited on Jan. 15, 2016).

providers, and the affordability, access, and quality of healthcare services they provide. The commission has met 15 times between May 20, 2015 and January 19, 2016, and will continue meeting. In its meetings the commission has heard testimony and collected data from numerous sources including physicians, hospitals, state agencies, and the public but it has not yet published conclusions or final recommendations. On November 19, 2015, the commission endorsed proposed bill language from Governor Scott which addresses the issue of healthcare price and quality transparency.[13] [14] Many of the concepts inherent to the Governor's proposal are addressed in SB 1496.

III. Effect of Proposed Changes:

Section 1 amends the licensure requirements for hospitals and ambulatory surgical centers (ASC) in s. 395.301, F.S., to require that such facilities meet new standards for providing financial information and quality of service measures to patients and the public.[15]

General Requirements for the Provision of Information to the Public

The bill requires each facility to:

- Provide timely and accurate financial information and quality of service measures to prospective patients, actual patients, and patient's legal guardians or survivors.
- Make information on payments made to that facility available on the facility's website.
  - The posted information must be presented and searchable in accordance with the system and service bundles established by the AHCA.
  - The minimum information that must be provided by the facility for each service bundle includes:
    - The estimated average payment received from all payors except Medicaid and Medicare; and
    - The estimated payment range.
  - The facility must state in plain language that the information provided is an estimate of costs for and that actual costs will be based on services actually provided.
  - The facility must assist the consumer in accessing his or her health insurer's, or HMO's, website for information on estimated copayments, deductibles, and other cost-sharing responsibilities.
- Post information on its website including:
  - The names, and a link to the website, of all health insurers and HMOs for which the facility is a network provider or a preferred provider;
  - Information for uninsured or out-of-network patients on:
    - The facility's financial assistance policy including the application process, payment plans, and discounts; and
    - The facility's charity care policy and collection procedures.

[13] Letter from the Commission on Healthcare and Hospital Funding to Senate President Andy Gardiner and Speaker of the House Steve Crisafulli (November 19, 2015) (on file with the Senate Committee on Health Policy).
[14] Governor's Recommended Bill, *Health Care Transparency*, available at http://www.healthandhospitalcommission.com/docs/HealthcareTransparencyProposal.pdf (last visited on Jan. 15, 2016).
[15] Note: Some of the effects detailed in the analysis of section 1 of the bill are requirements that are in current law and which are either kept intact or revised and restated. Due to the significant reorganization of s. 395.301, F.S., the total effects of all new, current law, and revised requirements are included in this analysis as effects of the bill.

- A notification to patients and prospective patients that services may be provided in the facility by the facility and by other health care providers who may bill separately; and
- Information that patients and prospective patients may request a personalized estimate of charges from the facility.
- A link to health-related data, including quality measures and statistics that are disseminated by the AHCA.

- Take action to notify the public that health-related data is electronically available to the public and provide a hyperlink to the AHCA's website.

Requirements to Respond to Specific Requests for Information

Upon specific request, the bill requires each facility to provide:

- A written, good faith estimate of reasonably anticipated facility charges for the non-emergency treatment of the requestor's specific condition. The bill specifies that:
  - The estimate must be provided within seven business days after the receipt of the request.
  - The facility is not required to adjust the estimate to account for any insurance coverage.
  - The estimate may be based on the service bundles created by the AHCA unless the patient requests a more specific estimate.
  - The facility must inform the patient that he or she may contact his or her health insurer or HMO for additional information on cost-sharing responsibilities.
  - The estimate must provide information on the facility's financial assistance policy, including the application process, payment plans, and discounts.
  - The estimate must provide information on the facility's charity care policy and collection procedures.
  - Upon request, the facility must notify the requestor of any revision to the estimate.
  - The estimate must contain a notice that services may be provided by other health care providers who may bill separately.
  - The facility must take action to notify the public that such estimates are available.
  - The facility will be fined $500 for each instance of failing to timely provide a requested estimate.
  - The provision of the estimate does not preclude the charges from exceeding the estimate.
- An itemized bill or statement to the patient, or the patient's survivor or legal guardian, within 7 days of the patient's discharge or the request for the statement.
  - The initial itemized statement or bill:
    - Must be provided within 7 days of the patient's discharge or the patient's request;
    - Must detail the specific nature of charges or expenses in plain language, comprehensible to an ordinary layperson;
    - Must contain a statement of specific services received and expenses incurred by date
    - Must enumerate in detail, as prescribed by the AHCA, the constituent components of the services received within each department of the facility;
    - Must include unit price data on rates charged by the facility;
    - Must identify each item as paid, pending payment by a third party, or pending payment by the patient;
    - Must include the amount due, if applicable;
    - Inform the patient or the patient's legal survivor or guardian, to contact the patient's health insurer or HMO regarding the patient's cost-sharing responsibilities;

- Must include a notice of hospital-based physicians and other health care providers who bill separately;
- May not include any generalized category of expenses;
- Must list drugs by brand or generic name; and
- Must identify the date, type, and length of treatment for any physical, occupational, or speech therapy provided.
- Must prominently display the telephone number of the medical facility's patient liaison.

- When providing a subsequent bill, the bill must contain all of the information required in the initial bill with any revisions clearly delineated.
- A facility must make available at no charge except copying fees, both in the facility's office and electronically, all records necessary for the verification of the accuracy for the patient's statement or bill within 10 business days, reduced from 30 days, after a request for such records and before payment of the statement or bill.
- Each facility must establish a method of responding to patient question about his or her itemized bill within 7 business days, reduced from 30 days, after the question is received. If the patient is not satisfied with the facility's response the facility must provide the patient with the address and contract information for the consumer advocate as provided in s. 627.0613, F.S.

Miscellaneous Provisions

The bill strikes language:

- Stating that any person who receives an itemized statement is fully and accurately informed as to each charge and service provided by the institution preparing the statement;
- Requiring an itemized statement to contain a disclosure identifying the ownership status, either for-profit or not-for-profit, of the facility preparing the statement;
- Requiring an itemized bill to be provided to the patient's physician at no charge;
- Restricting physicians, dentists, podiatrists, and other licensed facilities from adding to the price charged by a third party except for a service or handling charge which represents a cost actually incurred.

The bill also makes other technical and conforming changes.

Section 2 creates s. 395.3012, F.S., to allow the AHCA to impose fines based on the findings of the consumer advocate's investigation of billing complaints pursuant to s. 627.0613(6), F.S. The bill sets the fines for noncompliance at the greater of $2,500 per violation or double the amount that the charges exceeded fair charges.

Sections 3, 4, and 5 amend ss. 400.165, 400.487, and 400.934, F.S., to require nursing homes, home health agencies, and home medical equipment providers, respectively, to, upon request, provide a written good faith estimate of reasonably anticipated charges for services provided by that healthcare provider within seven business days after receiving a request and to provide information disclosing payment plans, discounts, other available assistance, and collection procedures. Additionally, home health agencies and home medical equipment providers must

inform the requestor that he or she may contact his or her health insurer or HMO for additional information concerning cost sharing responsibilities.

Section 6 amends s. 408.05, F.S., to replace the Florida Center for Health Information and Policy Analysis with the Florida Center for Health Information and Transparency (center) which is housed within the AHCA. Responsibilities are streamlined and updated to reflect current data needs. The center is tasked with collecting, compiling, coordinating, analyzing, indexing, and disseminating health-related data and statistics. The center and the AHCA must meet the following requirements:[16]

Health Related Data

The bill:

- Requires that the center be staffed as necessary to carry out its functions.
- Requires that the center maintain data sets in existence before July 1, 2016, unless such data is duplicated and readily available from other credible sources.
- Requires that the center collect data on:
  - Health resources, including licensed health care practitioners by specialty and type of practice and including data collected by the DOH pursuant to ss. 458.3191 and 456.0081, F.S.
  - Health service inventories, including acute care, long-term care, and other institutional care facilities and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care facilities.
  - Service utilization for licensed health care facilities.
  - Health care costs and financing.
  - The extent of public and private health insurance coverage in Florida.
  - Specific quality-of-care initiatives involving various health care providers when extant data is not adequate to achieve the objectives of the initiatives.
- Eliminates the requirement that the center collect data on:
  - The extent and nature of illness and disability of the state population;
  - The impact of illness and disability of the state population on the state economy;
  - Environmental, social, and other health hazards;
  - Health knowledge and practices of the people in Florida; and
  - Family formation, growth, and dissolution.

Health Information Transparency

The bill:

- Requires the AHCA to:
  - Contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures and allows for price comparison. The platform must allow a consumer to search by condition or service bundle that is comprehensible to an ordinary layperson and may not require registration, password, or user identification. The vendor must:

[16] Note: As similarly noted in section 1, due to significant revision and organizational changes in this section, the total effects of all new, revised, and current law requirements are included in this analysis as effects of the bill.

        - Be a nonprofit research institute that is qualified under s. 1874 of the Social Security Act to receive Medicare claims data and that receives claims data from multiple private insurers nationwide.
        - Have a national database consisting of at least 15 billion claim lines of administrative claims data from multiple payors capable of being expanded by adding third-party payors, including employers with Employee Retirement Income Security Act of 1974 (ERISA) plans.
        - Have a well-developed methodology for analyzing claims data within defined service bundles.
        - Have a bundling methodology that is available in the public domain to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.
    - Collect and compile information on and coordinate the activities of state agencies involved in providing health information to consumers.
    - Promote data sharing by making state-collected data available, transferable, and readily usable.
    - Develop written agreements with local, state and federal agencies to facilitate the sharing of data related to health care.
    - Establish by rule the types of data collected, complied, processed, used, or shared.
    - Consult with contracted vendors, the State Consumer Health Information and Policy Advisory Council, and other public and private users regarding the types of data that should be collected and the use of such data.
    - Monitor data collection procedures and test data quality to facility the dissemination of data that is accurate, valid, reliable, and complete.
    - Develop methods for archiving data, retrieving archived data, and data editing and verification.
    - Make available health care quality measures that will allow consumers to compare outcomes and other performance measures for health care services.
    - Make available the results of special health surveys, health care research, and health care evaluations conducted or supported by under s. 408.05, F.S.
- Restricts the AHCA from establishing an all-payor claims database without express legislative authority.
- Except as detailed above, the AHCA, or the center, is no longer required to:
    - Review the statistical activities of state agencies to ensure they are consistent with the comprehensive health information system.
    - Establish minimum health-care-related data sets.
    - Establish advisory standards for the quality of health statistical and epidemiological data collection.
    - Prescribe standards for the publication of health-care-related data.
    - Establish a long-range plan for making health care quality measures and financial data available.
    - Provide technical assistance to persons or organizations engaged in health planning activities.
    - Administer, manage, and monitor grants related to health information services.
    - Aid in the dissemination of data through the publication of reports, including an annual report, and conducting special studies and surveys.

Section 7 amends s. 408.061, F.S., to:

- Require that the AHCA mandate the submission of data from health care facilities, health care providers, and health insurers in order to facilitate transparency in health care pricing and quality measures.
- State that data submitted by health care providers may include actual charges to patients as specified by rule.
- State that data submitted by health insurers may include payments to health care facilities and health care providers as specified by rule.

Section 8 amends s. 456.0575, F.S., to require that every licensed health care practitioner must provide, upon request by a patient, a good faith estimate of reasonably anticipated charges for any nonemergency services to treat the patient's condition at a hospital or ASC. This estimate must be provided within seven business days after receiving the request and before providing the service for which the request for an estimate was made. The practitioner must inform the patient that he or she may contact his or her health insurer or HMO for additional information concerning cost-sharing responsibilities. The practitioner must also provide information to uninsured or out of network patients on the practitioner's financial assistance policy, including the application process, payment plans, discounts, and other available assistance; the practitioner's charity care policy, and the practitioner's collection procedures.

The bill states that providing such an estimate does not preclude the actual charges from exceeding the estimate and that failure to provide a requested estimate in accordance with the provisions stated and without good cause will result in disciplinary action and a fine of $500 for each instance of failure to provide the requested estimate.

Section 9 amends s. 456.072, F.S., to include the failure to comply with fair billing practices pursuant to s. 627.0613, F.S., (see section 10) in the list of grounds for which disciplinary actions may be taken against a health care practitioner.

Section 10 amends s. 627.0613, F.S., to expand the duties of the consumer advocate.[17]

The bill requires:

- The consumer advocate to maintain a process for receiving and investigating complaints concerning billing practices by hospitals, ASCs, and health care practitioners licensed under ch. 456, F.S. Such investigations are limited to determining compliance with the following:
  - The patient was informed before a nonemergency procedure of the expected payments related to the procedure, the contact information for health insurers or HMOs, and the expected involvement of other providers who may bill separately;
  - The patient was informed of policies and procedures to qualify for discounts;
  - The patient was informed of collection procedures and given the opportunity to participate in an extended payment schedule;
  - The patient was given a written, personal, and itemized estimate as required in ss. 395.301 for facilities and 456.0575 for health care practitioners for services in a facility;

[17] The consumer advocate is appointed by, and reports to, the Chief Financial Officer and is tasked with representing the general public before various state agencies.

  - The statement or bill delivered to the patient was accurate and included all required information; and
  - The billed amount were fair charges, defined as "the common and frequent range of charges for patients who are similarly situated requiring the same or similar medical services.
- The consumer advocate to report to the AHCA and the DOH the findings resulting from investigation of unresolved complaints concerning the billing practices of any hospital, ASC, or healthcare practitioner licensed under ch. 456, F.S.
- The AHCA and the DOH to grant the consumer advocate access to any files, records, and data which are necessary for such investigations.
- The consumer advocate to provide mediation between providers and patients to resolve billing complaints and negotiate arrangements for extended payment schedules.

Section 11 creates s. 627.6385, F.S., to require each health insurer to:
- Make available on its website:
  - A method for policyholders to estimate their cost-sharing responsibilities for health care services and procedures based on the service bundles established in s. 408.05(3)(c), F.S., or based on a personalized estimate.
    - The provision of the estimate does not preclude the actual amount from exceeding the estimate.
    - The estimates must be calculated according to the policyholder's policy and known plan usage during the coverage period and must be available based on providers that are in-network and out-of-network.
    - A policyholder must be able to create estimates from any combination of service bundles or by a specified provider or comparison of providers.
  - A link to the health and quality information disseminated by the AHCA.
- Include in every policy delivered or issued to a person in Florida a notice that the information required by this section is available electronically and the address of the website where the information can be accessed.
- If the health insurer participates in the state group health insurance plan or Medicaid managed care, provide all claims data to the fullest extent possible to the contracted vendor selected by the AHCA under s. 408.05(3)(c), F.S. A health insurer that provides such data is eligible for .05 percent credit against the premium tax established pursuant to s. 624.509, F.S. This credit may exceed the limitation on such tax credits that is imposed by that section of law.

Section 12 amends s. 641.54, F.S., to require each HMO to:
- Make available electronically or by request the estimated amount of any cost-sharing responsibilities for any covered services described by the service bundles established pursuant to s. 408.05(3)(c), F.S., or as described in a personalized estimate received from a health care facility or health care practitioner.
- If the HMO participates in the state group health insurance plan or Medicaid managed care, provide all claims data to the fullest extent possible to the contracted vendor selected by the AHCA under s. 408.05(3)(c), F.S. An HMO that provides such data is eligible for .05 percent credit against the premium tax established pursuant to s. 624.509, F.S. This credit may exceed the limitation on such tax credits that is imposed by that section of law.

- Create a link on its website to the health information disseminated by the AHCA.

Section 13 amends s. 409.967, F.S., to require that Medicaid managed care plans provide all claims data to the fullest extent possible to the contracted vendor selected by the AHCA under s. 408.05(3)(c).

Section 14 amends s. 110.123, F.S., to require that the DMS make arrangements to provide claims data of the state group health insurance plan to the contracted vendor selected by the AHCA pursuant to s. 408.05(3)(c), F.S. The bill also requires that each contracted vendor for the state group health insurance plan provide claims data to the selected vendor.

Sections 15 and 16 create ss. 212.099 and 220.197, F.S., to establish tax credits against sales and use tax and corporate income tax, respectively, to encourage the submission of healthcare claims data for employees receiving health coverage under ERISA. These provisions take effect on January 1, 2017. The bill:

- Defines:
  - "Eligible employer" as an employer that provides a health plan covered by the ERISA to eligible employees and provides qualifying health care claims information submissions on a quarterly basis.
  - "Eligible employee" as an employee who is employed by an eligible employer and is covered under the eligible employer's ERISA plan.
  - "Qualifying health care claims information submission" as the submission of health care claims information on eligible employees to the contract vendor selected by the AHCA pursuant to s. 408.05(3)(c), F.S.
- Establishes each tax credit to equal the number of eligible employees included on each qualifying health care claims information submission multiplied by $50 up to a maximum of $500,000.
- Allows any excess credit amounts to be taken within 12 months after such submission for sales tax and within 5 years for corporate income tax.
- States that corporations may use only one of the tax credits established in ss. 212.099 and 220.197, F.S.
- States that any person who fraudulently claims such a tax credit must repay 100 percent of the credit and commits a misdemeanor of the second degree.

Sections 17 - 23 amend various sections of law to make technical and conforming changes.

Section 24 states that, except as otherwise expressly provided in this act, the act takes effect on July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

SB 1496 establishes two new tax credits:

- A .05 percent tax credit against a health insurer or HMO's premium tax available to health insurers and HMOs that provide claims data to the vendor selected by the AHCA. This credit may exceed the statutory limitation on such tax credits established in s. 624.509, F.S.; and
- A tax credit of up to $500,000 against either state sales and use tax or state corporate income tax available to employers with ARISA plans who submit qualifying health care claims information to the vendor selected by the AHCA.

An estimate of these amounts is not available at this time.

B. Private Sector Impact:

SB 1496 may have a positive fiscal impact on consumers of healthcare services to the extent the transparency measures allow consumers to make better informed choices on where to obtain their healthcare services based on price and quality, take advantage of discounts or other financial assistance, or to negotiate with healthcare service providers on the specific costs of services.

The bill may have a negative fiscal impact on providers of healthcare services, health insurers, and HMOs related to posting healthcare information on their webpages or providing patient specific estimates.

The bill may have a positive fiscal impact on health insurers, HMOs, and employers with ERISA plans that are able to take advantage of the tax credits established in the bill.

C. Government Sector Impact:

The AHCA estimates that SB 1496 will have recurring costs to the agency of approximately $2.7 million per year. Contracted services generate approximately $2.5 to $2.6 million of the annual costs and approximately $133,000 of the annual costs are for two FTE positions. Additional recurring costs include approximately $12,000 per year for expenses and less than $1,000 per year for human resource services. The AHCA also estimates a one-time cost of $9,054 to implement the provisions of the bill.[18]

[18] Fiscal analysis provided by the AHCA on January 19, 2016. On file with Senate Health Policy staff.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.301, 400.165, 400.487, 400.934, 408.05, 408.061, 456.0575, 456.072, 627.0613, 641.54, 409.967, 110.123, 20.42, 381.026, 395.602, 395.6025, 408.07, 408.18, and 465.0244.

This bill creates the following sections of the Florida Statutes: 212.099, 220.197, 395.3012, and 627.6385.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Bradley

7-01281C-16 20161496__

A bill to be entitled

An act relating to transparency in health care; amending s. 395.301, F.S.; requiring a facility licensed under ch. 395, F.S., to provide timely and accurate financial information and quality of service measures to certain individuals; providing an exemption; requiring a licensed facility to make available on its website certain information on payments made to that facility for defined bundles of services and procedures and other information for consumers and patients; requiring that facility websites provide specified information and notify and inform patients or prospective patients of certain information; requiring a facility to provide a written, good faith estimate of charges to a patient or prospective patient within a certain timeframe; requiring a facility to provide information regarding financial assistance from the facility which may be available to a patient or a prospective patient; providing a penalty for failing to provide an estimate of charges to a patient; deleting a requirement that a licensed facility not operated by the state provide notice to a patient of his or her right to an itemized statement or bill within a certain timeframe; revising the information that must be included on a patient's statement or bill; requiring that certain records be made available through electronic means that comply with a specified law; reducing the response time for certain patient requests for information; creating s. 395.3012, F.S.; authorizing the Agency for Health Care Administration to impose penalties based on certain findings of an investigation as determined by the

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consumer advocate; amending ss. 400.165, 400.487, and 400.934, F.S.; requiring nursing homes, home health agencies, and home medical equipment providers to provide upon request certain written estimates of charges within a certain timeframe; amending s. 408.05, F.S.; revising requirements for the collection and use of health-related data by the agency; requiring the agency to contract with a vendor to provide an Internet-based platform with certain attributes; requiring potential vendors to have certain qualifications; prohibiting the agency from establishing a certain database under certain circumstances; amending s. 408.061, F.S.; revising requirements for the submission of health care data to the agency; amending s. 456.0575, F.S.; requiring a health care practitioner to provide a patient upon his or her request a written, good faith estimate of anticipated charges within a certain timeframe; amending s. 456.072, F.S.; providing that the failure to comply with fair billing practices by a health care practitioner is grounds for disciplinary action; amending s. 627.0613, F.S.; providing that the consumer advocate must represent the general public before other state agencies; authorizing the consumer advocate to report findings relating to certain investigations to the agency and the Department of Health; authorizing the consumer advocate to have access to files, records, and data of the agency and the department necessary for certain investigations;

authorizing the consumer advocate to maintain a process to receive and investigate complaints from patients relating to compliance with certain billing and notice requirements by licensed health care facilities and practitioners; defining a term; authorizing the consumer advocate to provide mediation between providers and consumers relating to certain matters; creating s. 627.6385, F.S.; requiring a health insurer to make available on its website certain methods that a policyholder can use to make estimates of certain costs and charges; providing that an estimate does not preclude an actual cost from exceeding the estimate; requiring a health insurer to make available on its website a hyperlink to certain health information; requiring a health insurer to include certain notice; requiring a health insurer that participates in the state group health insurance plan or Medicaid managed care to provide all claims data to a contracted vendor selected by the agency; providing a credit against the premium tax to certain health insurers; amending s. 641.54, F.S.; revising the provision requiring a health maintenance organization to make certain information available to its subscribers; requiring a health maintenance organization that participates in the state group health insurance plan or Medicaid managed care to provide all claims data to a contracted vendor selected by the agency; providing a credit against certain premium taxes to specified health maintenance

organizations; amending s. 409.967, F.S.; requiring managed care plans to provide all claims data to a contracted vendor selected by the agency; amending s. 110.123, F.S.; requiring the Department of Management Services to provide certain data to the contracted vendor for the price transparency database established by the agency; requiring a contracted vendor for the state group health insurance plan to provide claims data to the vendor selected by the agency; creating s. 212.099, F.S.; defining terms; authorizing a credit against sales and use tax for taxpayers that provide health care claims information; providing a limitation on credit amounts; providing penalties for fraudulently claiming the credit; creating s. 220.197, F.S.; defining terms; authorizing a credit against corporate income tax for corporations that provide health care claims information; providing a limitation on credit amounts; providing penalties for fraudulently claiming the credit; amending ss. 20.42, 381.026, 395.602, 395.6025, 408.07, 408.18, and 465.0244, F.S.; conforming provisions to changes made by the act; providing effective dates.

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

Section 1. Section 395.301, Florida Statutes, is amended to read:

395.301 Price transparency; itemized patient statement or bill; ~~form and content prescribed by the agency;~~ patient

admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to prospective and actual patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state mental health treatment facilities or as mobile surgical facilities are exempt from the requirements of this subsection.

(a) Each licensed facility shall make available to the public on its website information on payments made to that facility for defined bundles of services and procedures. The payment data must be presented and searchable in accordance with the system established by the agency and its vendor using the descriptive service bundles developed under s. 408.05(3)(c). At a minimum, the facility shall provide the estimated average payment received from all payors, excluding Medicaid and Medicare, for the descriptive service bundles available at that facility and the estimated payment range for such bundles. Using plain language, comprehensible to an ordinary layperson, the facility must disclose that the information on average payments and the payment ranges is an estimate of costs that may be incurred by the patient or prospective patient and that actual costs will be based on the services actually provided to the patient. The facility shall also assist the consumer in accessing his or her health insurer's or health maintenance organization's website for information on estimated copayments, deductibles, and other cost-sharing responsibilities. The

facility's website must:

1. Identify and post the names of all health insurers and health maintenance organizations for which the facility is a network provider or preferred provider and include a hyperlink to the website of each.

2. Provide information to uninsured patients and insured patients whose health insurer or health maintenance organization does not include the facility as a network provider or preferred provider on the facility's financial assistance policy, including the application process, payment plans, and discounts, and the facility's charity care policy and collection procedures.

3. Notify patients or prospective patients that services may be provided in the health care facility by the facility as well as by other health care providers who may separately bill the patient.

4. Inform patients or prospective patients that they may request from the facility and other health care providers a more personalized estimate of charges and other information.

(b)1. Upon request, and before providing any nonemergency medical services, each licensed facility shall provide a written, good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition. The facility must provide the estimate in writing to the patient or prospective patient within 7 business days after the receipt of the request and is not required to adjust the estimate for any potential insurance coverage. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c)

unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. Upon request, the facility shall notify the patient or prospective patient of any revision to the estimate.

4. In the estimate, the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient.

5. The facility shall take action to educate the public that such estimates are available upon request.

6. Failure to timely provide the estimate pursuant to this paragraph shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.

The provision of an estimate does not preclude the actual charges from exceeding the estimate.

(c) Each facility shall make available on its website a hyperlink to the health-related data, including quality measures and statistics that are disseminated by the agency pursuant to

s. 408.05. The facility shall also take action to notify the public that such information is electronically available and provide a hyperlink to the agency's website.

(d)1. Upon request, and after the patient's discharge or release from the facility, the facility must provide ~~A licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. Within 7 days following the patient's discharge or release from a licensed facility not operated by the state, the licensed facility providing the service shall, upon request, submit~~ to the patient~~,~~ or to the patient's survivor or legal guardian, as ~~may be~~ appropriate, an itemized statement or bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient.~~, which in~~ The initial statement or bill ~~billing~~ shall be provided within 7 days after the patient's discharge or release from the facility or after a request for such statement or bill, whichever is later. The initial statement or bill must contain a statement of specific services received and expenses incurred by date for such items of service, enumerating in detail as prescribed by the agency the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility~~, as prescribed by the agency~~. The statement or bill must identify each item as paid, pending payment by a third party, or pending payment by the patient and must include the amount due, if applicable. If an amount is due from the patient, a due date must be included. The initial statement or bill must inform the

patient or the patient's survivor or legal guardian, as appropriate, to contact the patient's insurer or health maintenance organization regarding the patient's cost-sharing responsibilities.

2. Any subsequent statement or bill provided to a patient or to the patient's survivor or legal guardian, as appropriate, relating to the episode of care must include all of the information required by subparagraph 1., with any revisions clearly delineated.

3.~~(2)(a)~~ Each ~~such~~ statement or bill provided ~~submitted~~ pursuant to this subsection ~~section~~:

a.~~1.~~ Must ~~May not~~ include notice ~~charges~~ of hospital-based physicians and other health care providers who bill ~~if billed~~ separately.

b.~~2.~~ May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

c.~~3.~~ Must ~~Shall~~ list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.

d.~~4.~~ Must ~~Shall~~ specifically identify physical, occupational, or speech therapy treatment as to the date, type, and length of treatment when such ~~therapy~~ treatment is a part of the statement or bill.

~~(b) Any person receiving a statement pursuant to this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.~~

~~(2)(3) On each itemized statement submitted pursuant to subsection (1) there shall appear the words "A FOR PROFIT (or NOT FOR PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially~~

~~similar words sufficient to identify clearly and plainly the ownership status of the licensed facility.~~ Each itemized statement or bill must prominently display the telephone ~~phone~~ number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or the patient's survivor or legal guardian ~~his or her representative~~, and the billing department.

~~(4) An itemized bill shall be provided once to the patient's physician at the physician's request, at no charge.~~

~~(5) In any billing for services subsequent to the initial billing for such services, the patient, or the patient's survivor or legal guardian, may elect, at his or her option, to receive a copy of the detailed statement of specific services received and expenses incurred for each such item of service as provided in subsection (1).~~

~~(6) No physician, dentist, podiatric physician, or licensed facility may add to the price charged by any third party except for a service or handling charge representing a cost actually incurred as an item of expense; however, the physician, dentist, podiatric physician, or licensed facility is entitled to fair compensation for all professional services rendered. The amount of the service or handling charge, if any, shall be set forth clearly in the bill to the patient.~~

~~(7) Each licensed facility not operated by the state shall provide, prior to provision of any nonemergency medical services, a written good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition upon written request of a prospective patient. The estimate shall be provided to the prospective patient within 7~~

~~business days after the receipt of the request. The estimate may be the average charges for that diagnosis related group or the average charges for that procedure. Upon request, the facility shall notify the patient of any revision to the good faith estimate. Such estimate shall not preclude the actual charges from exceeding the estimate. The facility shall place a notice in the reception area that such information is available. Failure to provide the estimate within the provisions established pursuant to this section shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.~~

~~(8) Each licensed facility that is not operated by the state shall provide any uninsured person seeking planned nonemergency elective admission a written good faith estimate of reasonably anticipated charges for the facility to treat such person. The estimate must be provided to the uninsured person within 7 business days after the person notifies the facility and the facility confirms that the person is uninsured. The estimate may be the average charges for that diagnosis-related group or the average charges for that procedure. Upon request, the facility shall notify the person of any revision to the good faith estimate. Such estimate does not preclude the actual charges from exceeding the estimate. The facility shall also provide to the uninsured person a copy of any facility discount and charity care discount policies for which the uninsured person may be eligible. The facility shall place a notice in the reception area where such information is available. Failure to provide the estimate as required by this subsection shall result in a fine of $500 for each instance of the facility's failure to~~

~~provide the requested information.~~

(3)~~(9)~~ If a licensed facility places a patient on observation status rather than inpatient status, observation services shall be documented in the patient's discharge papers. The patient or the patient's survivor or legal guardian ~~proxy~~ shall be notified of observation services through discharge papers, which may also include brochures, signage, or other forms of communication for this purpose.

(4)~~(10)~~ A licensed facility shall make available to a patient all records necessary for verification of the accuracy of the patient's statement or bill within 10 ~~30~~ business days after the request for such records. The records ~~verification information~~ must be made available in the facility's offices and through electronic means that comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such records must ~~shall~~ be available to the patient before ~~prior to~~ and after payment of the statement or bill ~~or claim~~. The facility may not charge the patient for making such verification records available; however, the facility may charge its usual fee for providing copies of records as specified in s. 395.3025.

(5)~~(11)~~ Each facility shall establish a method for reviewing and responding to questions from patients concerning the patient's itemized statement or bill. Such response shall be provided within 7 business ~~30~~ days after the date a question is received. If the patient is not satisfied with the response, the facility must provide the patient with the address and contact information of the consumer advocate as provided in s. 627.0613 ~~agency~~ to which the issue may be sent for review.

~~(12) Each licensed facility shall make available on its~~

~~Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(k). The facility shall place a notice in the reception area that the information is available electronically and the facility's Internet website address.~~

Section 2. Section 395.3012, Florida Statutes, is created to read:

395.3012 Penalties for unconscionable prices.—

(1) The agency may impose administrative fines based on the findings of the consumer advocate's investigation of billing complaints pursuant to s. 627.0613(6).

(2) The administrative fines for noncompliance with s. 395.301 are the greater of $2,500 per violation or double the amount of the charges that exceed fair charges.

Section 3. Present subsections (1) through (5) of section 400.165, Florida Statutes, are redesignated as subsections (2) through (6), respectively, a new subsection (1) is added to that section, and present subsection (4) of that section is amended, to read:

400.165 Itemized resident billing, form and content prescribed by the agency.—

(1) Every licensed nursing home shall provide upon the request of a resident or prospective resident or his or her legal guardian a written, good faith estimate of reasonably anticipated charges for the resident at the nursing home. The nursing home must provide the estimate to the requestor within 7 business days after receiving the request. The nursing home must also provide information disclosing the nursing home's payment

plans, discounts, and other available assistance and its collection procedures.

(5)~~(4)~~ In any billing for services subsequent to the initial billing for such services, the resident, or the resident's survivor or legal guardian, may elect, at his or her option, to receive a copy of the detailed statement of specific services received and expenses incurred for each such item of service as provided in subsection (2) ~~subsection (1)~~.

Section 4. Subsection (1) of section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's, physician assistant's, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.—

(1)(a) Services provided by a home health agency must be covered by an agreement between the home health agency and the patient or the patient's legal representative specifying the home health services to be provided, the rates or charges for services paid with private funds, and the sources of payment, which may include Medicare, Medicaid, private insurance, personal funds, or a combination thereof. A home health agency providing skilled care must make an assessment of the patient's needs within 48 hours after the start of services.

(b) Every licensed home health agency shall provide upon the request of a prospective patient or his or her legal guardian a written, good faith estimate of reasonably anticipated charges for the prospective patient for services provided by the home health agency. The home health agency must

provide the estimate to the requestor within 7 business days after receiving the request. The home health agency must inform the prospective patient, or his or her legal guardian, that he or she may contact the prospective patient's health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The home health agency must also provide information disclosing the home health agency's payment plans, discounts, and other available assistance and its collection procedures.

Section 5. Subsection (23) is added to section 400.934, Florida Statutes, to read:

400.934 Minimum standards.—As a requirement of licensure, home medical equipment providers shall:

(23) Provide upon the request of a prospective patient or his or her legal guardian a written, good faith estimate of reasonably anticipated charges for the prospective patient for services provided by the home medical equipment provider. The home medical equipment provider must provide the estimate to the requestor within 7 business days after receiving the request. The home medical equipment provider must inform the prospective patient, or his or her legal guardian, that he or she may contact the prospective patient's health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The home medical equipment provider must also provide information disclosing the home medical equipment provider's payment plans, discounts, and other available assistance and its collection procedures.

Section 6. Section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Transparency ~~Policy Analysis~~.—

(1) ESTABLISHMENT.—The agency shall establish and maintain a Florida Center for Health Information and Transparency to collect, compile, coordinate, analyze, index, and disseminate ~~Policy Analysis. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant~~ health-related data and statistics. The center shall be staffed as necessary ~~with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary~~ to carry out its functions.

(2) HEALTH-RELATED DATA.—The ~~comprehensive health information system operated by the~~ Florida Center for Health Information and Transparency ~~Policy Analysis~~ shall identify ~~the best~~ available data sets, compile new data when specifically authorized, ~~data sources~~ and promote the use ~~coordinate the compilation~~ of extant health-related data and statistics. The center must maintain any data sets in existence before July 1, 2016, unless such data sets duplicate information that is readily available from other credible sources, and may ~~and purposefully~~ collect or compile data on the following:

~~(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.~~

~~(b) The impact of illness and disability of the state population on the state economy and on other aspects of the~~

~~well-being of the people in this state.~~

~~(c) Environmental, social, and other health hazards.~~

~~(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.~~

(a) ~~(c)~~ Health resources, including licensed ~~physicians, dentists, nurses, and other~~ health care practitioners ~~professionals~~, by specialty and type of practice. Such data shall include information collected by the Department of Health pursuant to ss. 458.3191 and 459.0081.

(b) Health service inventories, including ~~and~~ acute care, long-term care, and other institutional care facilities ~~facility supplies~~ and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care facilities.

(c) ~~(f)~~ Service utilization for licensed health care facilities ~~of health care by type of provider~~.

(d) ~~(g)~~ Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.

~~(h) Family formation, growth, and dissolution.~~

(e) ~~(i)~~ The extent of public and private health insurance coverage in this state.

(f) ~~(j)~~ Specific quality-of-care initiatives involving ~~The quality of care provided by~~ various health care providers when extant data is not adequate to achieve the objectives of the initiatives.

(3) ~~COMPREHENSIVE~~ HEALTH INFORMATION TRANSPARENCY ~~SYSTEM~~.—

In order to disseminate and facilitate the availability of ~~produce~~ comparable and uniform health information ~~and statistics for the development of policy recommendations~~, the agency shall perform the following functions:

(a) Collect and compile information on and coordinate the activities of state agencies involved in providing ~~the design and implementation of the comprehensive~~ health information to consumers ~~system~~.

(b) Promote data sharing through dissemination of state-collected health data by making such data available, transferable, and readily usable ~~Undertake research, development, and evaluation respecting the comprehensive health information system~~.

(c) Contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures and allows for price comparison. The Internet-based platform must allow a consumer to search by condition or service bundles that are comprehensible to an ordinary layperson and may not require registration, a security password, or user identification. The vendor must be a nonprofit research institute that is qualified under s. 1874 of the Social Security Act to receive Medicare claims data and that receives claims data from multiple private insurers nationwide. The vendor must have:

1. A national database consisting of at least 15 billion claim lines of administrative claims data from multiple payors capable of being expanded by adding third-party payors, including employers with health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA).

2. A well-developed methodology for analyzing claims data within defined service bundles.

3. A bundling methodology that is available in the public domain to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.

~~(c) Review the statistical activities of state agencies to ensure that they are consistent with the comprehensive health information system.~~

(d) Develop written agreements with local, state, and federal agencies to facilitate ~~for~~ the sharing of data related to health care ~~health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under state contract shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center~~.

(e) Establish by rule the types of data collected, compiled, processed, used, or shared. ~~Decisions regarding center data sets should be made based on consultation with the State Consumer Health Information and Policy Advisory Council and other public and private users regarding the types of data which should be collected and their uses. The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the agency.~~

(f) Consult with contracted vendors, the State Consumer Health Information and Policy Advisory Council, and other public and private users regarding the types of data that should be

collected and the use of such data.

(g) Monitor data collection procedures and test data quality to facilitate the dissemination of data that is accurate, valid, reliable, and complete.

~~(f) Establish minimum health care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The agency shall periodically review ongoing health care data collections of the Department of Health and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.~~

~~(g) Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.~~

~~(h) Prescribe standards for the publication of health-care-related data reported pursuant to this section which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.~~

(h) ~~(i)~~ Develop ~~Prescribe standards for the maintenance and preservation of the center's data. This should include~~ methods for archiving data, retrieval of archived data, and data editing and verification.

~~(j) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.~~

(i) ~~(k)~~ Make ~~Develop, in conjunction with the State Consumer Health Information and Policy Advisory Council, and implement a long-range plan for making~~ available health care quality measures ~~and financial data~~ that will allow consumers to compare outcomes and other performance measures for health care services. ~~The health care quality measures and financial data the agency must make available include, but are not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall update the plan and report on the status of its implementation annually. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:~~

~~1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The terms "patient-safety indicators" and "inpatient quality indicators" have the same meaning as that ascribed by the Centers for Medicare and Medicaid Services, an accrediting organization whose standards incorporate comparable regulations required by this state, or a national entity that establishes standards to measure the performance of health care providers, or by other states. The agency shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the~~

~~council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the agency:~~

~~a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.~~

~~b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, an accrediting organization whose standards incorporate comparable regulations required by this state, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.~~

~~When determining which patient charge data to disclose, the agency shall include such measures as the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, the range of procedure charges from highest to lowest, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.~~

~~2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which health care~~

~~quality measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency such data or information that is not currently reported to the agency or the office.~~

~~3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the State Consumer Health Information and Policy Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider.~~

~~4. Publish on its website undiscounted charges for no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and~~

~~preventative procedures.~~

~~(4) TECHNICAL ASSISTANCE.—~~

~~(a) The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:~~

~~1. Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center, including procedures governing requests, the ordering of requests, timeframes for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies.~~

~~2. Provide assistance to data sources and users in the areas of database design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.~~

~~3. Identify health care data gaps and provide technical assistance to other public or private organizations for meeting documented health care data needs.~~

~~4. Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.~~

~~5. Provide statistical support to state agencies with regard to the use of databases maintained by the center.~~

~~6. To the extent possible, respond to multiple requests for information not currently collected by the center or available from other sources by initiating data collection.~~

~~7. Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.~~

~~8. Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.~~

~~9. Monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development of a health information network.~~

~~(b) The agency shall administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network. Any grant contract shall be evaluated to ensure the effective outcome of the health information project.~~

~~(c) The agency shall initiate, oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues and make that data available to any health care practitioner through a state health information network.~~

~~(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.—The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:~~

~~(a) The center shall publish and make available periodically to agencies and individuals health statistics~~

~~publications of general interest, including health plan consumer reports and health maintenance organization member satisfaction surveys; publications providing health statistics on topical health policy issues; publications that provide health status profiles of the people in this state; and other topical health statistics publications.~~

(j) ~~(b) The center shall publish,~~ Make available~~, and disseminate, promptly and as widely as practicable,~~ the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. ~~Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.~~

~~(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics.~~

~~(d) The center shall be responsible for publishing and disseminating an annual report on the center's activities.~~

~~(e) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analyses, or special data collections on the basis of their local, regional, or state~~

~~importance; the unique potential for definitive research on the problem; and opportunities for application of the study findings.~~

(4)~~(6)~~ PROVIDER DATA REPORTING.—This section does not confer on the agency the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law. The agency may not establish an all-payor claims database or a comparable database without express legislative authority.

(5)~~(7)~~ BUDGET; FEES.—

(a) The Legislature intends that funding for the Florida Center for Health Information and Transparency ~~Policy Analysis~~ be appropriated from the General Revenue Fund.

(b) The Florida Center for Health Information and Transparency ~~Policy Analysis~~ may apply for and receive and accept grants, gifts, and other payments, including property and services, from any governmental or other public or private entity or person and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health-care-related topics. Funds obtained pursuant to this paragraph may not be used to offset annual appropriations from the General Revenue Fund.

(c) The center may charge such reasonable fees for services as the agency prescribes by rule. The established fees may not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(6)~~(8)~~ STATE CONSUMER HEALTH INFORMATION AND POLICY

ADVISORY COUNCIL.—

(a) There is established in the agency the State Consumer Health Information and Policy Advisory Council to assist the center ~~in reviewing the comprehensive health information system, including the identification, collection, standardization, sharing, and coordination of health-related data, fraud and abuse data, and professional and facility licensing data among federal, state, local, and private entities and to recommend improvements for purposes of public health, policy analysis, and transparency of consumer health care information~~. The council consists ~~shall consist~~ of the following members:

1. An employee of the Executive Office of the Governor, to be appointed by the Governor.

2. An employee of the Office of Insurance Regulation, to be appointed by the director of the office.

3. An employee of the Department of Education, to be appointed by the Commissioner of Education.

4. Ten persons, to be appointed by the Secretary of Health Care Administration, representing other state and local agencies, state universities, business and health coalitions, local health councils, professional health-care-related associations, consumers, and purchasers.

(b) Each member of the council shall be appointed to serve for a term of 2 years following the date of appointment~~, except the term of appointment shall end 3 years following the date of appointment for members appointed in 2003, 2004, and 2005~~. A vacancy shall be filled by appointment for the remainder of the term, and each appointing authority retains the right to reappoint members whose terms of appointment have expired.

(c) The council may meet at the call of its chair, at the request of the agency, or at the request of a majority of its membership, but the council must meet at least quarterly.

(d) Members shall elect a chair and vice chair annually.

(e) A majority of the members constitutes a quorum, and the affirmative vote of a majority of a quorum is necessary to take action.

(f) The council shall maintain minutes of each meeting and shall make such minutes available to any person.

(g) Members of the council shall serve without compensation but shall be entitled to receive reimbursement for per diem and travel expenses as provided in s. 112.061.

(h) The council's duties and responsibilities include, but are not limited to, the following:

1. To develop a mission statement, goals, and a plan of action for the identification, collection, standardization, sharing, and coordination of health-related data across federal, state, and local government and private sector entities.

2. To develop a review process to ensure cooperative planning among agencies that collect or maintain health-related data.

3. To create ad hoc issue-oriented technical workgroups on an as-needed basis to make recommendations to the council.

(7)~~(9)~~ APPLICATION TO OTHER AGENCIES.~~ Nothing in~~ This section does not ~~shall~~ limit, restrict, affect, or control the collection, analysis, release, or publication of data by any state agency pursuant to its statutory authority, duties, or responsibilities.

Section 7. Subsection (1) of section 408.061, Florida

Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups or other bundled groupings as specified by rule, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and

demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically in accordance with rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

(b) Data to be submitted by health care providers may include, but are not limited to: professional organization and specialty board affiliations, Medicare and Medicaid participation, types of services offered to patients, actual charges to patients as specified by rule, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns. Data submitted shall be certified by the appropriate duly authorized representative or employee of the health care provider that the information submitted is true and accurate.

(c) Data to be submitted by health insurers may include, but are not limited to: claims, payments to health care facilities and health care providers as specified by rule, premium, administration, and financial information. Data submitted shall be certified by the chief financial officer, an appropriate and duly authorized representative, or an employee

of the insurer that the information submitted is true and accurate.

(d) Data required to be submitted by health care facilities, health care providers, or health insurers may ~~shall~~ not include specific provider contract reimbursement information. However, such specific provider reimbursement data shall be reasonably available for onsite inspection by the agency as is necessary to carry out the agency's regulatory duties. Any such data obtained by the agency as a result of onsite inspections may not be used by the state for purposes of direct provider contracting and are confidential and exempt from ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(e) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. Rules are not required, however, for the submission of data for a special study mandated by the Legislature or when information is being requested for a single health care facility, health care provider, or health insurer.

Section 8. Section 456.0575, Florida Statutes, is amended to read:

456.0575 Duty to notify patients.—

(1) Every licensed health care practitioner shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgment of admission of liability, nor can

such notifications be introduced as evidence.

(2) Every licensed health care practitioner must provide upon request by a patient, before providing any nonemergency medical services in a facility licensed under chapter 395, a written, good faith estimate of reasonably anticipated charges to treat the patient's condition at the licensed facility. The health care practitioner must provide the estimate to the patient within 7 business days after receiving the request and is not required to adjust the estimate for any potential insurance coverage. The health care practitioner must inform the patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The health care practitioner must provide information to uninsured patients and insured patients for whom the practitioner is not a network provider or preferred provider which discloses the practitioner's financial assistance policy, including the application process, payment plans, discounts, and other available assistance; the practitioner's charity care policy; and the practitioner's collection procedures. Such estimate does not preclude the actual charges from exceeding the estimate. Failure to provide the estimate in accordance with this subsection, without good cause, within the 7 business days shall result in disciplinary action against the health care practitioner and a fine of $500 for each instance of the practitioner's failure to provide the requested estimate.

Section 9. Paragraph (oo) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(oo) Failure to comply with fair billing practices pursuant to s. 627.0613(6).

Section 10. Section 627.0613, Florida Statutes, is amended to read:

627.0613 Consumer advocate.—The Chief Financial Officer must appoint a consumer advocate who must represent the general public of the state before the department, ~~and~~ the office, and other state agencies, as required by this section. The consumer advocate must report directly to the Chief Financial Officer, but is not otherwise under the authority of the department or of any employee of the department. The consumer advocate has such powers as are necessary to carry out the duties of the office of consumer advocate, including, but not limited to, the powers to:

(1) Recommend to the department or office, by petition, the commencement of any proceeding or action; appear in any proceeding or action before the department or office; or appear in any proceeding before the Division of Administrative Hearings relating to subject matter under the jurisdiction of the department or office.

(2) Report to the Agency for Health Care Administration and to the Department of Health any findings resulting from investigation of unresolved complaints concerning the billing practices of any health care facility licensed under chapter 395 or any health care practitioner subject to chapter 456.

(3)~~(2)~~ Have access to and use of all files, records, and data of the department or office.

(4) Have access to any files, records, and data of the Agency for Health Care Administration and the Department of Health which are necessary for the investigations authorized by subsection (6).

(5)~~(3)~~ Examine rate and form filings submitted to the office, hire consultants as necessary to aid in the review process, and recommend to the department or office any position deemed by the consumer advocate to be in the public interest.

(6) Maintain a process for receiving and investigating complaints from insured and uninsured patients of health care facilities licensed under chapter 395 and health care practitioners subject to chapter 456 concerning billing practices. Investigations by the office of the consumer advocate shall be limited to determining compliance with the following requirements:

(a) The patient was informed before a nonemergency procedure of expected payments related to the procedure as provided in s. 395.301, contact information for health insurers or health maintenance organizations to determine specific cost-sharing responsibilities, and the expected involvement in the procedure of other providers who may bill independently.

(b) The patient was informed of policies and procedures to qualify for discounted charges.

(c) The patient was informed of collection procedures and given the opportunity to participate in an extended payment schedule.

(d) The patient was given a written, personal, and itemized estimate upon request as provided in ss. 395.301 and 456.0575.

(e) The statement or bill delivered to the patient was

accurate and included all information required pursuant to s. 395.301.

(f) The billed amounts were fair charges. As used in this paragraph, the term "fair charges" means the common and frequent range of charges for patients who are similarly situated requiring the same or similar medical services.

(7) Provide mediation between providers and patients to resolve billing complaints and negotiate arrangements for extended payment schedules.

(8)~~(4)~~ Prepare an annual budget for presentation to the Legislature by the department, which budget must be adequate to carry out the duties of the office of consumer advocate.

Section 11. Section 627.6385, Florida Statutes, is created to read:

627.6385 Disclosures to policyholders; calculations of cost sharing.—

(1) Each health insurer shall make available on its website:

(a) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities for health care services and procedures. Such method of making an estimate shall be based on service bundles established pursuant to s. 408.05(3)(c). Estimates do not preclude the actual copayment, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.

1. Estimates shall be calculated according to the policy and known plan usage during the coverage period.

2. Estimates shall be made available based on providers that are in-network or out-of-network.

3. A policyholder must be able to create estimates by any combination of the service bundles established pursuant to s. 408.05(3)(c) or by a specified provider or a comparison of providers.

(b) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities based on a personalized estimate of charges received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575.

(c) A hyperlink to the health information, including, but not limited to, service bundles and quality of care information, which is disseminated by the Agency for Health Care Administration pursuant to s. 408.05(3).

(2) Each health insurer shall include in every policy delivered or issued for delivery to any person in the state or in materials provided as required by s. 627.64725 notice that the information required by this section is available electronically and the address of the website where the information can be accessed.

(3) Each health insurer that participates in the state group health insurance plan created pursuant to s. 110.123 or Medicaid managed care pursuant to part IV of chapter 409 shall provide all claims data to the fullest extent possible to the contracted vendor selected by the Agency for Health Care Administration under s. 408.05(3)(c).

(4) Each health insurer that provides all claims data to the fullest extent possible to the contracted vendor under s. 408.05(3)(c) is entitled to a 0.05 percent credit against the premium tax established pursuant to s. 624.509, notwithstanding

any premium tax credit limitation imposed by s. 624.509.

Section 12. Subsection (6) and present subsection (7) of section 641.54, Florida Statutes, are amended, present subsection (7) of that section is redesignated as subsection (9), and a new subsection (7) and subsection (8) are added to that section, to read:

641.54 Information disclosure.—

(6) Each health maintenance organization shall make available to its subscribers on its website or by request the estimated copayment ~~copay~~, coinsurance percentage, or deductible, whichever is applicable, for any covered services as described by the searchable bundles established on a consumer-friendly, Internet-based platform pursuant to s. 408.05(3)(c) or as described in a personalized estimate received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575, the status of the subscriber's maximum annual out-of-pocket payments for a covered individual or family, and the status of the subscriber's maximum lifetime benefit. Such estimate does ~~shall~~ not preclude the actual copayment ~~copay~~, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.

(7) Each health maintenance organization that participates in the state group health insurance plan created pursuant to s. 110.123 or Medicaid managed care pursuant to part IV of chapter 409 shall provide all claims data to the fullest extent possible to the contracted vendor selected by the Agency for Health Care Administration under s. 408.05(3)(c).

(8) Each health maintenance organization that provides all claims data to the fullest extent possible to the contracted

vendor under s. 408.05(3)(c) is entitled to a 0.05 percent credit against the premium tax established pursuant to s. 624.509, notwithstanding any premium tax credit limitation imposed by s. 624.509.

(9)~~(7)~~ Each health maintenance organization shall make available on its ~~Internet~~ website a hyperlink ~~link~~ to the health information ~~performance outcome and financial data~~ that is disseminated ~~published~~ by the Agency for Health Care Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and shall include in every policy delivered or issued for delivery to any person in the state or any materials provided as required by s. 627.64725 notice that such information is available electronically and the address of its Internet website.

Section 13. Paragraph (n) is added to subsection (2) of section 409.967, Florida Statutes, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(n) *Transparency.*—Managed care plans shall comply with ss. 627.6385(3) and 641.54(7).

Section 14. Paragraph (d) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(d)1. Notwithstanding ~~the provisions of~~ chapter 287 and the authority of the department, for the purpose of protecting the health of, and providing medical services to, state employees

participating in the state group insurance program, the department may contract to retain the services of professional administrators for the state group insurance program. The agency shall follow good purchasing practices of state procurement to the extent practicable under the circumstances.

2. Each vendor in a major procurement, and any other vendor if the department deems it necessary to protect the state's financial interests, shall, at the time of executing any contract with the department, post an appropriate bond with the department in an amount determined by the department to be adequate to protect the state's interests but not higher than the full amount estimated to be paid annually to the vendor under the contract.

3. Each major contract entered into by the department pursuant to this section shall contain a provision for payment of liquidated damages to the department for material noncompliance by a vendor with a contract provision. The department may require a liquidated damages provision in any contract if the department deems it necessary to protect the state's financial interests.

4. Section ~~The provisions of s.~~ 120.57(3) applies ~~apply~~ to the department's contracting process, except:

a. A formal written protest of any decision, intended decision, or other action subject to protest shall be filed within 72 hours after receipt of notice of the decision, intended decision, or other action.

b. As an alternative to any provision of s. 120.57(3), the department may proceed with the bid selection or contract award process if the director of the department sets forth, in

writing, particular facts and circumstances which demonstrate the necessity of continuing the procurement process or the contract award process in order to avoid a substantial disruption to the provision of any scheduled insurance services.

5. The department shall make arrangements as necessary to provide claims data of the state group health insurance plan to the contracted vendor selected by the Agency for Health Care Administration pursuant to s. 408.05(3)(c).

6. Each contracted vendor for the state group health insurance plan shall provide claims data to the fullest extent possible to the vendor selected by the Agency for Health Care Administration pursuant to s. 408.05(3)(c).

Section 15. Effective January 1, 2017, section 212.099, Florida Statutes, is created to read:

212.099 Health information and transparency tax credit.—

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

(a) "Eligible employee" means an employee who is employed in this state by an eligible employer and is covered under the eligible employer's health plan covered by the Employee Retirement Income Security Act of 1974.

(b) "Eligible employer" means an employer that provides a health plan covered by the Employee Retirement Income Security Act of 1974 to eligible employees and provides qualifying health care claims information submissions on a quarterly basis.

(c) "Qualifying health care claims information submission" means the submission of health care claims information on eligible employees to the contract vendor selected by the Agency for Health Care Administration pursuant to s. 408.05(3)(c).

(2) A credit against the tax imposed by this chapter is

authorized for qualifying health care claims information submissions made by an eligible employer. The credit is equal to the number of eligible employees included on each qualifying health care claims information submission multiplied by $50. The total credit that may be claimed by an eligible employer under this section is $500,000 annually.

(3) If the credit under this section is greater than can be taken on a single tax return, excess amounts may be taken as credits on any return submitted within 12 months after the submission of the qualifying health care claims information.

(4) A corporation may take the credit under this section against its corporate income tax liability, as provided in s. 220.197; however, a corporation that uses its credit against the tax imposed by chapter 220 may not receive the credit provided in this section. A credit may be taken against only one tax.

(5) Any person who fraudulently claims this credit is liable for repayment of the credit plus a mandatory penalty of 100 percent of the credit and commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 16. Effective January 1, 2017, section 220.197, Florida Statutes, is created to read:

220.197 Health information and transparency tax credit.—

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

(a) "Eligible employee" means an employee who is employed in this state by an eligible employer and is covered under the eligible employer's health plan covered by the Employee Retirement Income Security Act of 1974.

(b) "Eligible employer" means an employer that provides a

health plan covered by the Employee Retirement Income Security Act of 1974 to eligible employees and provides qualifying health care claims information submissions on a quarterly basis.

(c) "Qualifying health care claims information submission" means the submission of health care claims information on eligible employees to the contract vendor selected by the Agency for Health Care Administration pursuant to s. 408.05(3)(c).

(2) A credit against the tax imposed by this chapter is authorized for quarterly qualifying health care claims information submissions made by an eligible employer. The credit is equal to the number of eligible employees included on each qualifying health care claims information submission multiplied by $50. The credit must be claimed on the next annual return filed by the corporation under this chapter. The total credit that may be claimed by a corporation under this section is $500,000 annually.

(3) If the credit under this section is greater than can be taken on a single tax return, excess amounts may be carried forward for a period not to exceed 5 years.

(4) The credit provided for in this section may be taken on a consolidated return; however, the total credit taken by the affiliated group is subject to the limitation established under subsection (2).

(5) A corporation may take the credit under this section against its sales tax liability, as provided in s. 212.099; however, a corporation that uses its credit against the tax imposed by chapter 212 may not receive the credit provided in this section. A credit may be taken against only one tax.

(6) Any person who fraudulently claims this credit is

liable for repayment of the credit plus a mandatory penalty of 100 percent of the credit and commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 17. Subsection (3) of section 20.42, Florida Statutes, is amended to read:

20.42 Agency for Health Care Administration.—

(3) The department shall be the chief health policy and planning entity for the state. The department is responsible for health facility licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the implementation of the certificate of need program; the operation of the Florida Center for Health Information and Transparency ~~Policy Analysis~~; the administration of the Medicaid program; the administration of the contracts with the Florida Healthy Kids Corporation; the certification of health maintenance organizations and prepaid health clinics as set forth in part III of chapter 641; and any other duties prescribed by statute or agreement.

Section 18. Paragraph (c) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(4) RIGHTS OF PATIENTS.—Each health care facility or provider shall observe the following standards:

(c) *Financial information and disclosure.*—

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a

representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, before treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A primary care provider may publish a schedule of charges for the medical services that the provider offers to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the provider's office and must include, but is not limited to, the 50 services most frequently provided by the primary care provider. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. A primary care provider who publishes and maintains a schedule of charges for medical services is exempt from the license fee requirements for a single period of renewal of a professional license under chapter 456 for that licensure term and is exempt from the continuing education requirements of chapter 456 and the rules implementing those requirements for a single 2-year period.

4. If a primary care provider publishes a schedule of charges pursuant to subparagraph 3., he or she must continually

post it at all times for the duration of active licensure in this state when primary care services are provided to patients. If a primary care provider fails to post the schedule of charges in accordance with this subparagraph, the provider shall be required to pay any license fee and comply with any continuing education requirements for which an exemption was received.

5. A health care provider or a health care facility shall, upon request, furnish a person, before the provision of medical services, a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. Such estimates by a primary care provider must be consistent with the schedule posted under subparagraph 3. Estimates shall, to the extent possible, be written in language comprehensible to an ordinary layperson. Such reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

6. Each licensed facility, except a facility operating exclusively as a state mental health treatment facility or as a mobile surgical facility, ~~not operated by the state~~ shall make available to the public on its Internet website or by other electronic means a description of and a hyperlink ~~link~~ to the health information ~~performance outcome and financial data~~ that is disseminated ~~published~~ by the agency pursuant to s. 408.05(3)

~~s. 408.05(3)(k)~~. The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's statement or bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.

7. A patient has the right to receive a copy of an itemized statement or bill upon request. A patient has a right to be given an explanation of charges upon request.

Section 19. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency ~~Policy Analysis~~ at the agency; or

5. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 20. Section 395.6025, Florida Statutes, is amended to read:

395.6025 Rural hospital replacement facilities.—

Notwithstanding ~~the provisions of~~ s. 408.036, a hospital defined as a statutory rural hospital in accordance with s. 395.602, or a not-for-profit operator of rural hospitals, is not required to obtain a certificate of need for the construction of a new hospital located in a county with a population of at least 15,000 but no more than 18,000 and a density of fewer ~~less~~ than 30 persons per square mile, or a replacement facility, provided that the replacement, or new, facility is located within 10 miles of the site of the currently licensed rural hospital and within the current primary service area. As used in this section, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency ~~Policy Analysis~~ at the Agency for Health Care Administration.

Section 21. Subsection (43) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(43) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care

hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency ~~Policy Analysis~~ at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon application, including supporting documentation, to the Agency for Health Care Administration.

Section 22. Paragraph (a) of subsection (4) of section 408.18, Florida Statutes, is amended to read:

408.18 Health Care Community Antitrust Guidance Act; antitrust no-action letter; market-information collection and

education.—

(4)(a) Members of the health care community who seek antitrust guidance may request a review of their proposed business activity by the Attorney General's office. In conducting its review, the Attorney General's office may seek whatever documentation, data, or other material it deems necessary from the Agency for Health Care Administration, the Florida Center for Health Information and Transparency ~~Policy Analysis~~, and the Office of Insurance Regulation of the Financial Services Commission.

Section 23. Section 465.0244, Florida Statutes, is amended to read:

465.0244 Information disclosure.—Every pharmacy shall make available on its ~~Internet~~ website a hyperlink ~~link~~ to the health information ~~performance outcome and financial data~~ that is disseminated ~~published~~ by the Agency for Health Care Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and shall place in the area where customers receive filled prescriptions notice that such information is available electronically and the address of its Internet website.

Section 24. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

SB1496
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Bob Asztalos

Job Title Chief Lobbyist

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Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-224-3907

Email basztalos@fhca.org

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Health Care Assoc

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/16
Meeting Date

1496
Bill Number (if applicable)

Topic Transparency

Amendment Barcode (if applicable)

Name Mary Beth Vickers

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Speaking: ☐ For ☐ Against ☑ Information

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

Representing Governor's Office

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/19/ *Meeting Date*

1496 *Bill Number (if applicable)*

Topic Transparency

Amendment Barcode (if applicable)

Name Bill Bell

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TLH FL 32301 *City* *State* *Zip*

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Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida Hospital ASSN

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 1/19/2016 4:03:59 PM
Ends: 1/19/2016 5:26:14 PM Length: 01:22:16

4:03:58 PM Waiting for quorum --
4:04:33 PM Quorum present
4:04:38 PM Meeting called to order
4:04:50 PM Tab 3- SB 526 TP'ed
4:05:11 PM Roll call
4:05:33 PM Tab 5- SB 998(Ring) "Treatment Programs"
4:05:49 PM Sen Ring explain Strike-all Amendment 561784
4:06:19 PM Amendment adopted
4:07:19 PM Bill as amended
4:07:27 PM Sen Ring- Waive close
4:07:44 PM Sen Grimsley moves to consider SB 998 as CS
4:07:56 PM CS SB 998 Reported favorably
4:08:17 PM Tab 1 -SB 204(Clemens) "Musical Therapists"
4:08:53 PM Sen Clemens presents Strike-all Amendment 676326
4:09:23 PM Ron Watson-Certification Board for Music Therapists- Waive in support of amendment
4:09:46 PM Amendment 676326 adopted
4:09:49 PM Public testimony on bill as amended
4:09:57 PM Ron Watson- Certtification Board for Music Therapists- Waive in support
4:10:00 PM Lori Gooding- FL Music Therapy Task Force- Waive in support
4:10:05 PM Steve Sandler- Parkinsons Outreach Assoc- Waive in support
4:10:16 PM Caleb Trotter- Pacific Legal Fountation- Waive against
4:10:44 PM Sen Clemens waive close
4:10:49 PM Sen Braynon move to consider SB 204 as CS
4:11:01 PM Vote for final passage of CS SB 204
4:11:14 PM CS SB 204 Reported favorably
4:11:22 PM Tab 7- SB 1496 (Bradley) "Transparency in Health Care"
4:11:40 PM Sen Bradley presents SB 1496
4:15:55 PM Questions on SB 1496
4:16:10 PM Chair Bean question
4:17:17 PM Sen Bradley
4:17:32 PM Sen Grimsley
4:18:53 PM Sen Bradley
4:19:05 PM Defer to staff, Wormley recognized
4:19:31 PM Sem Grimsley follow up
4:20:31 PM Sen Bradley
4:21:24 PM Sen Galvano question
4:22:49 PM Sen Bradley
4:24:20 PM Vice Chair Sobel question
4:25:27 PM Sen Bradley
4:26:39 PM Vice Chair Sobel follow up
4:26:58 PM Sen Bradley
4:27:10 PM Sen Garcia question
4:27:59 PM Sen Bradley
4:29:27 PM Defer to staff, Wormley recognized
4:29:45 PM Sen Garcia
4:30:53 PM Defer to staff, Wormley
4:31:28 PM Sen Braynon question
4:31:32 PM Sen Bradley
4:32:39 PM Sen Braynon follow up
4:32:50 PM Sen Bradley
4:32:54 PM Public testimony
4:32:58 PM Mary Beth Vickers- Governor's Office- Speak in support

4:33:33 PM Bob Asztalos- FL Health Care Assoc- Speak in support/ information
4:35:29 PM Bill Bell- General Counsel, Florida Hospital Assoc- Speak in support
4:36:06 PM Sen Sobel question
4:36:50 PM Bill Bell
4:36:54 PM Sen Sobel follow up
4:37:26 PM Bill Bell
4:37:36 PM Chair Bean
4:37:38 PM Bill Bell
4:37:47 PM Sen Grimsley
4:37:57 PM Bill Bell
4:38:06 PM Sen Grimsely follow up
4:38:07 PM Bill Bell
4:38:20 PM Debate
4:38:40 PM Chair Bean
4:39:09 PM Sen Bradley close on SB 1496
4:39:43 PM Vote for final passage
4:39:51 PM SB 1496 Reported Favorably
4:40:06 PM Tab 6- SB 1034 (Simmons)
4:40:31 PM SB 1034- Diane LA to answer questions
4:40:53 PM Diane waive close
4:41:09 PM Vote for final passage of SB 1034
4:41:21 PM SB 1034 Reported favorably
4:41:38 PM Tab 4- SM 938 (Benaquisto) "Retail Sale of Dextromethorphan"
4:41:43 PM Legislative Aide, Mia, presents
4:42:06 PM Strike-all Amendment 854382- (Courtesy by Galvano) explained by Mia L.A.
4:42:51 PM Chair Bean question
4:43:00 PM Amendment 854382 adopted
4:43:46 PM Bill as amendmend, public testimony
4:43:54 PM Chris Hanson- Bayer Corp.- Waive in support
4:44:01 PM Sean Moore- Consumer Healthcare Products Assoc- Speaking in support
4:44:51 PM Sen Sobel question
4:45:41 PM Chair Bean
4:46:07 PM Debate, none
4:46:13 PM Waive close
4:46:17 PM SEn Garcia move to consider SB 938 as CS
4:46:24 PM Vote for final passage
4:46:39 PM CS SB 938 Reported favorably
4:46:49 PM Tab 2- SB 212 (Gaetz)- "Recovery Care Services"
4:46:59 PM Sen Gaetz introduces SB 212
4:47:21 PM Sen Gaetz presents Strike-all Amendment 974206
4:49:15 PM Sen Garcia presents Amendment 539582 (to amendment)
4:50:06 PM Melissa Fausz- Americans for Prosperity- Speaking against amendment
4:51:41 PM Sen Joyner question
4:52:16 PM Melissa Fausz
4:52:24 PM Sen Gaetz on amendment
4:53:34 PM Amendment 539582 adopted
4:53:40 PM Questions Amendment 974206, as amended
4:53:50 PM Sen Joyner
4:53:59 PM Chair Bean
4:54:00 PM Sen Joyner
4:54:10 PM Sen Gaetz
4:55:00 PM Sen Joyner follow up
4:55:11 PM Sen Gaetz
4:55:30 PM Sen Joyner
4:56:34 PM Sen Gaetz
4:56:43 PM Sen Joyner, continued follow up
4:57:22 PM Sen Gaetz
4:58:27 PM Sen Joyner
4:58:47 PM Sen Gaetz
4:59:54 PM Sen Joyner
5:00:46 PM Sen Gaetz
5:01:15 PM Sen Joyner

5:01:41 PM Sen Gaetz
5:02:02 PM Sen Braynon
5:02:07 PM Strike all amendment 974206, Adopted
5:02:21 PM Public testimony, SB 212 as amended
5:02:26 PM Melissa Fausz- Americans for Prosperity- Waive in support
5:02:32 PM Kathleen Myers-Director of Operations for SCA- Speak in support
5:05:13 PM John McCutchen MD- Retired physician- Speaking in support
5:08:56 PM David Shapiro- FL Society of Ambulatory Surgical Centers- Speaking in support
5:12:29 PM Sen Joyner question
5:13:45 PM David Shapiro
5:14:15 PM Michael Madewell- Panama City Surgery- Speak in support
5:18:04 PM Fraser Cobbe- FL Orthopedic Society- Waive in support
5:18:35 PM Bill Bell- FL Hospital Assoc- Speak against
5:19:50 PM Debate
5:20:02 PM Sen Braynon
5:20:23 PM Sen Grimsley
5:22:00 PM Sen Flores moves for SB 212 to be considered as CS
5:23:11 PM Sen Sobel, debate
5:23:28 PM Chair Bean
5:23:59 PM Sen Braynon
5:24:42 PM Sen Gaetz, Close
5:25:11 PM Vote for final passage
5:25:18 PM CS SB 212 Reported favorably
5:25:35 PM Sen Gaetz, Sen Joyner request to be reported for favorable votes
5:26:02 PM Braynon move to rise
5:26:05 PM Meeting adjourned